"Effectiveness of Multi-Modal Intervention regarding Health Promotion on Perception and Quality of Life among Geriatric Clients seeking Medical services at selected Hospitals, Kolar"

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For the requirement of a Degree

DOCTOR OF PHILOSOPHY (Ph.D.)

In

COMMUNITY HEALTH NURSING

Under the Faculty of Nursing

By

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TAMAKA, KOLAR

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I hereby declare that the Research thesis entitled **"Effectiveness of Multi-Modal Intervention regarding Health Promotion on Perception and Quality of Life among Geriatric Clients seeking Medical Services at Selected Hospitals, Kolar".** Is a bonafide and genuine research work carried out and submitted for the fulfillment of the requirement for the Doctor of Philosophy in the Department of Community Health Nursing under the guidance of **Dr. Zeanath Cariena. J**, Research supervisor, Professor, HOD, Department of Medical-Surgical Nursing, Sri Devaraj Urs College of Nursing, CNO(Add. Charge) at RLJH&RC, SDUAHER, Tamaka, Kolar, declare that the material in this thesis has not formed in any way, the basis for the award of any degree, diploma, or fellowship previously of this university or any other university.

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- ***Mrs. Vani.R***

LIST OF ABBREVIATIONS

ABBREVIATIONS	EXPANSIONS
ANOVA	Analysis of Variance
CDC	Centers For Disease Control and Prevention
CEC	Central Ethics Committee
CI	Confidence Interval
CINHAL	Cumulated Index to Nursing and Allied Health Literature
DV	Dependent Variable
ERIC	Education Resources Information Center
ICF	Informed Consent Form
LCD	Liquid-Crystal Display
MEDLINE	Medical Literature Analysis and Retrieval System Online
MMI	Multimodal Intervention
NS	Not Significant
OR	Odds Ratio
PIS	Participant Information sheet
PPT	PowerPoint Presentation
QOL/QoL	Quality of Life
RMANOVA	Repeated Measures of Analysis of Variance
SD	Standard Deviation
SPSS	SPSS Statistical Package for Social Sciences
SS	Statistically Significant
WHO	World Health Organisation

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ABSTRACT

Introduction: Old age is a privilege for a second childhood and a new stage of opportunity and strength. Older adults are the most rapidly growing segment of the population. By 2050, 80% of all older people will live in low- and middle-income countries.

Aim: To evaluate the effectiveness of Multimodal intervention on Perception and Quality of Life among geriatric clients.

Methods: Quantitative approach Quasi-Experimental nonrandomized control group with pre-test post-test design and follow-up study was adopted by using purposive sampling technique among 120 geriatric clients who gave consent for participation in the study at two different settings of hospitals from July 2022 to January 2023, Kolar. After obtaining ethical approval, data was collected using the structured perception &WHOQOL questionnaire. The Multimodal Intervention package consisting of a Snake & Ladder health promotion strategies game, Educational Video, and Informational pamphlet was distributed to the experimental group. In contrast, routine care was given to the Control group followed by Posttest on the 30^{th} day & 60^{th} day. The investigator carried out reinforcement on a fortnightly basis reminders through messages. Data were analyzed by using Descriptive & Inferential statistics such as RMANOVA, Independent 't'-test, Paired't-test, and Chi-square.

Results: The mean post-test perception scores were significantly higher than the pretest perception scores(mean ± SD post-test 1=46.35 ±6.1, post-test 2=48.33 ±4.7) after the multimodal intervention, among the geriatric clients in the experimental group, However in the control group there were no significant differences observed from pretest and posttest mean perception scores

Concerning the quality of life in the experimental group, the mean QOL scores was significantly higher during both posttests (mean ± SD post-test 1=74.11 ± 6.7, post-test 2=77.7± 4.99) after the multimodal intervention, However in the control group there were no significant differences observed from pretest and posttest mean the quality of life scores.

Thus, as per the findings of the study the multimodal intervention was proven to be very effective intervention in increasing the perception and quality of life regarding health promotion among geriatric clients.

Conclusion: Geriatric population was the biggest beneficiary, Multimodal Intervention was proven to be effective in improving the perception and Quality of life of geriatric clients to foster healthy aging.

CTRI Trial Reg no: CTRI/2021/07/034632

Key terms: Geriatric, Multimodal Intervention, Health Promotion.

CHAPTER -I

INTRODUCTION

CHAPTER –I

INTRODUCTION

Health is universal, and a country's ability to maintain its citizens' health is a measure of its strength. To fulfill fundamental requirements and lead a happy life, one must be in good health. Encouraging everyone to lead a healthy life is a global objective. The concept of health encompasses multiple dimensions, including biological, social, economic, psychological, and cultural aspects. [(1)]

To promote health through the adoption of healthy behaviors and the improvement of quality of life, health promotion methods are essential. The process of empowering people and communities to take charge of their health and make improvements is known as health promotion. Activities, plans, and treatments aimed at preserving or enhancing people's physical, mental, emotional, and social well-being are referred to as health promotion measures. [(2)]

According to the United Nations 2023**,** there are approximately 1.1 billion people aged 60 years or older worldwide, making up about 14% of the global population. By 2050, the number of older persons globally is expected to double, reaching 2.1 billion which accounts for nearly 22% of the global population**.** [(3)]

Health promotion initiatives have historically been ignored by the senior population. Strategies for health promotion aimed at the elderly population are very different from those for the younger population. To support independence, improve quality of life, and prolong a healthy lifespan, health promotion among the elderly is crucial. [(3)]

Life in an aging society is truly a novel experience. Aging is a natural phenomenon with opportunities and challenges. Aging cannot be prevented, but we can learn how to deal with rising conditions to achieve greater health among geriatric to lead a healthy life by

understanding their needs and concerns, lending emotional support & to keep them humorous, which is inevitably the ideal way to enhance a higher quality of life. [4]

Old age is a privilege for a second childhood and a new stage of opportunity and strength. Older adults are the most rapidly growing segment of the population. By 2050, 80% of all older people will live in low- and middle-income countries. A man's life is normally divided into five stages: infancy, childhood, adolescence, adulthood, and old age. In each of these stages, an individual has to adapt himself to different situations and different problems. Health promotion and disease prevention are emerging themes in the area of geriatric and health care. [4]

Geriatric care refers to medical attention for older adults. “Older” is preferred over "elderly," however, both are imprecise. Geriatric is considered as above 65 years of age in developed countries and 60years & above in developing countries. [4]

“International Day for Elderly” (UN) is celebrated every year on 1st October. The theme for 2024 -is "Ageing with Dignity: The Importance of Strengthening Care and Support Systems for Older Persons Worldwide”. It highlights the importance of improving healthcare, expanding training in geriatrics, and the need for policies that protect the human rights of older people. [5]

Factors influencing healthy aging and holistic health promotion-related needs in older people include Gratification (Purpose-Pleasure-Dignity), Connection (Self- spirit -Family, Society- Culture- Environment), and Physiological Balance (Respiration-Circulation-Nutrition-Hydration-Elimination-Movement-Rest-comfort-Immunity-Risk Reduction). [5]

As stated by, the United Nations Population Fund (UNFPA) 2023 India Ageing Report, India is experiencing a significant demographic shift, with its elderly population growing rapidly. Currently, about 10.5% of India's total population is aged 60 years or older, and is projected to rise to over 20% by 2050. This growth is driven by a combination of increased life expectancy and declining fertility rates. The number of people aged 80 and above is expected to grow by nearly 279% between 2022 and 2050. [6]

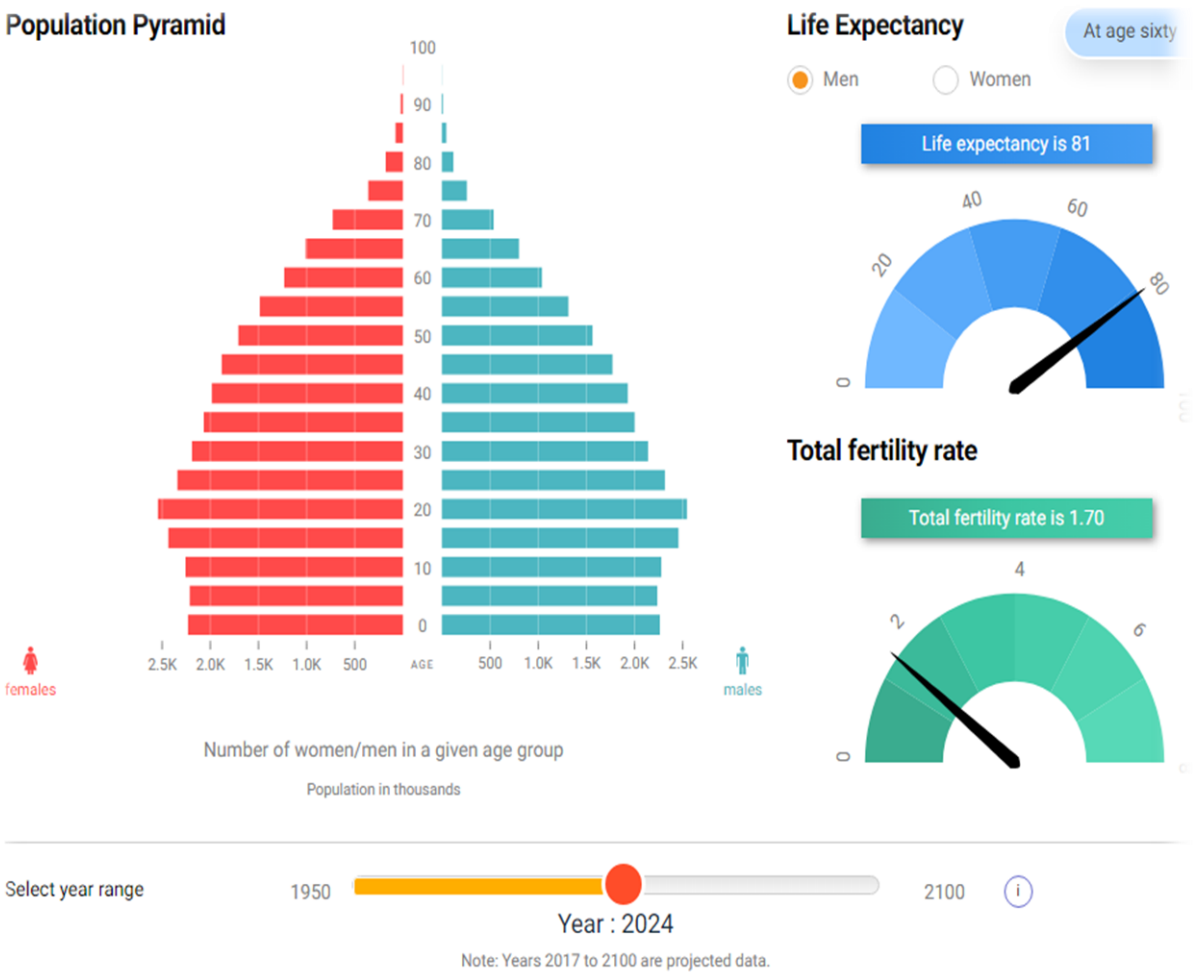


Fig:1 Depicts the demographic population pyramid of males and females-Geriatrics (United Nations Population Fund 2024)

As per the National Health Systems Resource Centre 2023, the elderly population in Karnataka constitutes approximately 11.5% of the state's total population. This reflects the growing demographic of people aged 60 years and above facing the challenges related to healthcare access, disability, and social security. (6)

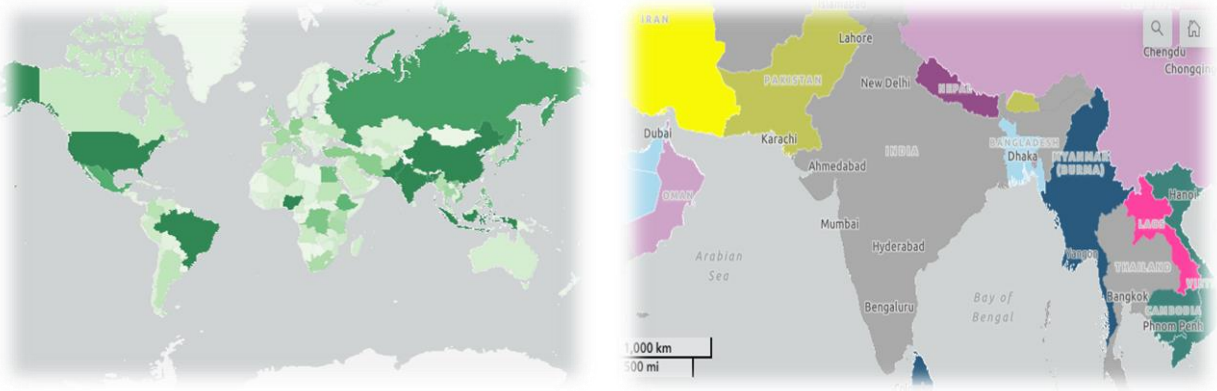


Fig:2&3 Depict the census report of global, Indian, and Karnataka-Geriatrics

(United Nations Population Fund 2021)

A systematic study was conducted to address the health needs of the elderly population, healthcare utilization, and healthcare expenditure. Out of 74 studies results report, that high health spending among the elderly coupled with the absence of insurance coverage exposes the elderly, particularly those belonging to lower socio-economic strata. The study also recommends addressing the health inequities among the elderly in India and efforts are required at the micro level to promote expansion in insurance coverage and provision of good-quality, subsidized, public health facilities. (7)

The Centers for Disease Control and Prevention (CDC) has released its trend analysis findings regarding older adults. These findings indicate that a significant number of older adults do not have the recommended access to preventive care, physical activity is low, 7% of older adults experience food insecurity, and chronic and psychological conditions frequently result in poor health outcomes for older adults. (8)

A study was investigated to assess the effects of health promotion programs on healthy aging, well-being, and health-promoting behavior among community-dwelling older adults. Four randomly selected health centers in Mansoura District, Egypt. The tools used were a structured interview questionnaire and, a healthy aging instrument (HAI). The results of the study represent that, all healthy aging factors, well-being domains, and health promoting behavior dimensions of the study group showed significant improvement after the health promotion program implementation ($p < 0.0001$). This study concludes that health promotion strategies have a positive effect on older adults' healthy aging, well-being, and health-promoting behavior. [9]

Disease prevention and Health promotion are important aspects of health of the older individuals. Up to 70% of all diseases are partially or preventable by quality Health promotional nursing interventions vis-à-vis lifestyle modification, risk factor management, and primary or secondary preventive practices. [9]

Nurses are in a pivotal role in providing the health promotion approach to emphasize the importance of lifestyle and personal behavior modifications required for maintaining and functioning optimal health status among geriatrics. It also provides nurses with information regarding the degree to which behavior modification and healthcare interventions can be successful in promoting health and averting illness. The current status of the quality of life for aging individuals in India reflects a mix of challenges. Thus, the key areas of improvement essential to enhance Quality of life among geriatrics include healthcare access, economic security, social participation, mental health, government policies, technology adoption, and community support.

The idea behind these strategies is to contribute to a longer, independent, and self-sufficient Quality of life.

NEED FOR THE STUDY

Surviving old age is an excellent accomplishment to have competence by satisfying all of these essential life necessities such as acquiring appropriate nourishment, staying generally safe, and sustaining the body's regular functioning. [10]

The crucial statistics of aging as per the WHO report 2021, indicates that, between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12% to 22%. Also by 2020, the number of people aged 60 years and older will outnumber children younger than 5 years. [11] In 2050 80% of older people will be living in low- and middle-income countries. Globally, people are living longer lifetimes. Nowadays, the majority of people may anticipate living into their sixties or later. [12]

India's elderly population (aged 60 and above) is projected to touch 194 million in 2031 from 138 million in 2021- National Statistical Office (NSO) elderly in India 2021. [12] In India life expectancy at birth, increased by about 20 years in the past 5 decades. In Karnataka, out of 5.5 crores of population, 8% are elderly citizens. [13]

A statistical study entitled "Older in India" 2021, recently issued by the National Statistics Office, depicts that the reliance ratio for the elderly has risen from 10.9 percent in 1961 to 14.2 percent in 2011. It arouse to 15.7% in 2021, it would rise to 20 % by 2031. By 2050, almost '38 percent of 1 billion elderly' (60 years and above) will reside in India and China alone (United Nations, 2011). Among them, 432 and 330 million of the elderly population will belong to China and India, respectively (United Nations, 2007). [13]

The National Programme of Health Care for the Elderly (NPHCE), the Government of India (GOI) offers numerous preventative, curative, and rehabilitative treatments to adults over the age of 60. The primary goal of the NPHCE initiative is to identify health concerns in the elderly and provide suitable health interventions in the community with referral services

to hospitals. It also provides older residents with privileges like insurance for health initiatives, tax exemptions, and discounts on train and plane prices. [13]

Based on the literary review, a mixed-method Quasi-experimental pilot study was conducted to assess educational Intervention to improve citizens' healthcare perception in rural Japanese Communities. Social & cognitive theory based educational interventions and semi-structured interviews were conducted among Japanese elderly (>65 years) from rural communities. Propensity score matching was performed and Interview contents were transcribed verbatim and analyzed based on thematic analysis. The intervention group scored significantly higher than the control group. Interviews revealed three themes: the ability to manage health conditions, the relationship with medical professionals, and the relationship among citizens. The findings suggest that educational interventions can positively impact rural citizens' self-efficacy in healthcare participation. [14]

Randomized controlled trials were conducted to assess the effectiveness of Life Review Therapy on Quality of Life in the daycare centers of Shiraz, Iran, with a pre-posttest design from April to Aug 2021 among 35 members randomly assigned to two groups. The experimental group attended 8 two-hour sessions of life review therapy. The QOL of the elderly participants was evaluated before, immediately, one month, and three months after the intervention using the quality of life questionnaire (WHOQOL_BREF). Data analysis was conducted through SPSS version 22. The study showed that life review therapy significantly improved the QOL of the elderly and recommended employing this convenient intervention to promote QOL. [15]

A descriptive awareness survey was carried out in 2020 among the elderly through an accidental sampling technique. Data was collected using a structured questionnaire from 385 respondents after which it was analyzed by descriptive & inferential statistics. Of 57% of

respondents had a moderate level of awareness regarding Health promotion measures & services for the elderly and 39% of the respondent's level of awareness was poor. Thus, there is low awareness regarding Health promotion measures & health services. It may impact adversely health status and quality of life among the elderly. Hence there is an urgent need to undertake actions to spread awareness regarding Health promotion measures among elderly people. [16]

In addition to direct care providers, nurses also play a crucial role in empowering older people by enhancing their capacity for self-care, removing or minimizing barriers, and engaging in counseling, communication, collaboration, and teaching in ways that uphold ethical standards, professionalism, and compassion. [17]

Health promotion is a critical aspect of improving the quality of life for the elderly. While there has been significant research on various health interventions, a comprehensive holistic health approach to outcomes remains underexplored.

Research gaps/lacunae of the study:

Often many of the literature reviews and studies highlight a significant underrepresentation of holistic health and have concentrated on specific health aspects, such as physical activity, and nutritional interventions, there is a noticeable gap in research that integrates physical, mental, social, and spiritual wellbeing which is essential for enhanced quality of life. The elderly represent a growing demographic-increasing population, their unique health needs are often ignored and underfunded, resulting in preventable illnesses, diminished quality of life, and undue suffering. To overlook this segment of the population, who have contributed to society their entire lives, is an indictment of our current public health priorities. The failure to prioritize health promotion in older adults not only burdens

healthcare systems but also perpetuates ageism, a dangerous societal ill that devalues the lives of the elderly. Much of the research has focused on younger populations or acute care for the elderly. This study fills the gap by promoting healthy practices that prevent or delay age-related associated illnesses.

Motivation for the study:

Geriatric populations are expanding globally and addressing their health needs is essential to reduce the strain on healthcare systems. By conducting research into health promotion for older adults, as a researcher it can directly impact policy and practices, leading to healthier aging populations and reducing long-term healthcare costs. It is an ethical duty to focus on vulnerable populations of geriatrics, who are the most neglected. Many healthcare systems prioritize acute care, neglecting the ongoing preventative needs of older adults. There's often a lack of geriatric-specific health policies or programs. Society may undervalue the importance of promoting health in older populations. Many regions lack adequate public health infrastructure to support older adults in preventative health, resulting in missed opportunities to enhance longevity and quality of life. There is an urgent need to emphasize telehealth services. They deserve to age with dignity, and it's our prime responsibility to provide evidence-based interventions that improve quality of life.

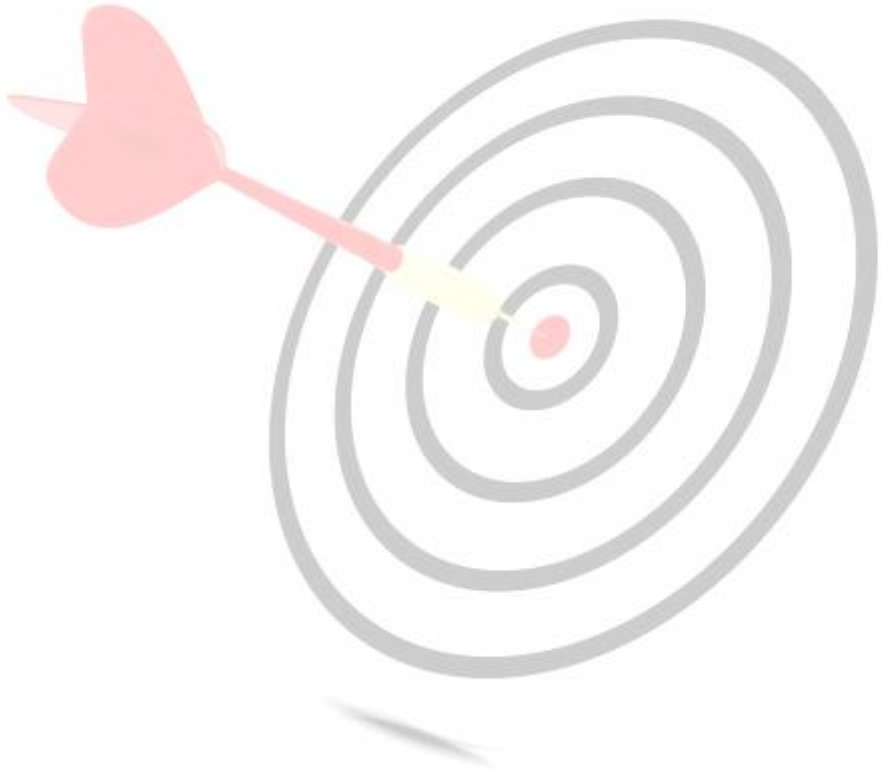
Based on the preliminary survey, researcher experience & literature gaps, the geriatrics were found to have compromised Quality of life thus, the researcher strongly felt the need to address these research gaps by initiating and implementing holistic health promotion preventive strategies by developing the multimodal intervention package which consists of Informational pamphlet, snake ladder game and video teachings highlighting on the concepts of physical activity, nutrition, social participation, fall prevention, pain and stress management, medication and follow up regimen and health schemes among geriatrics.

This study provides valuable insights to enhance the perception and Quality of Life of a super-aged healthy society and to create opportunities to foster healthy aging.

The background of the study, its genesis, and the importance and need of the study have all been covered in this chapter.

CHAPTER –II

OBJECTIVES



CHAPTER –II

OBJECTIVES

This chapter covers the research questions, aim of the study, research problem statement, objectives of the research, hypotheses, operational definitions, and conceptual framework of the study.

RESEARCH QUESTIONS:

1. Does Multi-Modal Intervention affect the Perception and Quality of Life of geriatric clients seeking medical services regarding health Promotion at selected Hospitals in Kolar?
2. How the geriatric clients 'Perceptions and Quality of life regarding health promotion vary after the Multimodal Intervention at selected hospitals in Kolar?

AIM OF THE STUDY:

To explore the Perception and Quality of life among geriatric clients and the impact of Multimodal Intervention regarding Health promotion in improving their perception and Quality of Life.

STATEMENT OF THE PROBLEM:

"Effectiveness of Multi-Modal Intervention regarding Health Promotion on Perception and Quality of Life among Geriatric Clients seeking Medical services at selected Hospitals, Kolar**"**.

OBJECTIVES OF THE STUDY:

1. To assess the perception and quality of life regarding health promotion among geriatric clients in the experimental & control group.
2. To evaluate the effectiveness of multi-modal intervention regarding health promotion on perception and quality of life among geriatric clients by comparing the pre and post-test scores in both experimental and control groups.
3. To find the correlation between Perception & Quality of life among geriatric clients in the experimental and control groups.
4. To determine the association on the pretest level of perception and quality of life with selected socio-demographic variables of geriatric clients in the experimental and control groups.

HYPOTHESES: The hypotheses were tested at a significance level of 0.05

H_1: There is a statistically significant difference in the mean pretest & posttest scores of perception & QOL among geriatric clients within the groups.

H_2: There is a significant difference in the mean post-test scores of perception & QOL among geriatric clients between the experimental & control group.

H_3: There is a significant correlation between perception and QOL scores among geriatric clients.

H_4: There is a significant association between perception scores with selected demographic variables.

H_5: There is a significant association between Quality of life scores with selected socio-demographic variables.

OPERATIONAL DEFINITIONS

1. **Effectiveness:** In this study, effectiveness refers to the extent to which the multimodal interventions have achieved the desired effect and is measured in terms of enhancement in perception and Quality of life scores by using the structured perception questionnaire & WHOQOL scale among geriatric clients.

2. **Multi-Modal Intervention:** In this study, multi-modal intervention refers to a comprehensive holistic approach developed by the researcher specifying a set of nursing care strategies designed to improve perception and QOL regarding health promotion outcomes consisting of an educational intervention package as multi-modal intervention (MMI) which was provided to the experimental group after the pretest. The multimodal intervention strategies implemented for the experimental group included

   - **Building rapport-** building rapport by collecting baseline information through communication.
   - **Information pamphlet** -Followed by the distribution of an Informational Pamphlet regarding health promotional strategies emphasizing the concepts of physical activity, nutrition, exercise, socialization, fall prevention, pain & medication management, spirituality, health schemes, and the role of nurse & caregiver.
   - **Snake ladder game** - Thereafter the group of geriatric clients was given guidance to play the Snake and Ladder Game to understand the components promoting healthy behaviors represented as a ladder and health declining components as a snake.
   - **Video Teaching sessions-** Finally, the video teaching session regarding health promotion measures through PowerPoint presentation was given to one basis for total duration of the intervention was (30-35) minutes. Fortnightly mobile reminders were sent to geriatric clients throughout the study and doubts were clarified.

3. **Health promotion:** In this study Health promotion refers to the improvements in multidimensional aspects of care among geriatric clients, which is assessed through improvements in perception scores and Quality of life scores before and after the Intervention in the experimental & control group.

4. **Perception:** In this study, Perception refers to the geriatric beliefs, views, and feelings on health promotion activities, which is measured by using a five-point Likert scale.

5. **Quality of Life:** This study, refers to the subjective response of geriatric clients on the perceived well-being of an individual in physical, mental, emotional, and social aspects, role limitations & vitality as measured by using a modified WHO Quality of Life questionnaire.

6. **Geriatric clients:** refers to clients with an age group of 60-65 years seeking medical services in inpatient departments of selected health care services who can speak and understand Kannada or English.

ASSUMPTIONS:

1. Geriatric clients may have some favorable perceptions and moderate QOL toward health promotional outcomes.
2. Multimodal Intervention may have an impact on enhancing geriatric clients' perception and QOL toward health promotion outcomes.
3. Multimodal intervention may result in lifestyle & behavioral change measurability among geriatric clients that facilitate the acquisition of favorable perceptions and QOL to promote health measures.

DELIMITATIONS:

The following limitations were recognized for the study

1. The study was limited to describing the effectiveness of multimodal intervention regarding health promotion outcomes and quality of life.
2. The study was limited to geriatric clients between the age group of 60- 75 years admitted in Inpatient departments of selected hospitals, Kolar.
3. The study was limited to Quasi-experimental research design only.

CONCEPTUAL FRAMEWORK OF THE STUDY:

A concept is an abstract idea or mental image of a phenomenon or reality. Conceptualization is a process of forming ideas, which utilizes and forms the conceptual framework for the development of research design. A framework is a basic structure that gives a clear picture for logical thinking, systematic observation, and interpreting the observed data or phenomenon. [18]

The conceptual framework deals with abstractions that are assembled by their relevance to a common theme. The most important purpose of the theoretical framework is to communicate the relationship of various concepts. The conceptual framework facilitates communication and provides the basis for a systematic approach to nursing, research, education, administration, and practice.

The conceptual framework selected for this study is the **Health Promotion Model.** This model is proposed by **Nola Pender** (revised in 2002) and it is designed to be a "complimentary counterpart to models of health protection. The health promotion model is a competence/approach-oriented model. The Health Promotion Model is directed at increasing a geriatric client's level of well-being.

The Health Promotion Model describes the multi-dimensional nature of persons as they interact within their environment to pursue health. The model focuses on the following three areas,

1) Individual characteristics and experiences

2) Behavioral-specific cognition and affect,

3) Behavioral outcomes.

The Health Promotion Model notes that each person has unique personal characteristics and experiences that affect subsequent actions. The set of variables for behavioral-specific knowledge and affect have important motivational significance. These variables can be modified through nursing actions. Health-promoting behavior is the desired outcome and is the endpoint in the HPM. (Potter, A. Patricia.2005).

Health-promoting behavior should result in improved health, enhanced functional ability, and better quality of life at all stages of development. This model is selected for the study, as it measures the effectiveness of multimodal intervention regarding health promotion to enhance favorable perception and improve QOL among geriatric clients.

In this study, the Individual Characteristics and Experiences are depicted by the personal background of selected variables of geriatric clients like age (in years), gender, educational status, religion, marital status, residence, socioeconomic status, type of family, history of comorbidity, history of health checkup. Also the Bio physiological parameters like nutritional status, visual acuity, hearing acuity, activities of daily living, sleep pattern, bowel pattern, bladder pattern, personal habits, status of financial dependence, and physical activities.

The Behavior Specific Cognition and effect in this study refers to the implementation of pre-test and post-test for both the Experimental and Control groups, and it also includes the implementation of a Multimodal intervention package consisting of an informational pamphlet, snake ladder game, and video teaching sessions focusing on the components of physical activity, nutrition, stress and pain management, social participation, fall prevention preventive measures, medication, health schemes to the geriatric clients of the experimental group. The behavior-specific cognition is represented as the change in the level of perception and behavior-specific modification with improved QOL.

The Behavioral Outcome in this study is represented by positive health promotion outcomes among geriatric clients, i.e., enhanced perception towards aging and higher QOL with functional ability as measured by a structured perception questionnaire and WHOQOL tool using five point Likert scale.

This chapter focused on the research questions, aim, problem statement, objectives, hypotheses, operational definitions, assumptions, delimitations, and conceptual framework.

CONCEPTUAL FRAMEWORK OF THE STUDY

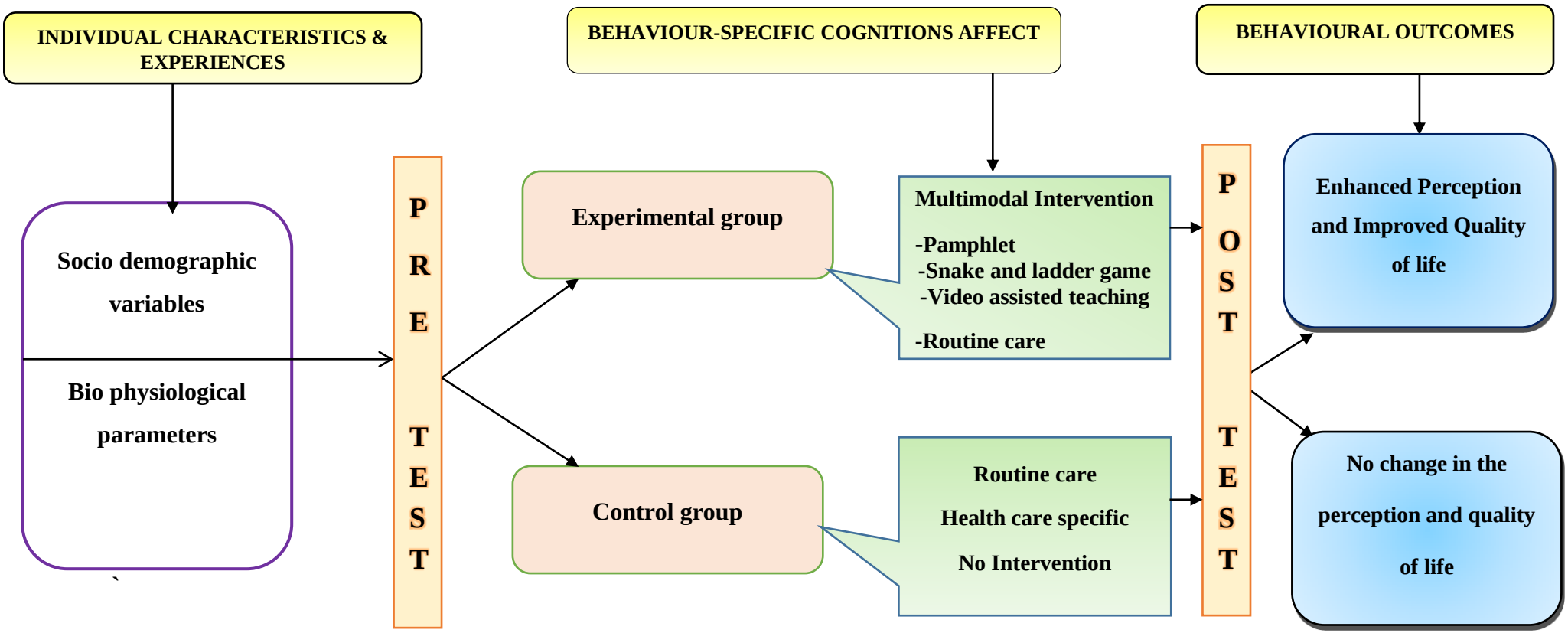


Fig 4: Modified conceptual framework based on Nola Pender Health promotion Model 1982 (revised in 2002)

CHAPTER –III

REVIEW OF LITERATURE

CHAPTER –III

REVIEW OF LITERATURE

This chapter presents a review of the literature related to the research topic. The review helped the investigator develop a deeper insight into the concept of Health Promotion, Multimodal Intervention, Perception, and Quality of life of geriatric clients in gaining information on the trends in various related studies in this area.

A review of the literature helps and guides the investigator to design the study systematically to achieve the desired outcome.

The literature reviewed for the present study has been organized under the following headings among geriatric clients:

1. Literature related to the effectiveness of Intervention regarding health promotion
2. Literature related to the perception of geriatric clients regarding health promotion
3. Literature related to Quality of life among geriatric clients regarding health promotion

1. Literature related to the effectiveness of Intervention regarding health promotion among geriatric clients

An integrative review of the literature was performed to identify interventions for the health promotion of frail elderly individuals and those at risk of frailty, in the following databases: LILACS, CINAHL, MEDLINE, Web of Science, COCHRANE, and Scopus, using the descriptors "frail elderly", "aging", "health services for the aged" and "health promotion" combined with Boolean operators "AND" and "OR". Randomized controlled clinical trials (RCTs) classified as level of evidence II represented 82.6% of studies. Interventions were analyzed according to the following categories: Interventions for the

elderly at risk of frailty and Interventions for the frail elderly and identified educational multi-professional group meetings, physical training, home visit/home care programs, nutrition assessment and supplementation, health maintenance programs, and cognitive training; models/programs of management and monitoring, use of assistive technology devices and hospitalization program for geriatric rehabilitation. [19]

A Meta-Analysis research was carried out intending to evaluate the effectiveness of intervention programs that aim to enhance the well-being of grandparent caregivers and the developmental outcomes of grandchildren. A comprehensive literature search of electronic databases and a random effects model was used to calculate effect sizes. 20 studies were included and published in and before April 2018. The review indicates that interventions for grandparent caregivers have positive effects regarding various well-being outcomes. Supportive and educational components could contribute to a promising intervention. The implementation of interventions for grandparents requires ongoing research efforts to obtain high-quality evidence for program effectiveness. The study suggests that future research be conducted to develop tailored interventions to meet the needs of different grandparent caregivers. [20]

A cluster- randomized controlled trial conducted on comprehensive geriatric intervention in community- dwelling older adults among 526 participants was randomized into one of two groups (CS 251, HB 275) based on their residential districts. And conducted a 12-week CGIP, which consisted of low- load resistance exercise, physical activity, oral function improvements, and a nutritional guide. All participants were encouraged to attend two 90-minute lectures that included instructions on the CGIP. The CS group attended 90-minute weekly sessions and independently executed the

program on other days, whereas the HB group only received instructions on how to execute the program. Physical functions, such as knee extension strength (KES), normal and maximum walking speed, and anterior thigh muscle thickness (MT), were measured and analyzed using intention- to- treat analysis before and after the 12-week intervention. Of the 526 participants identified, 517 (CS 243 age 74.0 ± 5.4 women 57.2%, HB 274 age 74.0 ± 5.6 women 58.8%) were enrolled. Both interventions significantly improved KES (CS 18.5%, HB 10.6%), normal walking speed (CS 3.7%, HB 2.8%), and MT (CS 3.2%, HB 3.5%). Greater improvement of KES was observed in the CS group (P = 0.003). Maximum walking speed (CS 4.7%, HB 1.8%; P = 0.001) significantly improved in the CS group only. The study suggests that HB intervention is cost- effective and may help prevent frailty in the large older population. [21]

An Efficacy of Bingocize**:** a game-centered mobile app study carried out to improve Physical and Cognitive Performance in Western Kentucky University in Older adults that can combine bingo with healthy activities such as exercise and/or health topic education, could (1) engender high rates of adherence among sedentary community-dwelling older adults, and (2) potentially improve aspects of physical and cognitive performance. Participants used the app for ∼1 hour, twice per week, for 10 weeks. Each using a tablet, they played the game in small social groups and were randomly assigned to either an Experimental (Bingo + Health Education + Exercise) or Control (Bingo + Health Education) group. Pre- and Post-intervention assessments of (1) functional performance, (2) fluid cognition, and (3) knowledge of two health topics (osteoarthritis and fall risks) were administered. Adherence was high in both groups (>93% attendance), suggesting the app was popular and engaging such that the Experimental group improved more relative to the Control group. Both groups improved their knowledge of the health topics

covered (all $P < 0.05$). The findings suggest that the fun and interactive nature of Bingocize® engenders high levels of adherence to a health-promoting program to improve the quality of life for older adults. [22]

An umbrella review (UR) summarized the findings of all current systematic reviews (SRs) and Meta-analyzes (MAs) on the effectiveness of a nutritional intervention designed to promote healthy aging in older individuals. Eligible articles published in English or Italian between January 2000 and May 2016 were identified in six databases. Several interventions, ranging from the prescription of supplements to environmental and organizational programs, resulted in an improvement in energy and protein intake, as well as positive weight outcomes. Positive findings were also found for the elderly at risk of malnutrition and for older patients with dementia. The findings of this UR indicate that the use of a wide range of supplements and environmental and organizational interventions improve some anthropometric, nutritional, and functional indices in the elderly. [23]

A systematic review and meta-analysis to estimate the effectiveness of a group-based Otago exercise program on physical function, frailty, and health status in older nursing home residents. Subgroup analysis was performed to identify the influences of the participant and intervention characteristics on the effects. The finding of the study found that twelve studies met the eligibility criteria and were included in this meta-analysis, and the overall quality was relatively high. The results showed that the group-based OEP significantly improved physical function, including mobility [SMD=-0.64, 95% CI (-0.83,-0.45), Z=6.55, p30-minute sessions (p=0.0004). Hence the Group-based OEP helps improve physical function, frailty, and health status in older nursing home residents. [24]

A Scoping review was conducted to identify the classification of health promotion and disease prevention interventions addressed to elderly people. The search strategy included the reviews published from January 2000 to April 2015 based on the identification of interventions reported as health promotion, primary disease prevention, screening, or social support. Out of 334 systematic reviews addressed -182 of them assessed interventions belonging to health promotion, 219 to primary prevention, 34 to screening, and 35 to social support. The study reveals that more emphasis is required on the area of health promotion including Health education, Behavior modification, and Health communication. [25]

A Randomized controlled trial conducted to assess the effect of health promotion interventions in active aging in the elderly was carried out from September to December 2021. Among 60 elderly individuals without disabling diseases and cognitive impairment they presented to the Daneshamooz Health Center in Mashhad in 2021. Through a simple block allocation scheme, the intervention group received the health promotion program during 6 sessions (one session per week) about nutrition, physical activity, responsibility, stress management, communications, and spiritual aspects. The data were gathered using the active aging questionnaire and analyzed using the SPSS software version 25. The results of this study demonstrated that after the intervention, the total active aging score in the intervention group increased significantly (68.5±3 to 85±8.25) ($P<0.001$) and there was a significant difference between the control and intervention groups (68±3.25 to 85±8.25) ($P<0.001$). According to the results, training based on a health-enhancement approach can effectively promote active aging in the elderly. [26]

A systematic review and meta-analysis study was conducted on health promotion interventions for community-dwelling older people with mild or pre-frailty. The study aimed to synthesize randomized controlled trials (RCTs) evaluating home and community-based health promotion interventions for older people with mild/pre-frailty. We searched 20 bibliographic databases and 3 trial registers (January 1990, May 2016) using mild/pre-frailty and associated terms. Included randomized controlled and crossover trials of health promotion interventions for community-dwelling older people (65+ years) with mild/pre-frailty and excluded studies focusing on populations in hospitals, long-term care facilities, or with a specific condition. The risk of bias was assessed by two reviewers using the Cochrane Risk of Bias tool. Included 10 articles reporting on seven trials (total $n = 506$ participants) and included five trials in a meta-analysis. Currently, the evidence base is of insufficient size, quality, and breadth to recommend specific health promotion interventions for older people with mild or pre-frailty. High-quality studies of rigorously developed interventions are needed. [27]

A study investigated a nutrition and exercise intervention and evaluation of telemonitoring. Interventions of exercise in groups showed mixed effects on functioning (no effects on self-reported functioning SMD 0.19 (95% CI -0.57 to 0.95) $n = 3$ studies; positive effects on performance-based functioning SMD 0.37 (95% CI 0.07 to 0.68) $n = 3$ studies). No studies assessed moves to long-term care or hospitalizations. Currently, the evidence base is of insufficient size, quality, and breadth to recommend specific health promotion interventions for older people with mild or pre-frailty. High-quality studies developed interventions are needed. [28]

A retrospective observational population-based study focused on investigating the impact of Intrinsic capacity domains on adverse health outcomes including new activities

of daily living (ADL) dependency, new instrumental activities of daily living (IADL) dependency, and mortality over a 1-year follow-up among 329 older hospitalized patients from Zhejiang Hospital in China. The 5 domains of intrinsic capacity including cognition, locomotion, sensory, vitality, and psychological capacity were assessed at admission. The higher intrinsic capacity composite score indicated the greater amount of functional capacities reserved. Multivariate logistic regression models were used. Results of the study revealed that 69 patients (22.5%) experienced new ADL dependency, 103 patients (33.6%) suffered from new IADL dependency, and 22 patients (6.7%) died. Higher intrinsic capacity composite score at admission was associated with decreased risks of 1-year new ADL dependency (OR = 0.53, 95% CI: 0.40–0.70. The study concludes that Loss of ICs at admission predicted adverse health outcomes including new ADL and IADL dependency and mortality one year after discharge among older hospitalized patients. [29]

A Web-Based Intervention for Loneliness was conducted in Washington, USA, to explore the experiences of vulnerable older adults. Older adult participants in a web-based loneliness intervention (n = 24) participated in semi-structured interviews eliciting feedback about their experience in the program and perceived outcomes. Participants' responses were analyzed using qualitative content analysis. Participants reported fewer negative perceptions of their social skills and future social interactions, gaining new social skills, improved relationships, and increased confidence to initiate and maintain social contact. Findings suggest the efficacy of combining a web-based loneliness intervention with cognitive behavioral therapy and provide implications for future web-based interventions for older adult populations. [30]

A systematic review aims to summarize and update the current knowledge on the effectiveness of the existing interventions for alleviating loneliness and social isolation among older persons. A search of PubMed, ISI Web of Science, SCOPUS, The Cochrane Library, and CINAHL databases was performed. Possible search terms were the following: social isolation, loneliness, old people, intervention, and effectiveness. Eligible studies were published between January 2011 and February 2016 in English or Italian language. Outcome measures in terms of the intervention effects needed to be reported. In total, 15 quantitative and five qualitative studies were ultimately included in this review. Eighteen interventions were reported across the quantitative studies. Six out of 11 group interventions (55%), one out of four mixed interventions (25%), and all three individual interventions reported at least one significant finding related to loneliness or social isolation. Our review suggested that new technologies and community-engaged arts might be seen as promising tools for tackling social isolation and loneliness among older individuals. Future studies need to work on methodological quality and take into consideration the suggestions of the present literature to provide firm evidence. [31]

A Nordic Multi-Professional focus group study exploring, the perspectives on health promotion practice among Older persons. This study aimed to explore a wide spectrum of practitioners' experiences of community-level health promotion targeting older adults in Finland and Sweden. Nine focus group interviews (34 informants) were conducted in 2019–2020. "Seeing the person" emerged as the ideal for health promotion targeting older adults, but this was not always realized in current practice. Barriers related to organizational structures and the practitioner role were identified. However, work methods connected to user involvement and technology-based tools were considered key facilitators, enabling tailored health promotion initiatives. [32]

A study was conducted to explore the direct and indirect associations (i.e., through the extent of the level of loneliness and perceived social support) between internet use for instrumental purposes and the quality of life (QoL) among elderly females and males in Poland. The analysis was based on 2001 face-to-face interviews performed among randomly selected individuals aged ≥65 years from the general population. The collected data was weighted to generalize the study sample for the reference population. The analysis was conducted using multiple linear regression models. The mediation effect was tested according to the Baron and Kenny approach. The obtained results indicate that internet use for instrumental purposes is directly related to a better QOL of the elderly. This positive effect among men also occurs indirectly, through the decrease in loneliness levels as well as the increase in social support scores. It has also been shown that among elderly females, the effect of internet use for instrumental purposes is not related to a better QoL, either directly or indirectly. Hence the study concludes that Internet use for instrumental purposes seems to be important in enhancing a successful life among elderly male adults. The study recommends that practitioners should be aware of the gender differences. [33]

A cross-sectional study was conducted to assess the relationship between Quality of Life and lifestyle health promotion behaviors among 230 retired elderly over 60 years selected by cluster sampling method in Hamadan retirement centers. A standard questionnaire for quality of life and lifestyle was used to collect data. Data were analyzed using SPSS-16 software, chi-square, and correlation analysis. The significance level was considered 5%. Findings Lifestyle in the elderly was undesirable (61.3%), and 38.7% had a moderate quality of life. Physical functioning was the most undesirable aspect of lifestyle, and physical activity was the most undesirable aspect of quality of life. The results of the Chi-squared test showed two significant relationships between lifestyle

status and gender as well as the quality of life with gender ($p<0.001$). The mean of lifestyle and quality of life were significantly different between marital variables ($p<0.001$). The results showed a positive correlation between lifestyle scores and quality of life ($r=0.479$, $p<0.001$). This study recommended that interventions be made to increase lifestyle and quality of life, especially in physical functioning, exercise, and physical activity in the elderly. [34]

2. Literature related to the perception of geriatric clients regarding health promotion

A qualitative study to examine the perceptions and experiences of older people regarding health promotion using a phenomenological design and semi-structured in-depth interviews was conducted with 22 older people in Turkey. Data analysis was carried out according to the Colaizzi's method. The analysis revealed five themes (health-promoting activities, outcome expectations, triggers for activities, supporting factors, and perceived obstacles). Older people emphasized healthy eating, walking, avoiding stress, and having health checkups as health-promoting behaviors. The study findings show that interventions to be developed to improve the health of older people should aim at both cognitive and behavioral changes. Nurses should plan multidisciplinary and community-based interventions to reduce the socioeconomic and environmental factors that prevent older people from participating in health-promoting activities. [35]

A qualitative investigation on the views of senior citizens on leading healthy lives and their interactions with specialists in this area. 18 older persons (between the ages of 55 and 98) residing in the Netherlands participated in semi-structured interviews. The transcripts were examined using a structure analysis technique. The results revealed three key themes: (a) a healthy life: regimens and exercise, (b) enacting good living: adopting and adapting, and (c) engagement with health professionals for healthy living: autonomy

and reciprocity. The study made clear that while promoting healthy living, health practitioners should concentrate on establishing an equitable relationship based on trust and emphasize positive health outcomes like autonomy and being self-sufficient. [36]

A cross-sectional study was to analyze barriers to physical activity in a cohort of older adults, allowing comparisons between men and women, and age groups. 1,937 older adults with a median age of 77 (range 72-93) years (53.3% female) took part in the 7-year follow-up telephone interviews of the getABI cohort. Participants who stated that they did not get enough physical activity were surveyed concerning barriers to physical activity. Multivariate logistic regression analysis was performed to evaluate differences between sexes and age groups. The level of significance (alpha < 0.05) was adjusted for multiple testing according to Bonferroni ($p < .004$). 1,607 (83.0%) participants stated that they were sufficiently physically active. 286 participants rated their physical activity as insufficient. The three most frequently cited barriers were poor health (57.7%), lack of company (43.0%), and lack of interest (36.7%). Lack of opportunities for sports or leisure activities (30.3% vs. 15.6%), and lack of transport (29.0% vs.7.1%) were more frequently stated by female respondents than male respondents. Analyses by age groups revealed that poor health was more frequently considered a barrier to physical activity. The present study provides promotion and intervention strategies that should consider the barriers and tailor measures to the specific needs of older adults to reduce the constraints to physical activity. [37]

A Cross-sectional qualitative study on health promotion among older adults in Austria was conducted to determine the types of attitudes to health promotion among older Austrians. Semi-structured interviews were conducted in a purposive sample consisting of

36 home-dwelling older persons from local communities in the federal province of Salzburg, Austria. Data were analyzed using qualitative content analysis there are three main types of attitudes to health promotion. Fitness-oriented people practiced sports of some type. Users of complementary methods practiced such methods to some degree. These types of attitudes could be further differentiated according to their outcome expectations. In addition to benefits for health, socializing was also an important outcome. Older adults have various attitudes to health promotion, but these are not immutable. The study emphasized on Health promotion programs not restricted to a narrow focus on health but provide the opportunity to socialize and may support older adults in maintaining a healthy lifestyle. [38]

A scoping review method used to review the distribution and trends in health promotion research and explore the use and contribution of eHealth technologies in health promotion in the elderly in six search databases: PubMed, CINAHL, the Cochrane Library, EMBASE, PubPsych, and ERIC (EBSCOhost), and studies published from January 2015 to October 2019, written in English, was included and analyzed. The findings reveal that the amount of literature on promoting health for the elderly has increased, and some specific types of interventions are still favored in current health promotion efforts for older adults. The most commonly used methods were found to be health promotion (n = 322), followed by screening (n = 264), primary prevention (n = 114), and finally social support (n = 72). eHealth technology is also used in health promotion activities to prevent the elderly from falling and to improve home safety, etc. However, the study emphasized that more rigorous research is needed about the application of ehealth technology in areas such as fall prevention, mental health promotion, and home security monitoring. [39]

A comprehensive scoping review literature was conducted on Interventions to address social connectedness and loneliness for older adults. Six electronic databases were searched from inception in July 2015, resulting in 5530 unique records, resulting in a set of 44 studies (reported in 54 articles). Interventions were described or evaluated in 39 studies, and five studies described strategies to affect the loneliness/social connectedness of older adults or their caregivers in a qualitative descriptive study. The studies were often conducted in the United States (38.6%) among community-dwelling (54.5%), cognitively intact (31.8%), and females (86.4%) samples. Few focused on non-white participants (4.5%). Strategies described most often were engaging in purposeful activity and maintaining contact with one's social network. The most frequently described were One-to-One Personal Contact and Group Activity. The study emphasized that Innovative conceptualizations of intervention targets are needed, such as purposeful activity to promote social connectedness among older adults. [40]

A study aimed to explore the relationships between aging attitudes and the outcomes of successful aging among 409 community-dwelling women aged 40–79 years in Australia completed the Reactions to Aging Questionnaire (RAQ), Geriatric Depression Scale, Center of Epidemiological Studies Depression Scale, and Geriatric Anxiety Inventory. Information about medical and mental health diagnoses was collected. The results of the study findings are, overall, aging attitudes and all three RAQ subscales were negatively correlated with scores on measures of depression and anxiety and several medical diagnoses. Unique RAQ domain-specific relationships were found with the number of mental health diagnoses. The findings support the link between aging attitudes and psychological outcomes, the potential clinical value of RAQ attitudinal typologies classification as well as a multidimensional conceptualization of aging attitudes. [41]

A quantitative, quasi-experimental quality improvement project was conducted to improve elderly patient outcomes by using the mobilization of Vulnerable Elders (MOVE) protocol among 234 older adult patients in Pennsylvania. The instruments utilized in this project were the MOVE protocol and the Early Mobilization Assessment Algorithm. Faye Abdellah's twenty-one nursing problems theory and Ian Graham's Knowledge-to-Action cycle provided the scientific underpinnings for this project. Results of the study were Mann-Whitney U was utilized to compare LOS among 234 patients; n = 126 in the pre-implementation group and n = 108 in the post-implementation group, U = 7,615, z = 1.6, p = 0.112, with a small effect size r = 0.11. However, implementation of the MOVE protocol indicated clinical significance evidence by 301 days (n = 94) in which a patient achieved three mobilizations in 24 hours. Results did not demonstrate statistical significance; however, the MOVE protocol promoted patient mobility. Therefore, the findings suggest that continued utilization of the MOVE protocol may enforce the need for mobility to improve LOS. Replication of the project is needed in larger settings and over a longer time. [42]

A Qualitative study aims to explore the needs of older adults and the current adult population which will become older in the coming decades (50–60 years). The study investigates the lifestyles of the target populations focusing on two main areas concerning health (healthy diet; and attitudes towards physical activity) and socio-relational housing and living conditions. 16 in-depth interviews developed over one month (February 2022). The conduct of the interviews was supported by the Italian Center for Sensory Analysis (CIAS). Emerging from the results, the concept of active aging is perceived by mature and older adults positively and optimistically. The sample considered wanting to re-engage in life, continue to be active, and useful, and maintain their self-esteem, social

life, and independence. However, despite older people's major concerns being preserving their physical abilities and social integration, this target group adopts behaviors focused more on current well-being. [43]

A systematic review and synthesized qualitative studies exploring older adults' experiences and perceptions of Immersive virtual reality were conducted following the ENTREQ (Enhancing Transparency in Reporting the Synthesis of Qualitative Research) guidelines. In total, 2 reviewers completed title and abstract screening, full-text screening, data extraction, and quality appraisal. Thematic synthesis is derived from the qualitative method, thematic analysis. It involves 3 key steps: initial coding and grouping of these codes, the formation of descriptive themes from these codes, and going beyond these data to form analytical themes. Overall, 13 studies were included in the final synthesis, including 224 participants across 9 countries and 5 continents. Confidence in the evidence ranged from high to moderate. Three descriptive themes were generated: practical aspects of IVR use, experiencing unique features of IVR, and perceptions of IVR. The findings from the descriptive themes suggested that several improvements need to be made to existing IVR devices to facilitate older adults' use of this technology. The analytical themes illustrated that older adults were willing to tolerate the discomforts that accompany existing IVR technologies to experience features such as immersive social networking. There was a discrepancy between older adults' perceptions of IVR before use which were generally negative and after use which were generally positive and IVR provided a platform for older adults to access certain activities and environments more easily than in the real world because of limitations caused by aging. This review offers insights into older adults' experiences and perceptions of new opportunities for older adults to take part in meaningful activities tailored to their needs and preferences. [44]

3. Literature related to Quality of life among geriatric clients regarding health promotion

The research was done to analyze the Impact of Quality of Life on the Health of Older participants from a Multidimensional Perspective, with a sample size of 500 participants drawn at random from the province of Granada (Spain)'s largest day centers for the elderly. For the inferential evaluation, the CUBRECAVI survey, a scale with multiple dimensions of health and quality of life, as well as the Katz and Garca determine questionnaires, are used to assess the quality of life, with results from the meta-analysis and validation studies indicating that respondents have a favorable opinion of their quality of life, taking into account health, leisure, quality of the environment, ability to function, degree of satisfaction, emotional support, relationships, and wealth. [45]

A study of the literature on the quality of life of older people aging in place was conducted to evaluate if the actual measurement of quality of life can be applied to aging in place. Web of Science, PubMed, CINAHL, Sociological Abstracts, and the Social Science Research Network were used to search for papers on "Ag(e)ing in place" AND "Quality of life." The study's findings indicated that evaluation is critical to a strategy aimed at improving people's quality of life, yet research shows that it is seldom carried out. Only a tiny portion of the research discusses quality-of-life assessments, including the tools employed and the outcomes. The data also show that there is no agreement on how to define the quality of life or any of its domain structures. As a result, the study suggests that, while no current tool measuring the quality of life of older persons aging in place has been discovered, such a tool should be developed, as any policy aimed at this rising population of individuals must be supported by an assessment. [46]

A cross-sectional community-based study investigated the quality of life and its related characteristics among home-dwelling elderly adults in the District of Colombo, Sri Lanka. The multistage cluster selection approach yielded a representative sample (n=723) of older individuals aged >65 years. The validated Sinhala version of the WHOQOL BREF Questionnaire was used to measure QOL. SPSS V.20 was used to analyze the data. The average SD age was 72.2+36.3 years, and the total QOL score was (mean SD) 56.73+12.57/100. The physical well-being, psychological well-being, social interactions, and environment domains had mean SD QOL scores of 55.8+11.80, 59.25+14.68, 46.36+20.08, and 64.61+11.96, respectively. The updated model revealed a substantial positive relationship between total QOL and educational status, living circumstances and participation in religious activities, being visited by friends or family, and financial independence. In the adjusted model, limits in activities of everyday life and instrumental activities of daily living, chronic arthritis, and heart disease were adversely linked with total QOL. The average QOL of Colombo District home-dwelling elderly is modest, with the lowest rating in social connections and the highest in the environment category. [47]

Community-based cross-sectional research was conducted at one of Ahmedabad's educational institutes' urban field practice regions. To understand the state of elderly people's quality of life (QOL), it is necessary to emphasize the physical and psychological issues they experience. A sample size of 250 was computed based on a prevalence of approximately 7.5% of persons aged 60 and over. The World Health Organization produced a predesigned questionnaire relating to the QOL of senior individuals, which was employed. The study's findings showed that the population's mean age was 65.8 years, with a standard deviation of 5 years. Nearly two-thirds of elderly people had married at the time. The list of common morbidities observed among the study population was joint discomfort (42.8%), cataracts

(32.8%), hypertension (22.4%), diabetes mellitus (17.2%), and dental disorders (12.4%). The study reveals that no geriatric had low QOL, whereas 56% had "good" QOL and 50.8% had "excellent" QOL based on the total assessment of the QOL profile. Males had considerably higher QOL across four distinct domains than females. Those who were educated and married and lived with their spouses fared better in the physical, environmental, and psychological realms. [48]

An RCT was conducted in Shiraz, Iran, to examine the impact of life review therapy on the quality of life in old age. 35 participants from an elderly day care center in Shiraz, Iran, who were randomly allocated to two groups (the experimental group and the control group) participated in the study, which was done with a pre-posttest design from April to August 2014. The experimental group's participants went to eight two-hour life review therapy sessions. Using the WHOQOL_BREF quality of life questionnaire, the senior participants' quality of life was assessed before, right afterward, one month after, and three months after the intervention. The Chi-square repeated measures test, and T-test statistical analyses were used for the data analysis, with a level of significance of 0.05, in SPSS version 22. The study's findings demonstrated that life review therapy treatments significantly increased the elderly's quality of life (P 0.05). The study's conclusions support the research assumptions and demonstrate the viability and effectiveness of the life review application. It is advised that all nursing facilities, as well as old people's relatives, use this simple, quick, and effective technique. [49]

An epidemiological study on quality of life was conducted to find out the Quality of Life among the elderly in the urban area of Thiruvallur district, Tamil Nadu. A sample of 199, elderly people above 60 years were selected by probability proportionate sampling. A semi-

structured pre-tested questionnaire was used for data collection regarding socio-demographic details and related factors. Katz scale was used to assess activities of daily living and Quality of life (QOL) was assessed using the WHO Quality of Life BREF (WHOQOL BREF) questionnaire. Results of the study revealed that a moderate score in QOL was obtained in all 4 domains with the highest in the Psychological and environmental domains. Nearly 99% had full activity on the Katz scale. All three QOL domains were found to have a statistically significant association with age and education. Gender and marital status were found to be associated with the psychological domain, and employment/pensioner status with the physical domain. The study highlighted that Measures like Health education have to be targeted for the elderly in ways to improve their physical and psychological wellbeing which can improve the quality of life. Primary care and family physicians have to be made aware and empowered to identify the various domains of QOL in the elderly. [50]

A community-based cross-sectional study was conducted regarding the Quality of Life of Elderly People in a Rural Area of West Bengal among 146 elderly participants (aged 60 years and above) selected using simple random sampling from Singur block from April to June 2017. A structured questionnaire was used to collect data on sociodemographic characteristics and self-reported comorbidities and QOL assessment was done using the validated Bengali version of EQ-5D-3L (EuroQol) questionnaire. Data entry and analysis were performed using SPSS version 16.0. The categorization of good and poor QOL was based on the median score. Among 146 participants, 54.1% of the participants were found to have poor QOL. The mean (standard deviation) age of the study participants was 68 (5.87) years and 59% of the respondents were female. Most of the study participants (76.7%) had reported comorbidities. A higher percentage of participants reported problems in the dimensions of pain/discomfort and anxiety/depression in both the 60–69 and >69 age groups. In multivariable logistic regression, increasing age, financial dependence, and the presence of

one or more comorbidities were significantly associated with poor QOL after adjusting with the other variables. The findings suggest the need for effective health promotion strategies with an emphasis on the prevention and management of chronic diseases. Provision for geriatric care with counseling and social assistance such as old age pension will further help improve their QOL. [51]

A community-based cross-sectional study to assess the quality of life and factors affecting the quality of life, residing in Bhavnagar city Gujarat among 260 subjects (aged ≥ 60 years) residing in 13 wards of Bhavnagar city during September 2019–2020 using the World Health Organization Quality of Life BREF-25 (WHO QOL BREF-25) scale. Assessed psychiatric morbidity using the General Health Questionnaire-12 scale. An Independent t-test was performed to find out factors associated with quality of life. Among 260 subjects, 36% were males. The study found the highest score in the psychological domain and the lowest score in the physical domain of the WHO QOL BREF-25 scale. Physical health was better among Muslims, geriatrics <75 years of age, not addicted to abusive substances, and no co‐morbid condition, whereas geriatrics belonged to upper socio‐economic status and normal as per the General Health Questionnaire‐12 scale had better social relationships. The environmental domain score was significantly better among males. These findings highlight the importance of active aging interventions to improve the quality of life. [52]

A cross-sectional study aimed to explore the relationships among sociodemographics, health literacy, self-efficacy, social support, health-promoting behavior, and health-related quality of life (HRQOL) in older adults. A total of 240 older adults aged >65 years were recruited from three community senior welfare centers in South Korea. Standardized self-administered questionnaires measuring sociodemographic characteristics, health literacy, social support, self-efficacy, health-promoting behavior, and HRQOL were distributed to older adults. Multiple regression analyses with stepwise selection were used, factors affecting a

higher physical and mental component score of HRQOL were a higher comprehension level of and numeracy in health literacy, physical health-promoting behavior, perceived emotional-informational support, and a lesser number of comorbidities. To improve HRQOL among older adults, nursing interventions are required to measure health literacy, empower physical health-promoting behavior and self-efficacy, and enhance emotional-informational support from family or other resources. [53]

A systematic review and meta-analysis, of health-related quality of life among healthy elderly Iranians, following the "Preferred Reporting Items of Systematic Reviews and Meta-Analyses" (PRISMA) guidelines. Embase, PubMed/MEDLINE, ISI/Web of Science (WOS), Scopus, and Iranian databases such as MagIran, SID, and Irandoc were mined from inception up to 1st September 2017. Two reviewers independently screened titles/abstracts, assessed full-text articles, extracted data, and appraised their quality using the "Strengthening the Reporting of Observational Studies in Epidemiology" (STROBE) checklist. Twenty-five studies were included. The mean overall HRQoL was 54.92 [95%CI 51.50–58.33], lower than the value found by studies done in other countries, especially in those economically developed. HRQoL among healthy elder Iranian individuals is generally low. Health policy-makers should put HRQoL among the elderly as a priority of their agenda, implementing ad hoc programs as well as increasing the participation of old people in community life and using their experiences. [54]

A Cross-Sectional study to explore the associations between nutritional status and health-related quality of life, physical activity, and sleep quality in Elderly Greek adults from Greece who were free of any severe disease. Mini Nutritional Assessment was used to assess nutritional status, health-related quality of life was assessed using the Short Form Healthy Survey questionnaire, sleep quality was assessed using the Pittsburgh Sleep Quality Index, and

physical activity levels were assessed via the International Physical Activity Questionnaire. 3405 community-dwelling men and women, over 65 years old from 14 different Greek regions were enrolled. Ten-point four percent (10.4%) of the participants were classified as malnourished, while 35.6% were "at risk of malnutrition". A better nutritional status was significantly and independently associated with higher physical activity levels ($p = 0.0011$) and better quality of life ($p = 0.0135$), as well as better sleep quality ($p = 0.0202$). The study highlights the interrelationships between a good nutritional status, high-quality sleep, an active lifestyle, and a good quality of life. Further interventional studies are needed to clarify the associations and test the feasibility of improving the nutritional status, physical activity levels, and sleep quality of the elderly, and the impact of these changes on the quality of life, and healthy aging. [55]

A Comparative Study aims to assess the quality of life (QoL) among the elderly and to compare the differences in QoL among the elderly population residing in homes and old age homes. An analytical cross-sectional study among elderly above the age of 60 years residing with families and other 40 elderly population residing in old age homes. A questionnaire-based interview was conducted using a standard semi structured World Health Organization-BREF QoL questionnaire. In the study, most of the participants 45 (56.3%) were male and 35 (43.8%) belonged to the age group of 70–79 years with a mean (standard deviation) age of 73.96 (7.44) years. The study found that there is nil significant difference in QOL among elderly living in old age homes and in family setups. The domain scores of psychological, social, and environmental domains showed a slight no significant increase in elderly among old age homes. The study showed nil significant difference in QOL score in all domains for the elderly. The concept of QOL needs to be looked into with more preference to psychological, social, and environmental domains. [56]

A Cross-sectional study was done to assess the Quality of life (QOL) among older persons in an urban and rural area of Bangalore, South India among 977 older persons 60 years and above. Census enumeration blocks in urban areas and villages in rural areas were randomly selected and all older persons meeting the inclusion criteria were administered the WHOQOL-Bref questionnaire. Mean QOL scores (SD) in the physical, psychological, social relationship and environmental domains were 50.5 (5.5), 49.2 (5.5), 49.4 (6.5) and 49.3 (5.1) in rural areas and 57.4 (8.9), 58.6 (8.8), 64.6 (10.8) and 60.0 (9.4) in urban areas, respectively. Compared to urban, rural older persons uniformly have lower QOL irrespective of sex, education, or financial dependence. Inequitable health resource distribution and inadequate social support systems must be addressed to improve the QOL of older persons, especially in rural areas. [57]

Based on the limited literature, researcher experience, and observations aided the researcher in comprehending the implications of the problem and analyzing the gaps from earlier studies, which has also helped in structuring the current study. Thus the researcher made the multimodal intervention preventive strategies as a holistic approach for geriatric clients. The challenge was to develop a multimodal intervention that would enable and promote the senior client's health. This study is specific to explore the effectiveness of multimodal intervention regarding health promotion on perception and quality of life among geriatric clients, and it makes a significant contribution to the geriatric clients, and health care systems as a whole to society.

CHAPTER –IV

RESEARCH METHODOLOGY

CHAPTER –IV

RESEARCH METHODOLOGY

This chapter deals with the methodology selected for the study it includes the research approach, design, setting, sample and sampling technique, development and description of the tools for data collection, method of administration of Multimodal Intervention on achieving positive Health promotion outcomes, along with the procedure of data collection and plan for data analysis. The methodology of the research indicates the general pattern of organizing the procedure for empirical study together with the method of obtaining valid and reliable data for the problem under investigation.

RESEARCH APPROACH

The research approach adopted for this study is the **Quantitative Research approach.** This helps to explain the effect of an independent variable on the dependent variable.

RESEARCH DESIGN

The research design adopted in this study was a **Quasi-Experimental non-randomized control group pretest posttest design** and follow-up**.**

Table no 1: Schematic representation of the research design is as follows,

Groups	Pre-test	Intervention (MMI)	Posttest-I (30th DAY)	Posttest-II (60th DAY)
Experimental Group	O1	X	O2	O3
Control Group	O1	-	O2	O3

Key:

O1: Pre-test observation of perception and Quality of life among geriatric clients.

X: "Multimodal Intervention (MMI)" this a comprehensive holistic health promotion strategy approach designed by the researchers which focuses on the concepts of Physical Activity, Lifestyle & Healthy Diet, Socialization, Fall prevention, Stress management, Pain management, Medication & follow up, Spirituality & Health Schemes. The intervention was provided through the distribution of informational pamphlets, participants grouped to play the game snake and ladder, and a video teaching session was given to all the participants of the experimental group.

- **:** Routine care received by the Control group.

O2: The first observation of posttest 1 was conducted on the 30^{th} day to assess the perception and Quality of life among geriatric clients.

O3: The first observation of posttest 2 was conducted on the 60^{th} day to assess the perception and Quality of life among geriatric clients.

Note: This study included manipulation and control except **randomization.**

VARIABLES OF THE STUDY:

Variables are the qualities, properties, or character of the person, things, or situation that can change or vary. Three types of variables are identified in this study. They are independent, dependent, and attribute variables.

Independent variable:

An independent variable is the variable that stands alone and it is not dependent on any other. It is the cause of the action.

In this study "Multimodal Intervention (MMI)" regarding health promotion strategies consists of an Informational Pamphlet, a Snake & Ladder game method, and video teaching as the independent variable.

Dependent variable:

A dependent variable is the effect of the action of the independent variable and cannot exist by itself.

In this study perception and quality of life among geriatric clients regarding health promotion are the dependent variables.

Attribute Variables:

Attribute variables are those variables that are present in the research environment which may interfere with the research findings by acting as unwanted independent variables.

The present study refers to the selected socio-demographic variables like age (in years), gender, educational status, religion, marital status, residence, socioeconomic status, type of family, history of comorbidity, history of health checkup and also includes bio-physiological parameters like nutritional status, visual acuity, hearing acuity, activities of daily living, sleep pattern, bowel pattern, bladder pattern, personal habits, status of financial dependence, physical activities.

SETTING:

The study for the experimental group was conducted in the Inpatient departments of R. L Jalappa Hospital & Research Centre, Tamaka, Kolar, a private multi-specialty Medical Teaching tertiary level, 1200 bedded nonprofit charitable organization dedicated to

establishing a center of health care of excellence and improving the well-being of the community through quality programs of preventive medicine, medical education, and research. It is dedicated to establishing patient patient-friendly approach and is committed to reaching out to the community with a bed occupancy of more than 90%. Every day, between 80 and 100 elderly patients are admitted to hospitals.

The study for the control group was conducted at District Sri Narasimha Raja District Hospital, it is a 70-year-old government hospital in Kolar, The hospital is funded by the World Bank and has a sanctioned capacity of 600 beds. It is meant to cater to a population of 0.12 million each year. The hospital receives a grant from the National Rural Health Mission (NHRM) and generates most of its revenues from clinical fees and user charges. The average out-patient (OPD) inflow is 800 every day of which 10-20% come from Kolar and the rest from nearby villages for general ailments, including diabetes and viral infections. The hospital features 40-bed specialized geriatric units.

To conduct the study, the investigator chose specific hospitals, such as the R. L Jalappa Hospital & Research Centre, Tamaka, Kolar, and District Sri Narasimha Raja District Hospital.

POPULATION:

Population is the entire aggregation of cases that meet designated criteria. In this study, the population refers to all the geriatric clients seeking medical services at in-patient departments of selected hospitals, Kolar.

SAMPLE AND SAMPLING TECHNIQUE:

The sample of the study consisted of geriatric clients (60-75years) seeking medical services at selected hospitals, Kolar, who fulfilled the predefined inclusion criteria during the study period was regarded as the study sample.

In this study, Non-Probability Purposive Sampling technique was adopted in selecting the final desired samples at selected hospitals in Kolar. The sampling framework for the study is presented in Fig 5.

CRITERIA FOR SELECTION OF SAMPLE:

Inclusion Criteria: includes the geriatric clients who are

1. Between the age group of 60-75 years.
2. Seeking medical services at In-Patient Departments.
3. Able to speak and understand Kannada or English.
4. Accessible for follow-up throughout the study period.

Exclusion criteria: refers to the geriatric clients who are

1. Terminally ill at the time of admission
2. Physical & Mental disability which doesn't allow them to participate
3. Not willing to participate in the study.

SAMPLE SIZE AND ITS DETERMINATION:

The sample size is **120 (60 Experimental, 60 Control group)**

By employing the Openepi statistical software(Power 80%, 95% confidence interval, expecting an attrition rate of 5% and the difference of mean Quality of life scores between Group 1 was mean 18± 2.6, variance 6.76 and group 2 mean scores 20±2.65, variance 7.02, the estimated sample size was around 56 in each group. If 5% of the sample's dropouts were taken into account, the estimated sample size was around 60 in each group.

Considering the **Cochran's formula:**

$$n = \frac{2(Z\alpha + Z\ 1\text{-}\beta)^2\ \sigma 2}{d^2}$$

Zα= 95% Confidence Interval

Z (1-β) = Power of the study as 80%

$\sigma 2$ Average variance estimation

d = Effect size.

***#Reference**: based on data from a similar study (Sharif F, Jahanbin I, Amirsadat A, Moghadam MH. Effectiveness of life review therapy on quality of life in the late-life at daycare centers of Shiraz, Iran: a randomized controlled trial. International journal of community based nursing and midwifery. 2020 Apr;6(2):136.)*

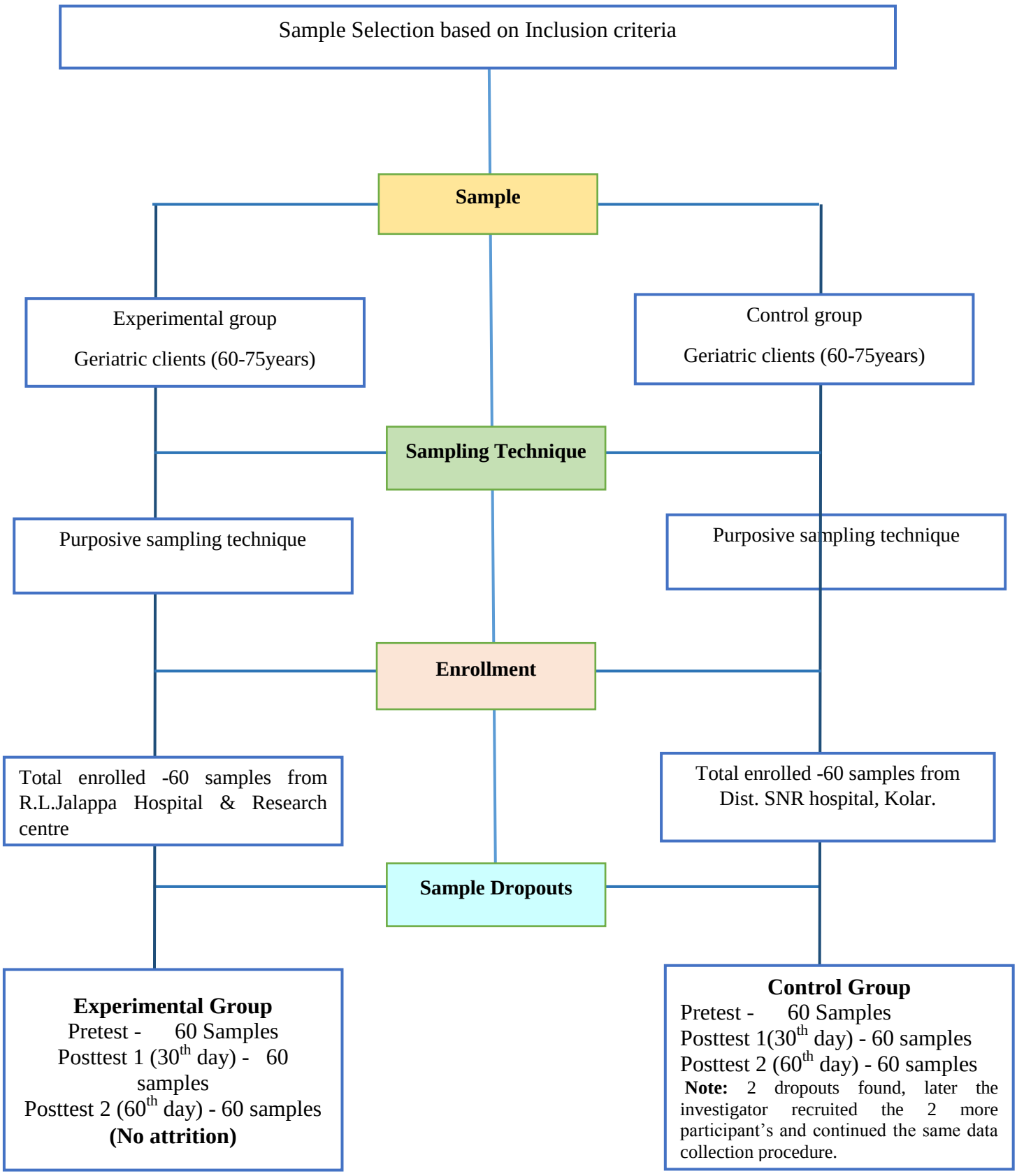


Fig 5. Sampling framework of the study

SELECTION AND DEVELOPMENT OF THE TOOL:

Data collection tools are the procedures of instruments used by the researcher to observe and measure the key variables in the research problem. For the present study structured perception questionnaire and standardized WHO QOL tool were used to assess perception and Quality of Life among geriatric clients.

Development of the tool:

The main purpose of developing this tool was to enhance the perception and Quality of Life among geriatric clients seeking medical services to achieve positive health promotion outcomes.

For the development of the tool, research and non-research literature is reviewed and suggestions of experts and present statistical approaches are taken to determine the concepts to be included in the tool.

The following steps are undertaken to prepare the final tool.

- Preparation of blueprint.
- Development of the tool.
- Development of criteria Likert scale.
- Content validity of the tool.
- Pretesting of the tool
- Reliability of the tool.

Preparation of Blue Print:

The investigator prepared the blueprint before constructing the questions. The perception-related five-point Likert questionnaire is distributed according to the content areas

in three domains such as perception of aging & health, physical psychological well-being, social relationships, and financial and spiritual aspects. Whereas for Quality of Life is a standardized WHOQOL tool on a point Likert scale which consists of 24 items under Six facets Sensory Abilities, Autonomy, Past, Present, and Future Activities, Social Participation, Death, and Dying Intimacy.

Development of the tool: The developed tool was organized under the following headings

TOOL-I

Consisted of the following sections:

Sec. A-Socio Demographic Data- Ten items (Annexure XIV)

It includes characteristics of geriatric clients such as Age, Gender, Religion, Educational status, Residence, Socioeconomic status, Type of family, History of comorbidity, and History of health checkups.

Sec. B-Bio physiological parameters –Ten items (Annexure XIV)

This section includes information related general health status of geriatric clients such as Nutritional status, Visual acuity, Hearing acuity, Activities of daily living, Sleep pattern Bowel pattern, Bladder pattern, Personal habits, Status of financial dependence, and Physical Activities.

TOOL-II

Sec. A - Structured Perception Questionnaire consisted of fifteen items. (Annexure XIV)

This a five-point Likert scale used to assess geriatric clients' perception which consists of 15 items under three areas/categories Perception of aging and Health, Physical & Psychological well-being, Social relationships, and Financial/Spiritual, and each has five options, there is no wrong answer; each response will be considered with a Minimum score-15 & Maximum score-75 which is graded as follows; 5 -Strongly Agree (SA), 4- Agree (A), 3- Uncertain, 2- Disagree (D), and 1 –Strongly Disagree by considering the positive & Negative statements.

TOOL-III

Sec. A- Standardized WHOOLD Quality of Life consisted of 24 items. (Annexure XIV)

Formal permission was obtained from the WHO to use the standardized WHOQOL tool to assess the Quality of Life of geriatric clients, on a five-point Likert scale which consists of 24 items under Six facets such as Sensory Abilities, Autonomy, Past, Present, and Future Activities, Social Participation, Death and Dying Intimacy, each of these facets has four items, the total score for all facets can range from 4 to 20, there is no wrong answer; each response will be considered.

TOOL-IV

Sec. A –An Opionnaire/Geriatric client satisfaction about the Multimodal Intervention consists of ten items.

BLUEPRINT OF THE TOOL

Section II A. Perception of geriatric clients on health promotion outcomes

Sl. No.	Area	Q. No.	No.	%
1	Perception of aging and Health	1-5	5	33.3
2	Physical and psychological well-being	6-11	6	40
3	Social relationships/Financial/Spiritual	12-15	4	26.6
	Total		15	100%

Section II B: Quality Of Life among Geriatric Clients

FACET	∑ items
Sensory Abilities	4
Autonomy	4
Past, Present, and Future Activities	4
Social Participation	4
Death and Dying	4
Intimacy	4

SCORE INTERPRETATION:

The total Perception and Quality of life scores obtained by the clients are arbitrarily graded as:

Perception scores (Max score: 75)	Percentage (%)	Grade
1-25	<50%	Poor
26-50	51-75%	Moderate
50 & above	>75%	Good

Quality of life scores (Max score: 120)	Percentage (%)	Grade
1-40	<50%	Poor
41-80	51-75%	Moderate
>81 & above)	>75%	High

FACET	Abbr	∑ items	Items of facets	Possible range of raw score (Min, Max)
Sensory Abilities	SAB	4	1 + 2 + 10 + 20	16 (4, 20)
Autonomy	ABOUT	4	3 + 4 + 5 + 11	16 (4, 20)
Past, Present, and Future Activities	PPF	4	12 + 13 + 15 + 19	16 (4, 20)
Social Participation	SOP	4	14 + 16 + 17 + 18	16 (4, 20)
Death and Dying	DAD	4	6 + 7 + 8 + 9	16 (4, 20)
Intimacy	INT	4	21 + 22 + 23 + 24	16 (4, 20)

The score interpretation for Quality of life as per the WHOQOL-OLD module consists of 24 Likert-scaled items assigned to six facets: "Sensory Abilities" (SAB), "Autonomy" (AUT), "Past, Present and Future Activities" PPF), "Social Participation" (SOP), "Death and Dying" (DAD) and "Intimacy" (INT). Each of the facets has 4 items, thus for all facets the score of possible values can range from 4 to 20. High scores represent high quality of life, and low scores represent low quality of life. Each facet scores were summed to get the raw facet score (RFS). To obtain a transformed facet score transformation rule was applied TFS = 6.25 x (RFS - 4).

DEVELOPMENT OF MULTIMODAL INTERVENTION:

Based on a literature review of the research, discussion, opinions, and suggestions from subject experts, Multi-Modal Intervention was developed to create awareness and to emphasize on comprehensive holistic approach specified to a set of nursing care strategies designed to improve health promotion outcomes among geriatric clients. **(Annexure XX)**

The steps involved in the development of Multimodal Intervention is

- **I.** Preparation of draft/script for multimodal intervention
- **II.** Preparation of content
- **III.** Development of criteria checklist
- **IV.** Content validity of multimodal Intervention
- **V.** Preparation of final content of multimodal Intervention
- **VI.** Translation of multimodal Intervention content

I. Preparation of draft/script for multimodal intervention

The script of teaching was prepared after reviewing the literature, and organized as per the sequence based on the suggestions and opinions given by the subject experts and

research guide. Factors such as time, level of understanding, and needs of the learner were considered while preparing a multimodal intervention package.

II. Preparation of Content

The content was prepared after reviewing the literature. The final content was organized with adequate Audio-Visual Aids as per the sequence based on the suggestions and opinions given by the subject experts and research guide.

III. Development of Criteria Checklist

A Criteria checklist for the validation of the multimodal intervention was developed. The aspects evaluated were grouped under the headings as formulation of objectives, selection of content, and organization of content, language, and audio-visual aids. The criteria checklist for multimodal Intervention was Very Relevant, Relevant Needs Modification, Not Relevant, and Remarks Columns.

IV. Content Validity of the Intervention information

The prepared multimodal intervention information along with the problem statement, hypotheses, operational definitions, blueprint, and criteria rating scale designed for validation was submitted to Fifteeen experts. The experts consisted of 15 experts from the fields of Community Health Nursing(8), Medical-Surgical Nursing(2), Community Medicine(1), Psychiatric Nursing (1), Geriatrician (1), Biostatistician (1), Counsellor (1). There was 100% agreement on all the content of teaching information.

Further degree of consistency was obtained by giving the content of multimodal intervention information to two raters (Inter-rater) who independently assigned scores. The

information on teaching was found relevant as the scores of the two raters were found to be equivalent.

V. Preparation of final content of multimodal Intervention

Based on the expert's suggestion and guide correction the multimodal intervention information was organized under the following headings:

- Information related to geriatric care, global statistics, importance and factors affecting
- Health problems of the elderly
- Health promotion and its importance
- Strategies of health promotion emphasizing the concepts of physical activity, nutrition, exercise, socialization, fall prevention, pain & medication management, spirituality, and health schemes.
- Role of nurse & caregiver.

VI. Translation and Retranslation of multimodal Intervention content

The English version of the multimodal intervention content was translated into the Kannada version as validated by a Kannada language expert. Finally, the intervention was retranslated for its feasibility and reliability.

CONTENT VALIDITY OF THE TOOL

The prepared data collection tool along with the problem statement, hypotheses, operational definitions, blueprint, and criteria rating scale designed for validation was submitted to ten experts. The experts consisted of 15 experts from the fields of Community Health Nursing(8), Medical-Surgical Nursing(2), Community Medicine(1), Psychiatric

Nursing (1), Geriatrician (1), Biostatistician (1), Counsellor (1). There was 100% agreement on all the content of multimodal teaching information. Experts recommended condensing and simplifying the 30-item perception tool as it is intended for older adults. A few of the questions were asked to be removed because they were repeated resulting in a finalized 15-item perception questionnaire. The standardized WHO QOL tool was obtained permission to utilize from WHO and the same tool was validated and recommended for the same. The tool was modified while consulting the research guide, taking into account the recommendations and views of the subject experts.

RELIABILITY OF THE TOOL:

Reliability of the instrument was inferred by administering the tool to twelve subjects, admitted in selected hospitals. The internal consistency reliability of the tool was established by split half method along with tool's stability was examined using the test-retest method, the internal consistency of the domains was satisfactory to good, yielding Cronbach's alpha of 0.79 for the perception questionnaire and the WHOQOL tool was a highly valid instrument and standardized in many countries and reliability found with Cronbach's alpha value 0.81**.** Hence, the tools were determined to be feasible and found to be reliable at an acceptable level.

PILOT STUDY:

A pilot study is a small preliminary investigation of the same general character as the major study. A pilot research study was carried out for the experimental group from June 20, 2022, to August 20, 2022, at the 350-bedded ETCM missionary hospital. A 200-bed Hope Health Care missionary hospital was chosen for the control group.

The investigator obtained written permission from the concerned authority before the study and the purpose of the study was explained to the study subjects and confidentiality was assured.

The data was collected by adopting a structured perception questionnaire to assess the perception of geriatric clients using a five-point likert scale and a standardized WHOQOL tool to assess the quality of life. The data was collected from 12 samples (10% of the total sample) i.e. 06 for the experimental and 06 for the control group respectively, who fulfilled the inclusion criteria for sample selection. Both the group's perception and quality of life were assessed as pretest on the day of recruitment.

The selected sample of the experimental group received a multimodal educational intervention package on the same day of pre-test. On the 30th and 60^{th} day, posttest 1 & posttest 2 was conducted with the same tool to assess the gain in perception scores and quality of life scores. The data was analyzed by using both descriptive and inferential statistics. Based on the pilot study findings, the objectives of the study could be achieved. Thus investigator felt the study could be conducted as it was feasible and practicable.

DATA COLLECTION PROCEDURE

The data was collected from September 2022 to February 2023 as per the availability of the sample. Formal written permission was obtained from the concerned authorities. The study was done on one hundred and twenty samples (60 experimental groups 60control group) in a selected hospitals of R.L.Jalappa Hospital and research Centre and Dist. SNR hospital, Kolar. The purpose of the study was explained to the study subjects and confidentiality was assured. The data was collected by using a structured perception questionnaire for assessing perception and, standardized WHOQOL tool to assess the Quality

of life of geriatric clients regarding health promotion outcomes. The data collection procedure consisted of three phases.

The first phase deals with the selection of the sample based on specified inclusion criteria, the development of structured multimodal educational intervention along with the tools of data collection, and pilot study was carried out.

The Second phase deals with the administration of structured multimodal educational intervention to the selected sample of the study after the pre-test.

The Third phase consists of an evaluation of the effectiveness of the multimodal intervention with the same structured perception questionnaire and Quality of life using the WHOQOL tool which was carried out on the 30th and 60th day to both groups of experimental and control group after intervention as posttest I and posttest II. Finally, the feedback was obtained by using opinnionaire tool from participants.

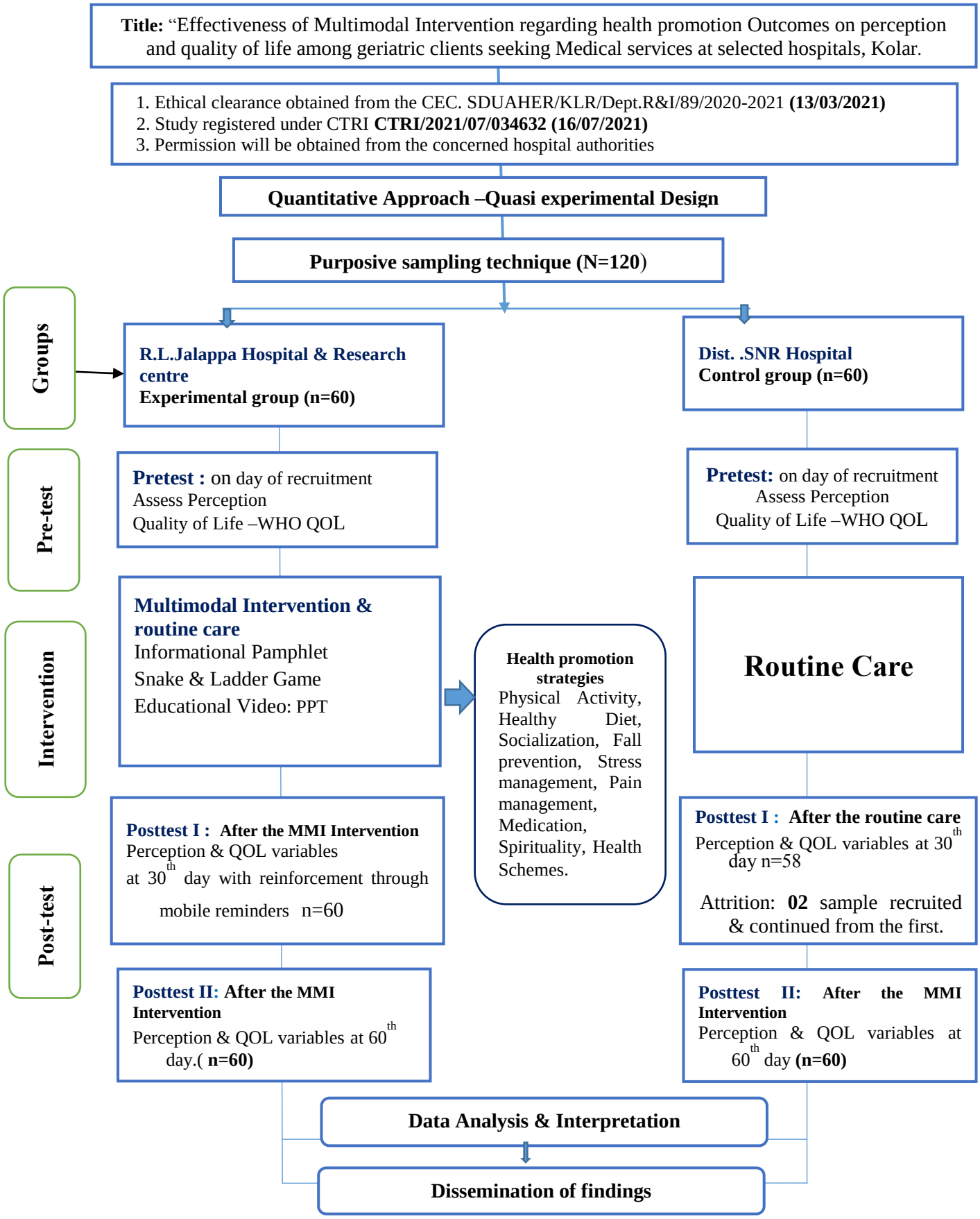


Fig 6. ***Schematic representation of Research study***

PLAN FOR DATA ANALYSIS

The data obtained for the study was analysed by using descriptive and inferential statistics on the basis of objectives and research hypotheses. (The gathered data was analyzed using SPSS software IBM SPSS Statistics version 20 and the necessary statistical techniques).

1. Descriptive statistics was used to analyse frequency, percentage of socio-demographic variables.
2. For evaluating the level of perception, and Quality of Life regarding health promotion outcomes among geriatric clients utilized descriptive statistics such as frequency, percentage distribution, mean, and standard deviation are used.
3. To determine the effectiveness of Multimodal Intervention, by comparing pretest and posttest scores within the group and between the groups paired' test and Independent't' test was used.
4. In order to determine the relationship between the perception and Quality of Life of geriatric clients, Karl Pearson's coefficient of correlation was used.
5. For the comparisons of variables and their differences during pretest and posttests, further statistical analysis such as Repeated Measures of ANOVA and Post-hoc test was performed.
6. Chi square was used to find out the association between perception and Quality of life of geriatric clients on health promotion outcomes with selected socio demographic variables.

ETHICAL CONSIDERATIONS:

All the ethical considerations were followed in the conduct of the study. Doctoral Research Advisory Committee approval by experts was obtained for the study on 13/10/2020. Central Ethics Committee approval obtained on 09/03/2021, SDUAHER/KLR/ Dept.R&I/89/2020-2021. Formal written permission was obtained from the Medical superintendents of respective hospitals. Permission from the Clinical Trials Registry of India and study been registered with (CTRI/2021/07/034632) on 06/07/2021. Before commencing the study, the researcher obtained written informed consent and a participant information sheet from the study subjects, ensuring the confidentiality and anonymity of the data.

This chapter has dealt with research approach, research design, and variables under study, setting of the study, population, sample, sampling technique, structured tools, pilot study findings, method of data collection and plan for data analysis.

CHAPTER V

RESULTS

CHAPTER –V

RESULTS-ANALYSIS AND INTERPRETATION

This chapter presents the results of the study conducted to find out the "Effectiveness of Multimodal Intervention regarding health promotion on Perception and Quality of Life among Geriatric Clients seeking Medical services at selected Hospitals, Kolar".

The data were collected through a structured perception questionnaire using five-point Likert scale and a standardized WHOQOL tool to assess the quality of life among geriatric clients consisting of 120 clients (60 experimental and 60 control groups). The data analysis was carried out by using both descriptive and inferential statistical methods. The analysis and interpretation of data was based on the objectives and research hypotheses of the study.

Organization of Findings

The analyzed data is organized and presented under the following sections:

Section I: This section deals with the data pertaining to socio-demographic and bio physiological parameters.

Table -2: Distribution of sample according to socio-demographic variables of both experimental and control groups.

Table -3: Distribution of sample according to biophysiological parameters in both experimental and control groups.

Section II: Deals with the data analysis as per the **first objective of the study** which focused on assessing the "perception and quality of life of geriatric clients in Experimental and Control groups.

Table-4: Distribution of sample according to overall level of perception among experimental and control groups.

Table-5 : Area-wise distribution of perception regarding health promotion among experimental and control groups of geriatric clients.

Table-6: Distribution of sample according to overall Quality of life scores among experimental and control groups.

Table-7: Area-wise distribution of quality of life regarding health promotion among experimental and control groups of geriatric clients.

Table-8 : Distribution of area-wise RFS & TFS scores of QOL regarding health promotion among experimental and control groups of geriatric clients.

Section III: Deals with the data analysis on the **second objective of the study** which was to "evaluate the effectiveness of multi-modal intervention regarding health promotion on perception and quality of life among geriatric clients by comparing pretest and post-test scores in both experimental and control groups".

Table-9& 10: Comparison of the Perception and QOL among Geriatric clients **within the** experimental and the control groups.

Table-11 &12: Comparison of perception & QOL among geriatric clients **between the groups** of experimental & control groups.

Table-13 &14: Assessing Perception and QOL among geriatric clients in experimental and control groups using Repeated Measures of ANOVA.

Table-15 & 16: Assessing Perception and QOL among geriatric clients in experimental and control groups using Bonferroni Post hoc test.

Section IV: Deals with the data analysis on **the third objective** of the study which was to find the correlation between perception & quality of life among geriatric clients in the experimental and control groups.

Table-17: Distribution of sample to find the relationship between perception and QOL among geriatric clients in experimental and control groups.

Section V: Deals with information on the **fourth objective** of the study which was to determine the association on the pretest level of perception and quality of life with selected demographic variables of geriatric clients in the experimental and control groups.

Table-18: Association of pretest perception with selected socio-demographic variables.

Table-19: Association of pretest quality of life with selected socio-demographic variables.

SECTION I- Distribution of sample according to socio-demographic variables

Table -2: Frequency and percentage distribution of sample according to socio-demographic variables.

(n=60+60)

Sl. no	Demographic Variables	Category	Study groups f (%)		df	χ^2 &(p value)
			Experimental	Control		
1.	**Age (in Years)**	60-67	41(68.3)	47(78.3)	1	1.534 (.215) NS
		68-75	19(31.7)	13(21.7)		
2.	**Gender**	Male	33(55)	25(41.6)	1	2.135 (.143) NS
		Female	27(45)	35(58.4)		
3.	**Educational status**	Formal Education	23(38.3)	21(35)	1	0.143 (.704) NS
		No formal education	37(61.7)	39(65)		
4.	**Religion**	Hindu	34(56.6)	41(68.3)	2	1.845 (.397) NS
		Muslim	18(30)	14(23.4)		
		Christian	8(13.4)	5(8.3)		
5.	**Marital status**	Married	43(71.6)	41(68.3)	2	0.695 (.706) NS
		Separated	6(10)	9(15)		
		Widow/Widower	11(18.4)	10(16.7)		
6.	**Residence**	Rural	42(70)	46(76.6)	1	0.681(.408)NS
		Semi urban/Urban	18(30)	14(23.4)		
7.	**Socioeconomic status**	APL	13(21.6)	15(25)	1	0.1863(.665)NS
		BPL	47(78.4)	45(75)		
8.	**Type of family**	Nuclear family	18(30)	21(35)	1	0.341(.558)NS
		Joint family	42(70)	39(65)		
9.	**History of comorbidity**	Diabetes & Hypertension	40(66.6)	47(78.3)	1	2.048 (.152)NS
		Cardiac and other health problems	20(33.4)	13(21.7)		
10.	**History of health checkup**	No	33(55)	41(68.3)	1	2.256(.1330) NS
		Yes (1-2 Years)	27(45)	19(31.7)		

Data presentation: *The data of both study groups are expressed as frequency (f) and percentage.* ***Homogeneity test:*** *The Chi-square test was used for comparison of the demographic variables of the geriatric clients of the Experimental and control groups. The level of significance at $p<0.05$ was considered significant, and $p>0.05$ was considered non-significant.*

Table 2: reveals that in the Experimental group, the majority(68.3%) of the geriatric clients were in the age group of 60-67 years and the mean age found to be (68.02) were males (55%) while in the control group, majority(78.3%) were aged 60-67 years with the mean age (68.23) and were females (58.4%).

In both the groups, the majority (61.7%) of the geriatric clients had no formal education in experimental group and control group (39%) and Most (56.6%) belonged to Hindu religion in experimental group whereas in control group-(68.3%) respectively.

In terms of marital status in both groups majority (71.6%) were married in experimental and (68.3%) in control group and most(70%) of the geriatrics belonged to from rural residences in experimental group and control group is (76.6%).

Regarding Socioeconomic status, both groups belonged to the below poverty line (experimental group-78.4%, control group-75%). In the type of family, both the groups belonged to the Joint family system (experimental group-70%, control group-65%).

In both groups, the majority (66.6%) had a history of co-morbid conditions such as diabetes& hypertension in experimental group and found (78.3%) in control group.

In response to the history of health checkups, the in experimental group majority (55%) and (68.3%) in control group had not undergone health checkups within 1 year of duration.

Also table depicts that, there is no significant difference ($p>0.05$) in any of the demographic characteristics of the geriatric clients in the experimental and control groups. Hence both the groups were considered homogenous.

Table 3: Distribution of sample according to biophysiological parameters in both experimental and control groups. **(n =60+60)**

Sl.no	Variables	Category	Study groups f (%)		df	χ^2 & (p-value)
			Experimental	Control		
1.	**Nutritional status**	Underweight	26(43.3)	30(50)	1	1.534 (.215) NS
		Normal weight	28(46.7)	19(31.7)		
		Overweight/Obese	6(10)	11(18.3)		
2	**Visual acuity**	Normal	31(51.6)	26(43.3)	1	2.135 (.143) NS
		Deficit	29(48.4)	34(56.7)		
3.	**Hearing acuity**	Normal	43(71.7)	44(73.3)	1	0.143 (.704) NS
		Deficit	17(28.3)	16(26.7)		
4.	**Activities of daily living**	Independent	38(63.3)	32(53.3)	2	1.845 (.397) NS
		Dependent& partially dependent	22(36.7)	28(46.7)		
5.	**Sleep pattern**	Normal/Adequate	29(48.3)	19(31.6)	2	0.695 (.706) NS
		Disturbed/Inadequate	31(51.7)	41(68.4)		
6.	**Bowel pattern**	Regular	36(60)	45(75)	1	0.681(.408)NS
		Irregular	24(40)	15(25)		
7.	**Bladder pattern**	Normal	41(68.3)	43(71.6)	1	0.1863(.665)NS
		Urinary incontinence	19(31.7)	17(28.4)		
8.	**Personal habits**	Smoking/Drinking Alcohol/Chewing tobacco	45(75)	50(83.4)	1	0.341(.5587)NS
		No	15(25)	10(16.6)		
9.	**Status of financial dependence**	Independent	16(26.6)	17(28.3)	1	2.048 (.1524)NS
		Partially dependent	23(38.4)	26(43.3)		
		Dependent	21(35)	17(28.4)		
10.	**Physical Activities**	Not involved	24(40)	22(36.6)	1	2.256(.1338) NS
		Low(less than 20min/day)	19(31.7)	11(18.4)		
		High (more than 30 min/day	17(28.3)	27(45)		

Level of significance – p<0.05 was considered significant, and p>0.05 was considered non-significant.

Table 3 represents the distribution of the sample according to the biophysiological parameters below, Concerning, assessment of nutritional status Majority 28(46.7%) in experimental and 30(50%) in the control group were undernourished and 28(46.7%) in the experimental and 19 (31.7%) in the control group were found to be in the normal weight, whereas 4(6.7%) & 11(18.3%) were obese in experimental & control group respectively.

Regarding Visual Acuity, 31(51.7%) in the experimental group and 26 (43.3%) in the control group had normal visual acuity, while 29(48.3%) & 34(56.7%) had deficit visual acuity in the experimental & control group respectively.

The Hearing acuity found to be Normal in most 43(71.7%) and 44(73.3%) in the experimental & control groups. While 17(28.3%) in the experimental group and 16(26.7%) in the control group had deficit hearing acuity of geriatric clients.

About, Activities of Daily Living, Majority 38(63.3%) of respondents were found to have Independent ADLs in experimental and 32 (53.3%) in the control group. Dependent respondents were 22(36.7%) in the experimental group and 25(41.7%) in the control group.

The Sleep pattern status was adequate among 29(48.3%) in the experimental & 19(31.7%) in the control group. 31(51.7%) had inadequate sleep in experimental group & 41(68.3%) in control group respectively.

Regarding bowel patterns, almost 36(60%) in the experimental & 45(75%) in the control group had regular patterns, while 24(40%) and 15(25%) respondents had Irregular bowel patterns in the experimental & control group. In terms of Bladder pattern, Overall 36(60%) in the experimental group and 45(75%) in the control group had regular bladder patterns whereas 24 (40%) in the experimental group and 15(25%) control group reported Urinary incontinence.

The experimental group regarding Personal habits reported that 45(75%) of respondents & 50(83.3%) had habits of smoking, and tobacco chewing in the control group. No habits

were reported among 15(25%) in the experimental group & 10(16.7%) control group respectively.

Regarding status of Financial Dependence majority, 23(38.3%) in experimental & control group 26(43.3%) were partially dependent and 21(35%) in experimental group & 17(28.4%) in Control group were totally dependent while 16(26.7%) and 17 (28.3%) were Independent.

In terms of Physical activity, almost 24(40%) respondents in the experimental and 22(36.6%) in the control group not involved in any physical activity, whereas respondents involved less than 20 minutes of physical activity in the Experimental group is 19(31.7%) and 11(18.4%) in the control group.

The homogeneity of the samples according to biophysiological parameters was found to be consistent between experimental and control groups by using the Chi-square test.

Table 3 shows that there is no significant difference ($p>0.05$) in any of the demographic characteristics of the geriatric clients in the experimental and control groups. Hence both the groups were considered to be homogenous.

Section II: Overall and area-wise level of perception and quality of life among experimental and control groups.

Table 4: Distribution of sample according to overall level of perception among experimental and control groups. (n=60+60)

Sl.no	Perception grading	Perception scores	Experimental group f (%)			Control group f (%)		
			Pretest	Posttest 1	Posttest 2	Pretest	Posttest 1	Posttest 2
1.	Poor	0-25	18(30)	0(0)	0(0)	20(33.4)	18(30)	21(35)
2.	Moderate	26-50	42(70)	46(76.7)	34(56.7)	37(61.6)	42(70)	39(65)
3.	Good	>51 & above	0(0)	14(23.3)	26(43.3)	3(5)	0(0)	0(0)
		Total	60	100	60	100	60	100

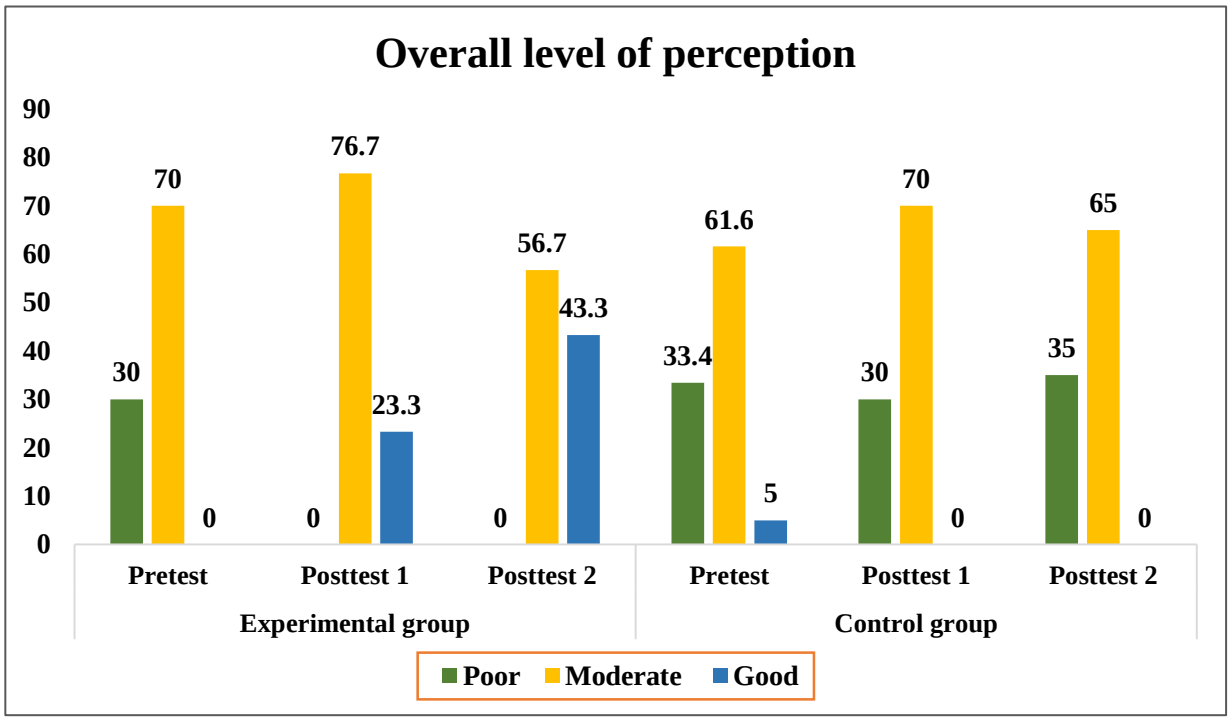


Fig no 7: Bar diagram showing the percentage distribution of level of perception among geriatric clients in experimental group and control groups.

Table: 4 & fig 7 represent the overall level of Perception in experimental & control groups.

The findings in the pretest represent, the majority of the geriatrics in the experiment group (70%) had a moderate level of perception, (30%) had poor perception, and none of the study participants belonged to a good level of perception regarding health promotion outcomes. At the time of posttest assessment 1 on the 30^{th} day after the Multimodal intervention, the majority (76.7%) had moderate level of perception, (23.3%) had a good level of perception, and none had a poor level of perception. On the 60^{th} day of posttest 2, the majority (56.7%) had moderate perception and (43.3%) had a good perception regarding health promotion outcomes and none of the study participants had a poor level of perception.

Whereas in the control group in the pretest majority of the geriatrics (61.6%) had a moderate level of perception, (33.4%) had poor perception, while, and (5%) had good level of perception regarding health promotion. At the time of posttest assessment 1 on 30^{th} day, majority (70%) had moderate level of perception, (30%) had poor perception and none of the samples had good level of perception. On 60^{th} day posttest 2, the majority (65%) had moderate perception and (35%) had poor perception regarding health promotion outcomes and none of the study participants belonged to good level of perception.

Pretest and post-test scores on the level of perception were enhanced in the experimental group after the multimodal intervention, Thus the stated **Research Hypotheses H_1 is accepted**.

Table 5: Area wise distribution of perception regarding health promotion among experimental and control groups of geriatric clients. (n=60+60)

Sl. no	Area wise (Perception)	Max score	Experimental Group			Control Group		
			Pretest	Posttest 1	Posttest 2	Pretest	Posttest 1	Posttest 2
			Mean±SD			Mean±SD		
1	Perception of aging and Health	25	10.2±2.9	13.9±3.8	14.2±3.8	11.3±3.86	11.8±4.01	12.5±3.9
2	Physical, Psychological Health	30	14.9±4.03	17.2±3.4	18.3±2.9	14.2±4.6	13.3±4.00	12.9±3.9
3	Social relationships, Financial & Spiritual	20	10.5±3.4	15.1±2.5	15.8±2.3	9.0±3.1	8.9±2.89	9.5±3.2
	Enhancement	75	35.6	46.35	48.33	34.60	34.100	34.9

The data represented is perception scores as mean ± SD.

Table 5 depicts the perception scores regarding health promotion outcomes in experimental and control groups. Among the geriatric clients in the experimental group who received the Multimodal Intervention, observed an improved mean perception score enhancement from (**35.6, 46.35, and 48.33**)respectively, and mean perception scores were seen to be highest in the physical, and psychological health domains with mean and SD from (**14.9±4.03 to 18.3±2.9)**.

Whereas in the Control group, the enhancement of mean perception scores observed was (**34.60, 34.10, and 34.9)** respectively with minimal/no change in the mean perception scores.

Table 6: Distribution of sample according to overall scores of quality of life among experimental and control groups. (n=60+60)

Sl.no	QOL grading	QOL scores	Experimental group f (%)			Control group f (%)		
			Pretest	Posttest 1	Posttest 2	Pretest	Posttest 1	Posttest 2
1.	Poor	0-40	21(35)	0(0)	0(0)	16(26.6)	12(20)	18(30)
2.	Moderate	41-80	39(65)	38(63.3)	35(58.3)	44(73.4)	42(80)	42(70)
3.	Good	>81 & above	0(0)	22(36.7)	25(41.7)	0(0)	0(0)	0(0)
		Total	60	100	60	100	60	100

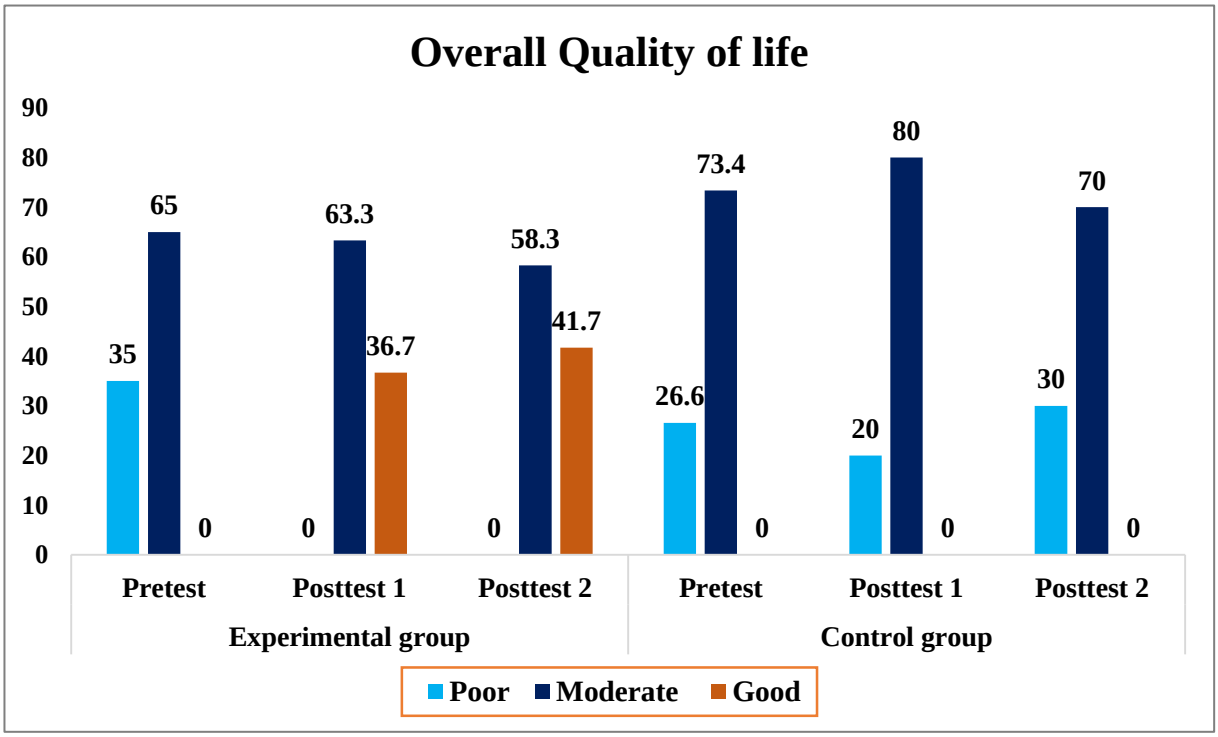


Fig no 8: Bar diagram showing percentage distribution of Quality of life among geriatric clients in experimental group and control groups.

Table: 6 & Fig 8 represents the overall level Quality of Life scores in experimental & control groups.

The findings in the pretest represents, majority of the geriatrics in the experiment group (65%) had moderate level of QOL, (35 % had poor QOL, and none of the study participants belonged to good level of QOL regarding health promotion outcomes. At the time of posttest assessment 1 on 30th day after the Multimodal intervention, majority (63.3%) had moderate level of QOL, (36.7%) had good level of QOL, and none of the study participants had poor level of QOL. On 60th day posttest 2, majority (58.3%) had moderate QOL and (41.7%) had good QOL regarding health promotion and none of the samples had poor QOL.

Whereas in control group in the pretest majority of the geriatrics (73.4%) had moderate level of QOL, (26.6%) had poor QOL, while none of the study participants belonged to good level of QOL regarding health promotion. At the time of posttest assessment 1 on 30th day, majority (80%) had moderate level of QOL, (20%) had poor QOL and none of the samples had good level of QOL. On 60th day posttest 2, majority (70%) had moderate QOL and (30%) had poor QOL regarding health promotion outcomes and none of study participants had good QOL.

Pretest and posttest scores on the quality of life were improved in the experimental group after the multimodal intervention, thus the stated **Research Hypotheses H_1 is accepted**.

Table 7: Area wise distribution of quality of life regarding health promotion among experimental and control groups of geriatric clients. (n=60+60)

Sl.no	Area wise (QOL)	Max score	Experimental Group(n=60)			Control Group (n=60)		
			Pretest	Posttest I	Posttest II	Pretest	Posttest I	Posttest II
			Mean±SD			Mean±SD		
1	Sensory Abilities	20	8.3±2.5	13.5±1.87	13.1±1.97	11.78±4.2	8.98±2.7	8.3±2.23
2	Autonomy	20	9.2±3.08	10.6±2.4	10.9±1.2	7.5±1.6	7.8±2.1	7.9±2.28
3	Past, Present and Future Activities	20	9.3±2.84	11.4±2.00	12.7±1.14	7.8±2.1	8.5±2.4	8.6±2.3
4	Social Participation	20	7.1±1.16	11.2±2.2	12.8±1.8	8.5±2.9	9.6±2.9	8.7±2.56
5	Death and Dying	20	11.5±2.1	16.2±2.08	13.5±1.9	13.0±4.6	9.7 ±3.5	9.53± 2.9
6	Intimacy	20	9.1±2.24	11.0±1.8	14.5±1.48	8.1±2.7	8.2 ±1.9	8.8± 2.4
	Overall	120	54.5	73.92	77.5	55.6	55.7	51.25

Table 7 depicts the Quality of Life scores regarding Health promotion outcomes in experimental and control groups. Among the geriatric clients in the experimental group who received the Multimodal Intervention observed an improved mean QOL scores enhancement from (**54.5, 73.92 and 77.5)** respectively.

In Control group the enhancement of mean QOL scores observed was (**55.6, 55.7 and 51.25)** respectively with minimal/no change in the mean QOL scores. Hence there was an increase in the mean scores from pretest to posttest 2 in the experimental group with highest scores seen to be in the domain areas of Sensory abilities, Death & Dying & Intimacy.

Table 8: Distribution of area-wise RFS & TFS Scores of QOL regarding health promotion among geriatric clients in experimental & control Group.

(n =60+60)

Area wise (QOL)	Test	Experimental Group			Control Group		
		RFS	TFS	p-value	RFS	TFS	p value
SAB	Pretest	8.3 ± 2.5	27.1 ± 16.1		11.7 ± 4.2	48.3±26.6	
	Posttest I	13.5 ± 1.8	59.4± 11.7	0.01	9.0 ± 2.7	31.2± 16.9	0.3
	Posttest II	13.1 ± 1.9	57.1±12.3		8.3 ± 2.2	27.0± 13.9	
ABOUT	Pretest	9.2 ± 3.0	32.7±19.2		7.5 ± 1.6	21.8±10.0	
	Posttest I	10.6 ± 2.4	41.4±15.2	0.3	7.8 ± 2.1	24.0± 13.5	0.5
	Posttest II	10.9 ± 1.2	43.3 ±7.5		7.9 ± 2.2	24.3± 14.2	
PPF	Pretest	9.3 ± 2.8	33.5± 17.7		7.8 ± 2.1	24.1±13.4	
	Posttest I	11.4 ± 2.0	46.6± 12.5	0.7	8.5 ± 2.3	28.3± 14.9	
	Posttest II	12.7 ± 1.1	54.5 ± 7.1		8.6 ± 2.3	28.9± 14.4	0.4
SOP	Pretest	7.1 ±1.1	19.5± 7.0		8.5± 2.9	28.2± 18.7	
	Posttest I	11.2± 2.2	45.0± 14.0	0.34	8.8± 2.9	30.0± 18.1	
	Posttest II	12.8± 1.8	55.0± 11.7		8.7 ± 2.5	29.5± 16.0	
DAD	Pretest	11.5± 2.1	47.2± 13.6		13.0± 4.6	56.2± 28.9	0.6
	Posttest I	16.2 ± 2.0	76.6 ± 13.0		9.8± 3.5	36.4± 21.9	
	Posttest II	13.5± 1.9	59.5 ± 12.2	0.03	9.5± 2.9	34.5± 18.3	
INT	Pretest	9.1 ± 2.2	31.9 ± 14.0		8.2± 2.6	26.6± 16.3	
	Posttest I	11.0± 1.8	44.1 ± 11.6		8.0± 2.1	25.1± 13.5	0.4
	Posttest II	14.5 ± 1.4	66.0± 9.3	0.01	8.8± 2.4	30.2± 15.4	

t- test. RFS=Raw facet score, TFS=Transformed facet scores, SAB=Sensory abilities, AUT=Autonomy, PPF=Present and future activities, SOP=Social participation, DAD=Death and dying, INT=Intimacy. Transformed facet score obtained using transformation rule:: TFS = 6.25 x (RFS - 4) the score ranges between 0 and 100.

Table 8 indicates the area-wise RFS & TFS Scores of QOL regarding health promotion among geriatric clients in the experimental & control Group. However, a statistically significant difference was seen in the domain areas like Sensory abilities, Death and dying, and Intimacy which presents improved scores signifying that the better quality of life the QOL. Whereas in the control group, all the domains showed non-significant changes. High scores represent high quality of life.

Section III: Effectiveness of multi-modal intervention regarding health promotion on perception and quality of life among geriatric clients in experimental and control groups.

Table 9: Comparison of the Perception scores among geriatric clients within the experimental and the control groups.

(n =60+60)

Sl.no	Duration of Assessment	Experimental group			Control Group		
		Mean±SD	Enhancement	Paired t-test p-value	Mean±SD	Enhancement	Paired t-test p-value
1	Pretest	35.7 ±7.9	10.5	8.9 <0.001** **SS**	34.9 ± 8.8	0.81	.72 .470 NS
	Posttest I	46.3 ±6.1			34.1 ± 7.9		
2	Pretest	35.7 ±7.9	12.5	11.1 <0.001** SS	34.9 ± 8.8	0.17	.11 .907 NS
	Posttest II	48.3 ±4.7			35.0 ± 8.7		
3	Posttest I	46.3±6.1	1.9	3.4 <0.001** SS	34.1 ± 7.9	0.98	.68 .494 NS
	Posttest II	48.3 ±4.7			35.0 ± 8.7		

Level of significance: $p<0.05$ is considered as significant, $p \geq 0.05$ was considered non-significant; **$p<0.001$ was considered highly significant**.**

Table 9, fig 9 shows that in the Experimental group the mean post-test perception scores were significantly higher than the pretest perception scores(mean ± SD post-test 1=46.35 ±6.1, post-test 2=48.33 ±4.7) after the multimodal intervention, which proved that multimodal intervention is very effective in increasing the perception regarding health promotion among the geriatric clients in the experimental group, However in the control group there was no significant differences observed from pretest and posttest mean perception scores.

Multimodal intervention is found to be effective in enhancing the level of perception among geriatric clients in the experimental group. Thus the stated **Research Hypotheses H_2** is accepted.

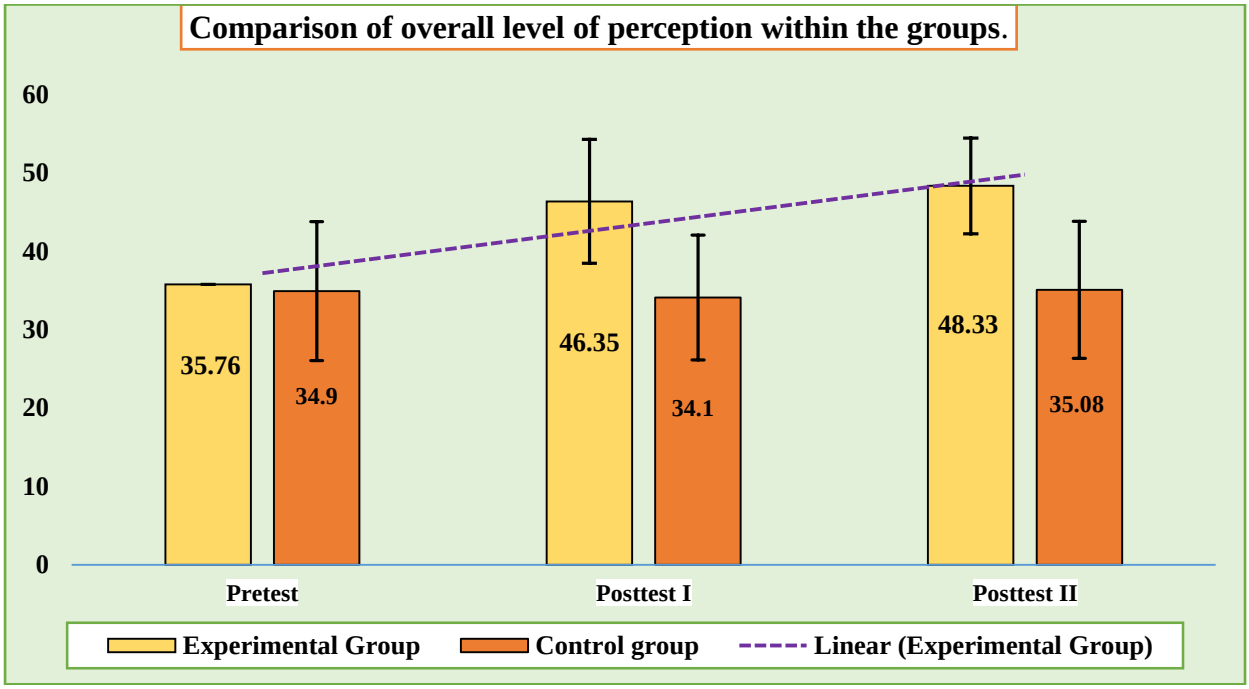
Table 10: Comparison of the Quality of life scores among geriatric clients within the experimental and the control groups. (n =60+60)

Sl.no	Duration of Assessment	Experimental group			Control Group		
		Mean±SD	Enhancement	Paired t-test p-value	Mean±SD	Enhancement	Paired t test p-value
1	Pretest	54.7 ±10.3	19.35	14.1 <0.001** **SS**	55.6 ± 12.7	.3833	.213 .832 NS
	Posttest I	74.1 ±6.7			55.4± 11.5		
2	Pretest	54.7±10.3	22.95	15.41 <0.001** **SS**	55.6 ± 12.7	3.533	2.04 .045 NS
	Posttest II	77.7± 4.9			52.3 ± 11.3		
3	Posttest I	74.11 ±6.7	3.60	3.51 <0.001** **SS**	55.4± 11.5	3.150	1.69 .096 NS
	Posttest II	77.7± 4.9			52.3 ± 11.3		

Level of significance: $p<0.05$ is considered as significant, $p \geq 0.05$ was considered non-significant;**$p<0.001$ was considered highly significant.

Table 10 & fig 10 represent that in the experimental group the mean quality of life scores were significantly higher during both posttests (mean ± SD post-test 1=74.11 ± 6.7, post-test 2=77.7± 4.99) after the multimodal intervention, which proved that multimodal intervention is very effective in increasing the quality of life regarding health promotion among the geriatric clients in the experimental group, However in the control group there were no significant differences observed from pretest and posttest mean quality of life scores.

Multimodal intervention is found to be effective in enhancing the Quality of life among geriatric clients in the experimental group. Thus the stated **Research Hypotheses H_2** is accepted.



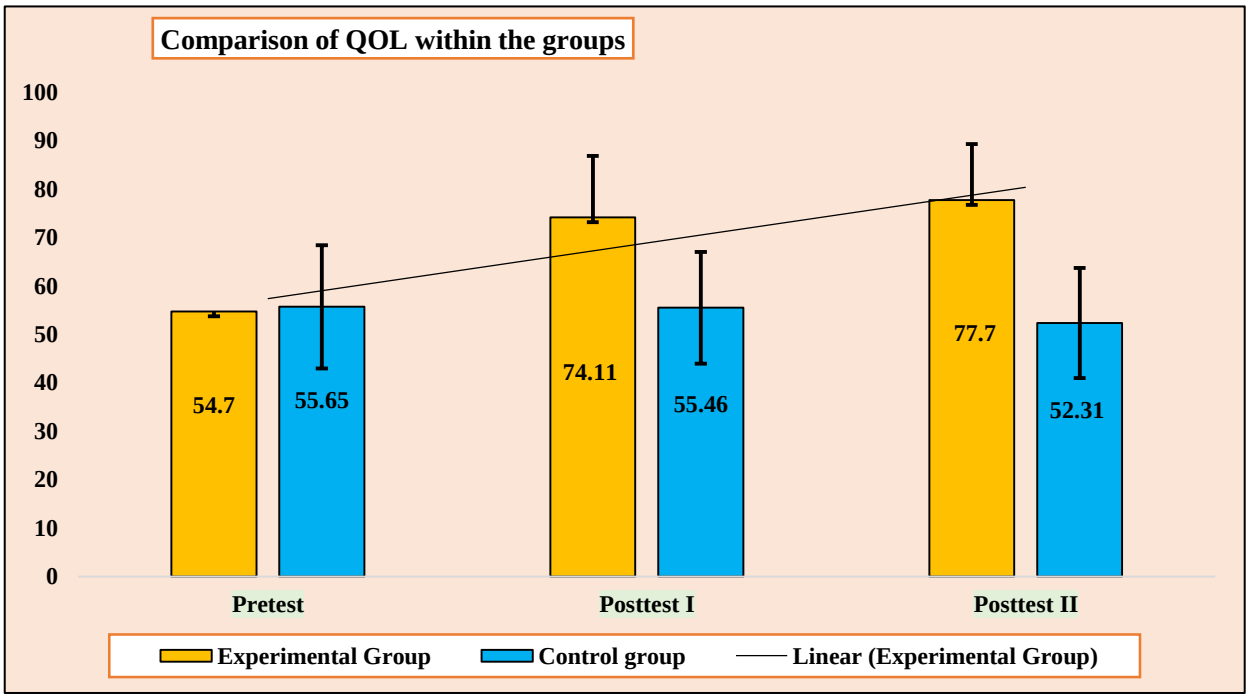


Fig 9 & 10: Depicts the Bar diagram mean scores of Perception and Quality of life within the study groups.

Table 11: Comparison of the level of perception scores between experimental and control groups. (n =60+60)

sl.no	Level of Perception	Experimental group	Control group	MD	Independent 't' Value	p-Value & Inference
		Mean±SD				
1.	Pretest	35.6± 10.3	34.6±11.5	1	.74	.45 NS
2.	Posttest I	46.3 ±9.7	34.10±10.8	12.2	9.44	<0.001** SS
3.	Posttest II	48.3 ± 9.0	34.9± 11.0	13.4	10.30	<0.001**SS

Level of significance: p<0.05 is considered as significant, p ≥0.05 was considered non-significant; **p<0.001 was considered highly significant.

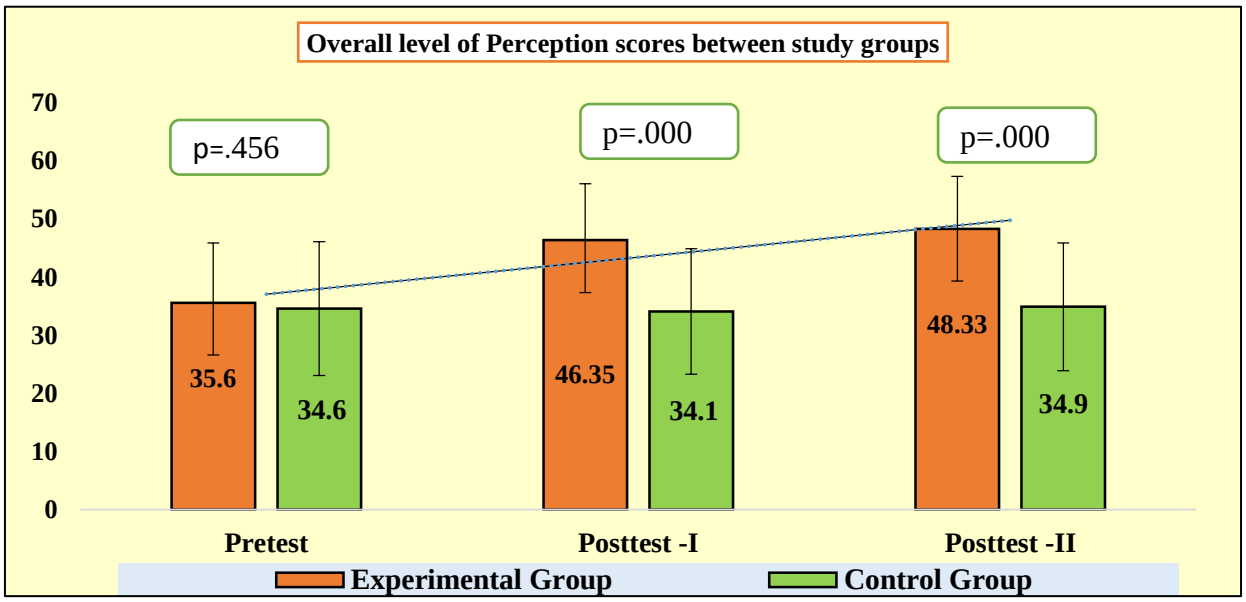


Fig 11: Depicts the Bar diagram mean scores of the level of perception between the study groups.

Table 11, figure 11 is evident that the post-test mean perception scores in the experimental group were found to be higher and significant at (p=<.000) after the multimodal intervention, whereas in the control group, no significant changes were observed.

There was a significant enhancement in the level of perception scores in the experimental group compared to the control group. Hence the stated **research hypotheses H_2** is accepted.

Table 12: Comparison of the Quality of life scores among geriatric clients between experimental and the control groups. (n =60+60)

Sl.no	Level of QOL	Experimental group Mean±SD	Control group Mean±SD	MD	Independent 't' Value	p-Value & Inference
1.	Pretest	54.5 ± 13.8	55.6± 18.1	1.1	.409	.686 NS
2.	Posttest -I	73.9 ±12.3	55.7 ±15.5	22.5	3.74	<0.001**SS
3.	Posttest -II	78.2 ± 9.4	51.2 ± 14.6	27	6.15	<0.001**SS

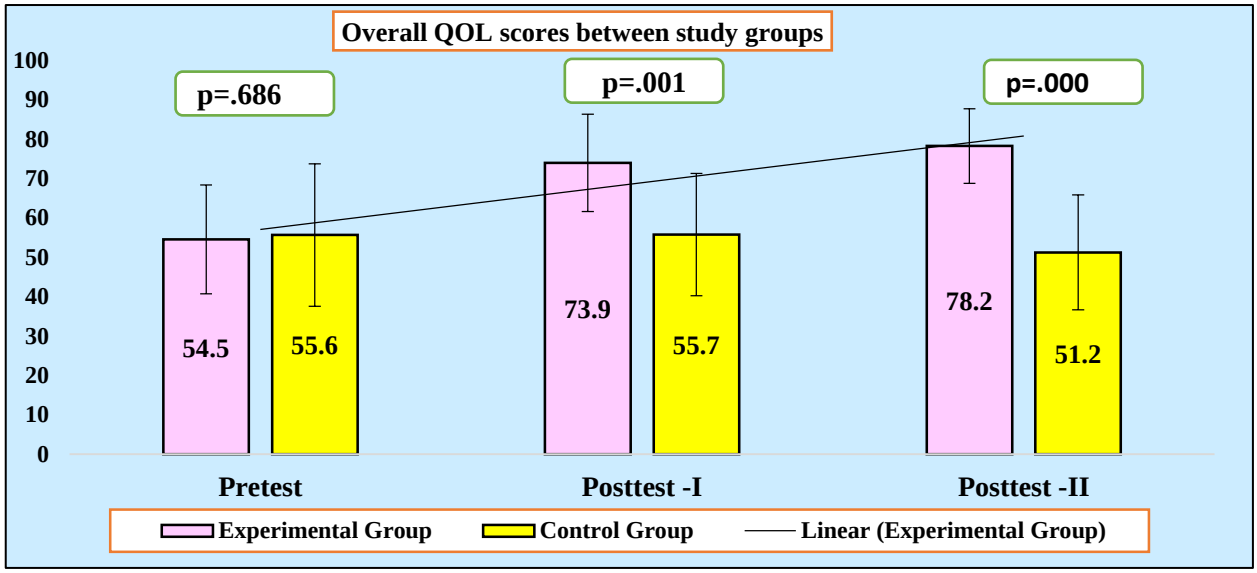


Fig 12: Depicts the Bar diagram mean scores of Quality of life between the study groups.

Table 12 & figure 12 it is evident that the posttest means the quality of life scores in the experimental group were found to be higher and significant at (p=<.000) after the multimodal intervention, whereas, in the control group, no significant changes were observed during the posttest.

There was a significant improvement in the Quality of life scores in the experimental group compared to the control group. Hence the stated **Research Hypotheses H_2** is accepted.

Table 13: Repeated Measures of ANOVA of Perception scores in experimental and control Groups. (N=120)

Sl.no	Assessment	Experimental	Control	df	F	WL & Sig	Partial eta squared
		Mean±SD					
1.	Pretest	35.7±7.9	34.6±9.0			.319	
2.	Posttest 1	46.3±6.1	34.1±7.9	2	61.88		.6816
3.	Posttest 2	48.3±4.7	35.0±8.7			<0.001**SS	

The statistical test used is repeated measures ANOVA. Level of significance: $p<0.05$ is considered as significant, $p \geq 0.05$ was considered non-significant; df= 2,188, **$p<0.001$ was considered highly significant.

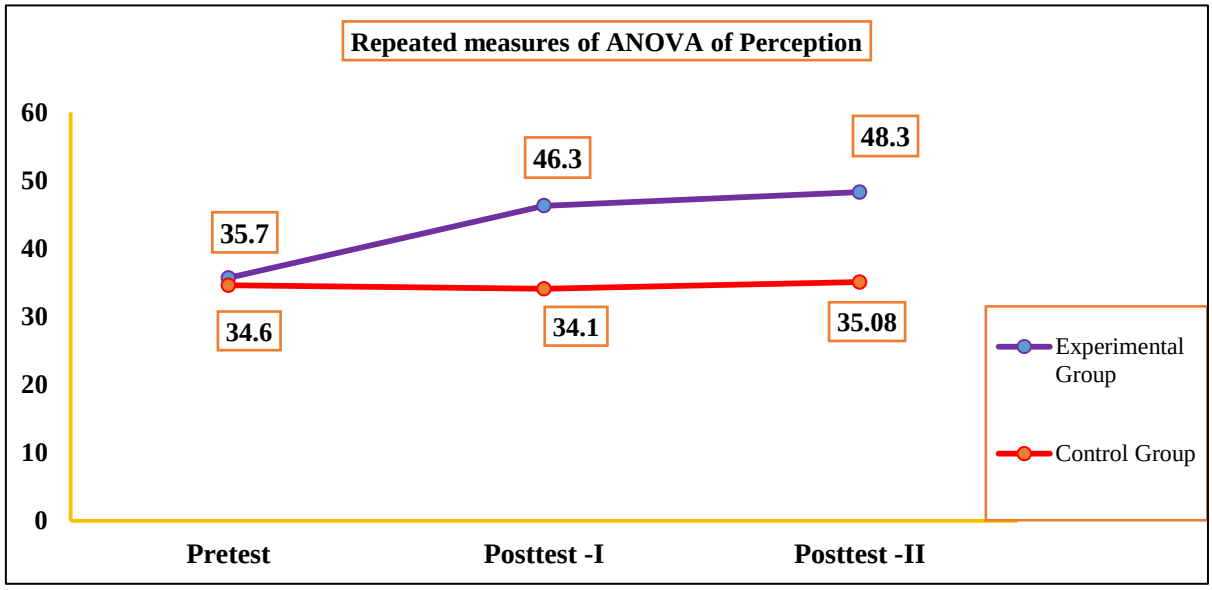


Fig 13: Line graph showing Repeated measures of ANOVA of mean perception scores

Table 13 &figure 13 describes that Over a period of time, there is a consistent increase in mean perception scores after the intervention and relatively significant effect size with partial eta-squared (ηp2=.6816) and Wilks lamba value of (.319) highly significant at (p= .000) in the experimental group whereas in the control group, no significant changes observed.

Conclusion: Multimodal Intervention was found very effective in increasing the perception regarding health promotion among geriatric clients. Hence Stated research **Hypotheses H_2** is accepted**.**

Table 14: Repeated Measures of ANOVA of Quality of Life scores in experimental and control groups. **(N=120)**

S l.no	Assessment	Experimental	Control	df	F	WL & Sig	Partial eta squared
		Mean±SD					
1.	Pretest	54.76±10.39	55.85±12.72	2	22.30	.726 <0.001**SS	.274
2.	Posttest 1	74.15±6.75	55.46±11.55				
3.	Posttest 2	77.71±4.99	52.31±11.390				

Level of significance: p<0.05 is considered as significant, p ≥0.05 was considered non-significant; df= 2,188, **p<0.001 was considered highly significant.

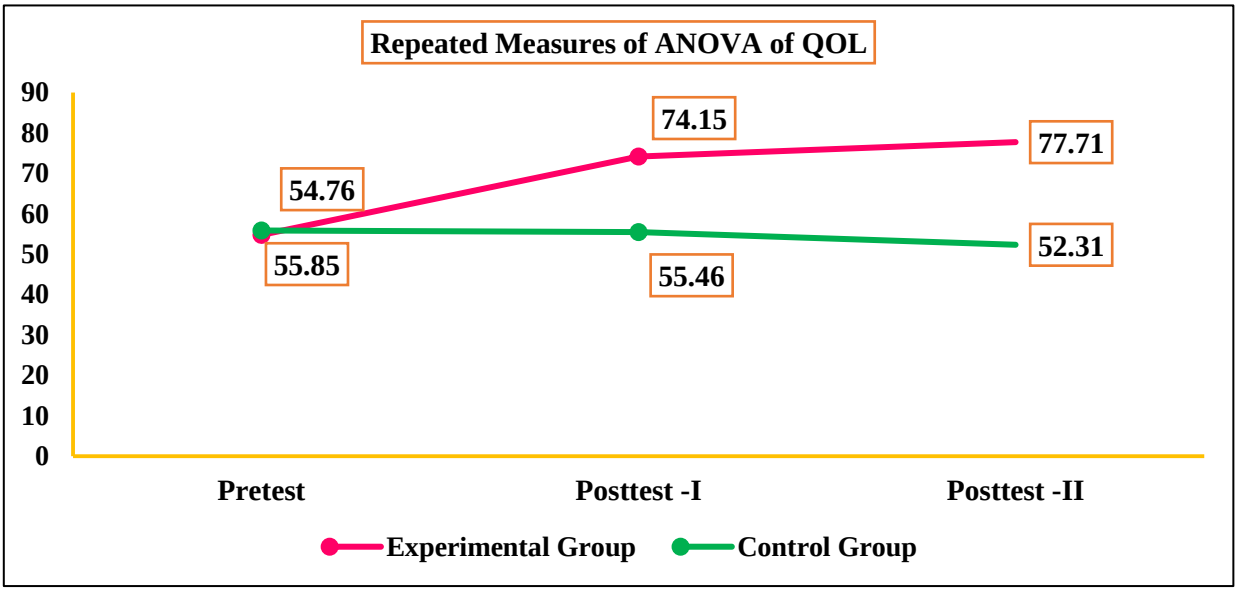


Fig 14: Line graph showing Repeated measures of ANOVA of mean QOL scores

Table 14 & figure 14 describe that Over a period of time, there is a consistent increase in mean quality of life scores after the intervention and a relatively significant effect size with partial eta-squared (ηp2=0.274) and Wilks Lamba value with a large effect size of (.726) significant at (.000) in experimental group whereas in control group no significant change was observed.

Conclusion: Multimodal Intervention was very effective in improving the quality of life regarding health promotion among geriatric clients. Hence stated **Research Hypotheses H_2** is accepted**.**

Table 15: Bonferroni Post hoc test to assess the perception among geriatric clients between study groups. (N=120)

Experimental					Control group				
(I) Time	(J) Time	Mean Difference (I-J)	Std. Error	p-value	(I) Time	(J) Time	Mean difference (I-J)	Std.error	P value
Pretest	Posttest 1	10.583*	1.179	<0.001	Pretest	Posttest 1	.500	1.101	1.000
Pretest	Posttest 2	12.567*	1.131	<0.001	Pretest	Posttest 2	-.483	1.423	1.000
Posttest1	Posttest 2	1.983*	.580	.003	Posttest1	Posttest 2	-.983	1.429	1.000

Level of significance: $p<0.05$ was considered significant, and $p \geq 0.05$ was considered non-significant. **$p<0.001$ was considered highly significant.

Post hoc analysis was carried out using the Bonferroni test to compare the effect between different times of observation. Data in Table 15 shows that there is a significant difference in the change in mean pre and post-test scores of perception of geriatric clients between the experimental and control groups at different points of time ($p<0.05$).

A significant difference in the mean perception scores was observed at different points of time in the experimental group compared to the control group.

Therefore, the stated **Research Hypotheses H_2** is accepted.

Table-16: Bonferroni Post hoc test to assess the Quality of life among geriatric clients between study groups. (N=120)

Experimental					Control group				
(I) Time	(J) Time	Mean Difference (I-J)	Std. Error	p-value	(I) Time	(J) Time	Mean differen ce(I-J)	Std. error	P value
Pretest	Posttest 1	5.65*	2.013	.020	Pretest	Posttest 1	.383	1.796	1.000
Pretest	Posttest 2	5.75*	2.161	.030	Pretest	Posttest 2	3.53	1.726	.135
Posttest1	Posttest 2	.100*	1.829	0.001	Posttest 1	Posttest 2	3.15	1.863	.288

Level of significance: $p<0.05$ was considered significant, and $p \geq 0.05$ was considered non-significant. **$p<0.001$ was considered highly significant.

Post hoc analysis is done by the Bonferroni test to compare the effect between different times of observation. Data in Table 16 shows that there is a significant difference in the mean Quality of Life scores of geriatric clients between the experimental and control groups at different points of time ($p<0.05$).

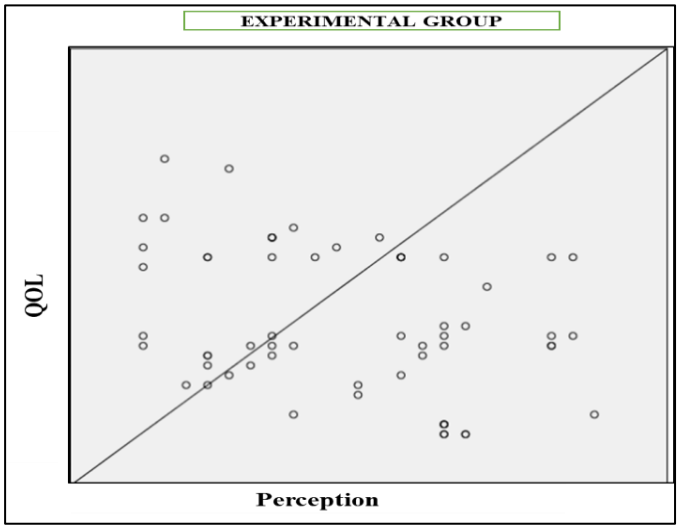
A significant difference in the mean QOL scores was observed at different points of time in the experimental group compared to the control group.

Therefore, the stated **Research Hypotheses H_2** is accepted.

Section IV: To find the correlation between perception & quality of life among geriatric clients in the experimental and control groups.

Table 17: Distribution of sample to find the relationship of perception and QOL among geriatric clients in experimental and control groups. (N=120)

Sl.n	Variables	Group	Posttest 1	Posttest 2	Inference
			r &p value	r &p value	
1	Perception and Quality of Life	Experimental Group	r= .318 (.013) **** SS**	r= .273 (.035)**** SS**	Positive Correlation p<0.005, **SS****
		Control Group	r= .198 (.129) **NS**	r=- - .162 (.215)	Moderately negative correlation



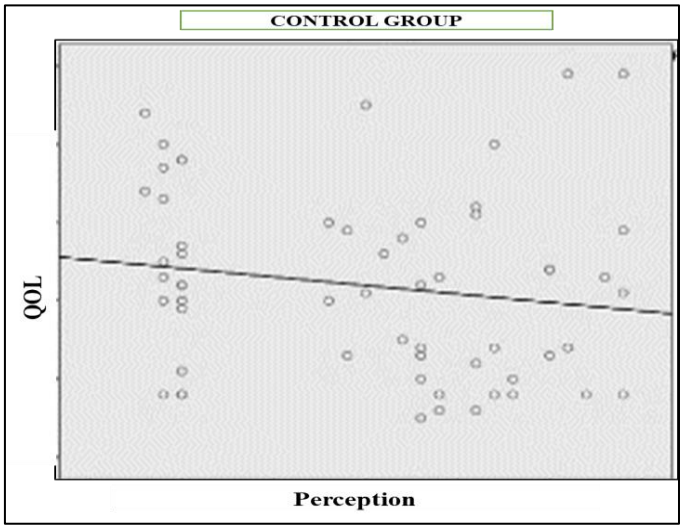


Table 17, fig 15 & 16 Scatter diagram showing the correlation between perception and QOL in the study groups.

It is observed that there was a strong positive correlation between perception and QOL variables which was significant at $p < 0.05$ in the experimental group after the multimodal intervention, so it states that, as the perception increases the Quality of Life also increases towards health promotion outcomes. There was a statistically significant relationship between perception and Quality of Life variables. Thus the stated research hypothesis $\mathbf{H_3}$ is accepted.

Section V: Association between pretest perception and Quality of life scores among geriatric clients and the selected socio-demographic variables.

Table-18: Association between pretest perception scores and the selected socio-demographic variables in experimental and control groups (n=60+60)

Sl. no	Demographic Variables	Experimental			Control Group		
		Poor(18)	Moderate (>26)	χ^2 &p value	Poor<18	Moderate (>26)	χ^2 &p value
1.	**Age**						3.14(.076)
a.	60-67 years	10	31	6.61(.010)	13	34	df= 1, **NS**
b.	68-75 years	8	11	df=1, **SS***	7	6	
2.	**Gender**						
a.	Male	11	22	0.38(.53)	9	11	2.96(.084)
b.	Female	7	20	df=1, **NS**	11	29	df=1, **NS**
3	**Educational status**						0.32(.565)
a.	Formal Education	8	15	0.40(.52)	8	13	df=1, **NS**
b.	No formal education	10	27	df= 1, **NS**	12	27	
04	**Religion**						
a.	Hindu	11	23	0.20(.6492)	14	27	0.038(.844)
b.	Muslim & Others	7	19	df=1, **NS**	6	13	df=1, **NS**
05	**Marital status**						
a.	Married	12	31	0.31(.573)	7	34	15.4(<0.001)
b.	Widow/Widower/Separated	6	11	df=1 **NS**	13	6	df=1, **SS***
06	**Residence**						
a.	Rural	9	33	4.89(.026)	12	32	2.72(.098)
b.	Semi-urban/Urban	9	9	df=1, **SS***	8	8	df=1,**NS**
07	**Socioeconomic status**						
a.	APL	6	7	2.06(.15)	8	7	3.6(.057)
b.	BPL	12	35	df=1, **NS**	12	33	df=1, **NS**
08	**Type of family**						
a.	Nuclear Family	7	11	0.96(.325)	7	13	0.32 (.565)
b.	Joint Family	11	31	df=1, **NS**	13	27	df=1, **NS**
09	**History of comorbidity**						
a	Diabetes & Hypertension	12	28	0.03(.859)	13	34	3.14(.076)
b	Other health problems	6	14	df=1, **NS**	7	6	df=1, **NS**
10	**History of health checkup**	.					
a	No	6	27	4.87(.027)	10	31	3.47(.062)
b	Yes(1-2 Years)	12	15	df=1, **SS***	10	9	df=1 ,**NS**

df=1, table value =3.84 SS* Statistically significant, NS Not significant

Table 18 indicated that the obtained $\chi 2$ value was greater than the table value only in the sample of the experimental group concerning **age** ($\chi 2$ 6.61, p=.010), **residence** ($\chi 2$ 4.89, p= .026), and **history of health checkup** ($\chi 2$ 4.87, p= .027). Hence the Research Hypotheses **H_4 is accepted**. Whereas the obtained value was not statistically significant for the other variables like gender ($\chi 2$ =0.38, p=.53), educational status ($\chi 2$ =0.40 p=.52), religion ($\chi 2$= 0.20p=.6492), marital Status ($\chi 2$= 0.3, p=.573) socioeconomic status ($\chi 2$ 2.06p=.15) type of Family ($\chi 2$=0.96p=.325) and history of comorbidity ($\chi 2$=0.03p=859). Hence it shows that, no statistically significant association with selected socio-demographic variables in the experimental group.

In the control group, it was found that the $\chi 2$ value was greater than the table value only in **marital status** ($\chi 2$=15.4p=0.001) which indicates a significant association. Whereas the obtained value was not statistically significant for the other variables like age ($\chi 2$= 3.14,p=.076),gender$\chi 2$=2.96 p=.084), educational status($\chi 2$=0.32p=.565), religion ($\chi 2$=1.27 and p=.528), residence ($\chi 2$= 2.72 p=.098), socioeconomic status ($\chi 2$ =3.6,p=.057), type of family ($\chi 2$ =0.32 p=.565), history of comorbidity ($\chi 2$ =3.14,p=.076), history of health check-up ($\chi 2$ =3.47p=.062).

The association was found to be significant for selected variables in the experimental group compared to the control group thus, the stated research hypotheses **H_4** was accepted.

Table-19: Association between pretest Quality of life scores and the selected socio-demographic variables in experimental and control groups (n=60+60)

Sl.no	Demographic Variables	Experimental			Control Group		
		Poor (<40)	Moderate (>41)	Inference	Poor (<40)	Moderate (>41)	Inference
1.	**Age**						
a.	60-67 years	14	27	0.041(.838)	10	37	3.22(.0726)
b.	68-75 years	7	12	df=1 **NS**	6	7	df=1, **NS**
02	**Gender**			1.77(.182)			1.90(.167)
a	Male	14	19	df=1,**NS**	9	16	df=1, **NS**
b	Female	7	20		7	28	
03	**Educational status**			12.5(<0.001)			2.15(.141)
a	Formal Education	14	8	df= 1,**SS***	8	13	df=1, **NS**
b	No formal education	7	31		8	31	
04	**Religion**			3.52(.060)			6.09(.013)
a	Hindu	15	18	df=1, **NS**	7	34	df=1, **SS***
b	Muslim & Others	6	21		9	10	
05	**Marital status**			0.39(.528)			3.3(.0656)
a	Married	14	29	df=1, **NS**	8	33	df=1, **NS**
b	Widow/Widower/Separated	7	10		8	11	
06	**Residence**			4.83(.027)			2.44(.117)
a.	Rural	9	28	df=1, **SS***	10	36	df=1**,NS**
b.	Semi-urban/Urban	12	11		6	8	
07	**Socioeconomic status**			2.59(.107)			0.454(.500)
a.	APL	7	6	df=1, **NS**	5	10	df=1, **NS**
b	BPL	14	33		11	34	
08	**Type of family**			7.70(.005)			2.96(.085)
a.	Nuclear Family	11	7	df=1, **SS***	9	14	df=1,**NS**
b.	Joint Family	10	32		7	30	
09	**History of comorbidity**						3.22(.072)
a	Diabetes & Hypertension	12	28	4.14(.034)	10	37	df=1,**NS**
b	Other health problems	8	12	df=1, **SS***	6	7	
10	**History of health check up.**						
a	No	13	20	0.62(.430)	8	33	3.38(.065)
b	Yes(1-2 Years)	8	19	df=1,**NS**	8	11	df=,**NS**

df=1, table value =3.84 SS* Statistically significant, NS Not significant

Table 19 indicated that the obtained $\chi 2$ value was greater than the table value in sample of experimental group about **educational status** ($\chi 2$ 12.5p=0.001), **residence** ($\chi 2$ 4.83, p=.027), **type of family (**$\chi 2$= 7.70, p=.005) and **history of comorbidity** ($\chi 2$ =4.14, p=.034), Hence the Research Hypotheses **H_5, is accepted**. Whereas the obtained value was not statistically significant for the remaining variables like age ($\chi 2$=0.041, p=.838) gender ($\chi 2$=1.77, p=.182), religion ($\chi 2$=3.52,p=.060) marital Status ($\chi 2$=0.39,p=.528), socioeconomic status ($\chi 2$ =2.59, p=.107), type of family ($\chi 2$=0.96,p=.325) and history of health checkup ($\chi 2$= 0.62,p=.430).

Whereas in the control group, it is found that, the $\chi 2$ value was greater than the table value about **religion only** (χ^2 = 6.09, p=.013) indicates a significant association. And found non-significant to other variables like age ($\chi 2$ =3.22,p=.0726) ,gender ($\chi 2$ =1.90,p=.167) ,educational status ($\chi 2$ =2.15,p=.141) marital Status, ($\chi 2$ =3.3,p=.065), residence ($\chi 2$=2.44,p=.117) ,socioeconomic status ($\chi 2$ =0.454,p=.500),type of Family ($\chi 2$=2.96 ,p=.085),history of comorbidity ($\chi 2$=3.14,p=.076) history of health check-up ($\chi 2$=3.38,p=.065).

The association was found to be significant for selected variables in the experimental group compared to the control group thus, the stated research hypothesis **H_5** is accepted.

SEC VI: Feedback /Opinionnaire Regarding Multimodal Intervention On Health Promotion Strategies N-30

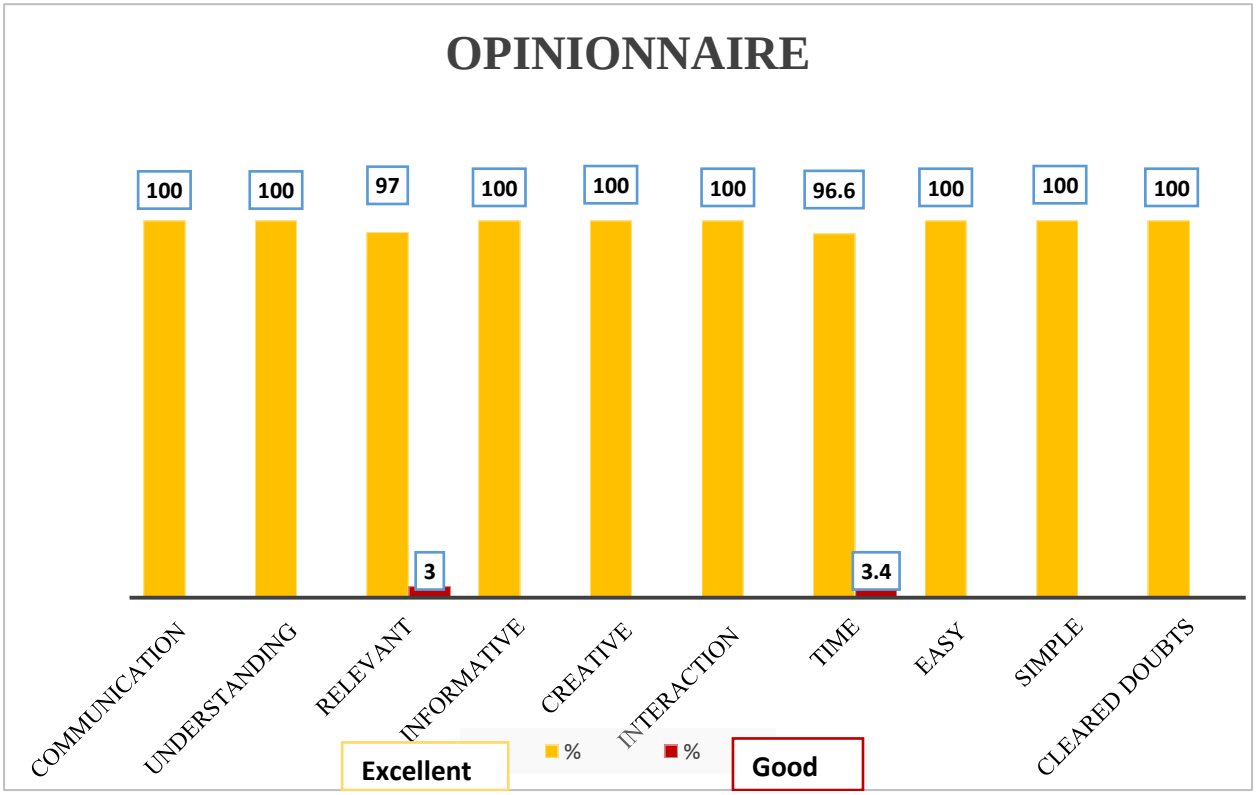


Fig 17: depicts the bar diagram showing the percentage of participants' response/feedback regarding MMI Intervention

This chapter dealt with the data analysis findings and interpretations of the study represented in tabular and graphical presentations.

CHAPTER –VI

DISCUSSION

CHAPTER-VI

DISCUSSION

Optimizing health promotion outcomes for geriatric clients requires the collaborative and coordinated efforts of physician's nurses, health personnel, and caregivers. Geriatric health promotion is always been the need of the hour for the present situation. Today's nurses enter a realm of opportunities and challenges in providing high-quality evidence-based care in healthcare settings.

Health promotion among geriatrics serves as a standard strategy to foster healthy aging and improve better quality of life. Thus, multimodal intervention acts as an effective way to create awareness.

The perspectives of the findings have been discussed regarding the research problem, conceptual framework, objectives, hypotheses, and assumptions of the study. The present study aimed to evaluate the **"**Effectiveness of Multi-Modal Intervention regarding Health Promotion on Perception and Quality of Life among Geriatric Clients seeking Medical services at selected Hospitals, Kolar**"**.

OBJECTIVES OF THE STUDY:

1. To assess the perception and quality of life regarding health promotion among geriatric clients in the experimental & control group.
2. To evaluate the effectiveness of multi-modal intervention regarding health promotion on perception and quality of life among geriatric clients by comparing pretest and post-test scores in both experimental and control groups.
3. To find the correlation between Perception & Quality of life among geriatric clients in the experimental and control groups.

4. To determine the association on the pretest level of perception and quality of life with selected demographic variables of geriatric clients in the experimental and control groups.

This chapter discusses the major findings of the study based on objectives and hypotheses, which are reviewed in terms of results obtained by other investigators.

Organization of Findings: The analyzed data is organized and presented under the following sections

Section 1: Socio-demographic variables and bio physiological parameters of both experimental and Control groups.

Section II: Overall and area-wise perception and quality of life scores of sample among experimental and control groups.

Section III: Effectiveness of multimodal intervention regarding health promotion on perception and quality of life among experimental and control groups.

Section IV: Relationship between perception and quality of life among geriatric clients.

Section V: Association between the perception and quality of life with selected socio-demographic variables in both experimental and control groups.

Section 1: Socio-demographic variables and bio-physiological parameters of both experimental and Control groups.

The socio-demographic variables of the sample reveal that in the experimental group, majority (68.3%) of the geriatric clients were in the age group of 60-67 years and the mean age found to be (68.02) were males (55%) while in the control group, majority (78.3%) were aged 60-67 years with the mean age (68.23) and were females (58.4%).

In both the groups, the majority (61.7%) of the geriatric clients had no formal education in experimental group and control group (39%) and Most (56.6%) belonged to Hindu religion in experimental group whereas in control group-(68.3%) respectively.

In terms of marital status in both groups majority (71.6%) were married in experimental and (68.3%) in control group and most (70%) of the geriatrics belonged to from rural residences in experimental group and control group is (76.6%).

Regarding Socioeconomic status, both groups belonged to the below poverty line (experimental group-78.4%, control group-75%). In the type of family, both the groups belonged to the Joint family system (experimental group-70%, control group-65%).

In both groups, the majority (66.6%) had a history of co-morbid conditions such as diabetes& hypertension in experimental group and found (78.3%) in control group.

In response to the history of health checkups, the in experimental group majority (55%) and (68.3%) in control group had not undergone health checkups within 1 year of duration.

There is no significant difference ($p>0.05$) in any of the demographic characteristics of the geriatric clients in the experimental and control groups. Hence both the groups were considered homogenous.

Bio-physiological parameters of both experimental and Control groups.

Concerning, assessment of nutritional status Majority 28(46.7%) in experimental and 30(50%) in the control group were undernourished and 28(46.7%) in the experimental and 19 (31.7%) in the control group were found to be in the normal weight, whereas 4(6.7%) & 11(18.3%) were obese in experimental & control group respectively.

Regarding Visual Acuity, 31(51.7%) in the experimental group and 26 (43.3%) in the control group had normal visual acuity, while 29(48.3%) & 34(56.7%) had deficit visual acuity in the experimental & control group respectively.

The Hearing acuity found to be Normal in most 43(71.7%) and 44(73.3%) in the experimental & control groups. While 17(28.3%) in the experimental group and 16(26.7%) in the control group had deficit hearing acuity of geriatric clients.

About, Activities of Daily Living, Majority 38(63.3%) of respondents were found to have Independent ADLs in experimental and 32 (53.3%) in the control group. Dependent respondents were 22(36.7%) in the experimental group and 25(41.7%) in the control group.

The Sleep pattern status was adequate among 29(48.3%) in the experimental & 19(31.7%) in the control group. 31(51.7%) had inadequate sleep in experimental group & 41(68.3%) in control group respectively.

Regarding bowel patterns, almost 36(60%) in the experimental & 45(75%) in the control group had regular patterns, while 24(40%) and 15(25%) respondents had Irregular bowel patterns in the experimental & control group. In terms of Bladder pattern, Overall 36(60%) in the experimental group and 45(75%) in the control group had regular bladder patterns whereas 24 (40%) in the experimental group and 15(25%) control group reported Urinary incontinence.

The experimental group regarding Personal habits reported that 45(75%) of respondents & 50(83.3%) had habits of smoking, and tobacco chewing in the control group. No habits were reported among 15(25%) in the experimental group & 10(16.7%) control group respectively.

Regarding status of Financial Dependence majority, 23(38.3%) in experimental & control group 26(43.3%) were partially dependent and 21(35%) in experimental group & 17(28.4%) in Control group were totally dependent while 16(26.7%) and 17 (28.3%) were Independent.

In terms of Physical activity, almost 24(40%) respondents in the experimental and 22(36.6%) in the control group not involved in any physical activity, whereas respondents involved less than 20 minutes of physical activity in the Experimental group is 19(31.7%) and 11(18.4%) in the control group. The homogeneity of the samples according to biophysiological parameters was found to be consistent between experimental and control groups by using the Chi-square test.

The above findings are consistent with the findings of the following studies conducted by various researchers:

Similarly, in correspondence to the present study, a cross-sectional descriptive study was conducted to determine the socio-demographic factors affecting the QOL of elderly patients attending the General Outpatient Clinics of the University of Teaching Hospital (UUTH), Uyo, South Nigeria among 310 elderly persons. Out of 310 respondents, one hundred and seventy-seven (57.1%) were female and one hundred and thirty-three (42.9%) were male, the mean age was 67.4 (±6.6) years. 232 respondents (74.8%) had at least a primary level of education and 169 (51.9%) were married. From the study, 85.5% of the elderly reported an overall good QoL. High income grade ($P = 0.019$), high social class ($P = 0.036$), and high level of education ($P < 0.001$) were the factors associated with good QoL in this study on univariate analysis.[58]

Likewise the current findings of the study, a cross-sectional survey study to explore the associated factors of the health-promoting lifestyle of the elderly based on the theory of social ecosystem was carried out to include 627 elderly people in communities in three cities of Hebei Province (Shijiazhuang, Tangshan, and Zhangjiakou) from October 2021 to January 2022 for questionnaire survey (601 validly returned cases). The questionnaire survey was

conducted by using the general demographic data, health promotion life scale, frailty scale, general self-efficacy scale, health engagement scale, and the health promotion lifestyle of the elderly in Hebei Province was at the lower limit score of 100.20±16.2. Hence, it needs the joint action of individuals, families, and society to encourage the elderly to adopt the health promotion lifestyle and realize healthy aging. [59]

Similarly, a cross-sectional community-based study was conducted in the Kavrepalanchowk district of Nepal to assess the Socio-demographic variables related to self-esteem, psychological stress, and health-related quality of life among older adults. The mean score for the social relationship domain and physical health domain of health-related quality of life were 12.0 and 11.9, respectively. Comparing the domains of physical health, psychological health and social relationship with age and education level were statistically significant. [60]

Comparably to the findings of the current research, a cross-sectional study to explore the associations between nutritional status and health-related quality of life, physical activity, and sleep quality in Elderly Greek adults was conducted. Mini Nutritional Assessment was used to assess nutritional status, HRQoLwas assessed using the Short Form Healthy Survey questionnaire, sleep quality was assessed using the Pittsburgh Sleep Quality Index, and physical activity levels were assessed via the International Physical Activity Questionnaire. 3405 community-dwelling men and women, over 65 years old from 14 different Greek regions were enrolled. (10.4%) of the participants were classified as malnourished, while 35.6% were "at risk of malnutrition". A better nutritional status was significantly and independently associated with higher physical activity levels ($p = 0.0011$) and better quality of life ($p = 0.0135$), as well as better sleep quality ($p = 0.0202$). The study highlights the interrelationships between a good nutritional status, high-quality sleep, an active lifestyle, and

a good quality of life. Thus the present study also presents that, older adults are prone to malnutrition as per the findings observed. [61]

Section II: Overall perception and quality of life scores of sample among experimental and control groups.

Perception Level:

The findings in the pretest represent, that the majority of the geriatrics in the experiment group (70%) had a moderate level of perception, 30% had poor perception, and none of the study participants belonged to a good level of perception regarding health promotion outcomes. At the time of posttest assessment 1 on the 30th day after the Multimodal intervention, the majority (76.7%) had a moderate level of perception, 23.3% had a good level of perception, and none had a poor level of perception. On the 60th day of posttest 2, the majority 56.7% had moderate perception and 43.3% had good perception regarding health promotion outcomes and none of the study participants had a poor level of perception.

Whereas in the control group in the pretest majority of the geriatrics (61.6%) had a moderate level of perception, 33.4 % had poor perception, and 5% had a good level of perception regarding health promotion. At the time of posttest assessment, 1 on the 30th day, the majority (70%) had a moderate level of perception, 30% had poor perception and none of the samples had a good level of perception. On the 60th day of posttest 2, the majority 65% had moderate perception 35% had poor perception regarding health promotion outcomes and none of the study participants belonged to a good level of perception.

Quality of Life:

The findings in the pretest represent, that the majority of the geriatrics in the experiment group (65%) had a moderate level of QOL, 35 % had poor QOL, and none of the

study participants belonged to a good level of QOL regarding health promotion outcomes. At the time of posttest assessment 1 on the 30th day after the Multimodal intervention, the majority (63.3%) had a moderate level of QOL, 36.7% had a good level of QOL, and none of the study participants had a poor level of QOL. On the 60th day of posttest 2, the majority 58.3% had moderate QOL and 41.7% had good QOL regarding health promotion and none of the samples had poor QOL.

Whereas in the control group in the pretest majority of the geriatrics (73.4%) had a moderate level of QOL, 26.6% had poor QOL, while none of the study participants belonged to a good level of QOL regarding health promotion. At the time of posttest assessment 1 on the 30th day, the majority (80%) had a moderate level of QOL, 20 % had poor QOL and none of the samples had a good level of QOL. On the 60th day of posttest 2, the majority 70% had moderate QOL and 30% had poor QOL regarding health promotion outcomes and none of the study participants had good QOL.

Several related literatures have supported the findings of the present study,

Similarly, a systematic review study was conducted to support the findings of my study to synthesize existing research on the relationship between older adults' perceptions of aging and their health and functioning. A systematic search was conducted of five electronic databases (ASSIA, CINAHL, IBSS, MEDLINE, and PsycINFO). Observational studies were included if they included perceptions of aging and health-related measures involving participants aged 60 years and older. Twenty-eight reports met the criteria for inclusion. Perceptions were related to health and functioning across seven health domains: memory and cognitive performance, physical and physiological performance, care seeking, self-rated health, quality of life, and death. All the studies reported a relationship between aging perceptions and health status, well-being, and QOL. Thus it serves as the basis for the study

conducted by the researcher which also highlights that aging perception increases the well-being among older adults. [61]

Correspondingly supporting the study findings of the present study, a study attempted to prepare a Super-Aged Society by analyzing the major factors affecting the quality of Life of the elderly in Korea. The data was collected using a questionnaire consisting of 22 questions in total, and a mobile survey was conducted between September and October 202. The results revealed that major factors found to determine the quality of life of the elderly were age, subjective health status, monthly household income, leisure activities, and health inequality fairness. It was found that the higher the age, the lower the quality of life. Further, the higher the subjective health status, monthly household income, participation in leisure activities, and perceptions of health inequality as fair, the more the quality of life of the elderly was affected. Therefore, policy support such as leisure activity, health programs, and medical welfare services for the elderly and sufficient attention from our society are all required. [62]

Section III: Effectiveness of multimodal intervention regarding health promotion on perception and quality of life among experimental and control groups.

The present study showed that there was a significant difference in the mean pretest & posttest Perception and Quality of Life scores of geriatric clients before Intervention between the experimental and control groups. The geriatric clients in the experimental group exhibited improved perception and enhanced Quality of life after the Multimodal intervention in comparison with the geriatric clients in the control group. Multimodal Intervention (MMI) covers all the areas of health promotional strategies to promote healthy aging. A brief Kannada translation of the researcher's explanation of the significance of health promotion measures was displayed in the video under the categories of physical activity, a nutritious

diet, fall prevention, socialization, stress management, pain management, medication, and health schemes. This allowed the elderly clients to comprehend the researcher's perspective on improving health and adjusting to their daily routines. Their ability to recall information was aided by the information pamphlet's inclusion of pertinent details about health promotion initiatives.

Simultaneously, the elderly clients benefited from a distraction game that allowed them to learn by playing: the snake ladder game. In light of this, the elderly clients in the experimental group likely had better perceptions and a higher quality of life than those in the control group. According to the study's findings, multimodal intervention was successful in raising participants' perceptions of and quality of life about health promotion strategies.

Hence there was a significant difference in mean perception and quality of life scores in the experimental group after the intervention than in the control group.

Thus, the **second objective was proven to be effective** by accepting the **research hypotheses H_1, H_2**

The above findings are similar to the findings of the following studies conducted by various researchers.

Similarly, to support the current study intervention—a population health management review of Interventions for Promoting Successful Ageing across the health continuum applied to older adults, literature on population health and health interventions for older adults was found through the use of internet search engines. The effectiveness of a population health management (PHM) strategy to enhance health and well-being was demonstrated in this article as well. This study also sheds light on the current gaps in geriatric health, whereby interventions of various types of research focused on promoting health to target specific diseases, health behaviors, or risk factors rather than a broad definition of wellness. More

research is required in this area because many of the older adult interventions are only research-based and have little generalizability. [62]

Likewise, a systematic review was conducted aimed at investigating the types and characteristics of effective interventions to improve the independence of the elderly during activities of daily living. Search strategy performed at the various databases, including PubMed, Scopus, Cochrane Library, Science Direct, Proquest, and Embase. Eight randomized controlled trials were included in the final analysis. Three types of interventions were identified and categorized as cognitive training, physical exercises, and multicomponent interventions. All reviewed studies provided evidence of the effectiveness of interventions in improving older people's ability to perform the activities of daily living. However, this study highlights that there is a lack of uniform measurement indicators which forced the investigators to develop a conceptual framework for designing future interventional research. This conceptual framework included designing tailored interventions and creating an age-friendly environment as well as financial, psychological, and social support. Therefore, the researcher's current work serves as added credit to the elderly population focusing on comprehensive health promotion by developing a multimodal intervention. [63]

Section IV: Relationship between perception and quality of life among geriatric clients.

The correlation between Perception and QOL among Geriatric clients in the Experimental group was found to have a strong positive correlation between perception and QOL during posttest I ($r = .318$) and II ($r = .273$) which was found to be a statistically significant positive correlation at $p < 0.05$, which confirms that as Perception increases, Quality of Life also increases or vice versa towards health promotional outcomes among Geriatric clients.

The present research found that there was a significant correlation between the perception and Quality of Life of geriatric clients in the experimental group with a moderately negative correlation in the control group.

Thus, the research hypothesis **H_3** was found to be statistically significant in the experimental group. This is the first study to explore the relationship between elderly clients' perceptions and their Quality of Life; no previous research has been done in this area.

Section V: Association between the perception and quality of life with selected socio-demographic variables in both experimental and control groups.

Level of perception

The association of study findings about perception represents that, obtained $\chi 2$ value was greater than the table value only in the sample of the experimental group about age ($\chi 2$ 6.61, p=.010), residence ($\chi 2$ 4.89, p= .026), and history of health checkup ($\chi 2$ 4.87, p= .027). Hence the Research Hypotheses H_4 is accepted.

Whereas the obtained value was not statistically significant for the other variables like gender ($\chi 2$ =0.38, p=.53), educational status ($\chi 2$ =0.40 p=.52), religion ($\chi 2$= 0.20p=.6492), marital Status ($\chi 2$= 0.3, p=.573) socioeconomic status ($\chi 2$ 2.06p=.15) type of Family ($\chi 2$=0.96p=.325) and history of comorbidity ($\chi 2$=0.03p=859). Hence it shows that, no statistically significant association with selected socio-demographic variables in the experimental group.

In the control group, it was found that the $\chi 2$ value was greater than the table value only in marital status ($\chi 2$=15.4p=0.001) which indicates a significant association. Whereas the obtained value was not statistically significant for the other variables like age

(χ2= 3.14,p=.076), gender (χ2=2.96 p=.084), educational status(χ2=0.32p=.565), religion (χ2=1.27,p=.528), residence (χ2= 2.72 p=.098), socioeconomic status (χ2 =3.6,p=.057), type of family (χ2 =0.32 p=.565), history of comorbidity (χ2 =3.14,p=.076), history of health check-up (χ2 =3.47p=.062).

The association was found to be significant for selected variables in the experimental group compared to the control group thus, the stated research hypotheses H_4 accepted.

Quality of life

The association of study findings concerning quality of life indicated that the obtained χ2 value was greater than the table value in sample of experimental group about educational status (χ2 12.5p=0.001), residence (χ2 4.83, p=.027), type of family (χ2= 7.70, p=.005) and history of comorbidity (χ2 =4.14, p=.034), Hence the Research Hypotheses H_5, is accepted.

Whereas the obtained value was not statistically significant for the remaining variables like age (χ2=0.041, p=.838) gender (χ2=1.77, p=.182), religion (χ2=3.52,p=.060) marital Status (χ2=0.39,p=.528), socioeconomic status (χ2 =2.59, p=.107), type of family (χ2=0.96,p=.325) and history of health checkup (χ2= 0.62,p=.430).

Whereas in the control group, it is found that, the χ2 value was greater than the table value only for religion (χ2= 6.09, p=.013) indicating a significant association. And found non-significant to other variables like age (χ2 =3.22,p=.0726) ,gender (χ2 =1.90,p=.167),educational status (χ2=2.15,p=.141), marital Status, (χ2=3.3,p=.065), residence (χ2=2.44,p=.117) ,socioeconomic status (χ2 =0.454,p=.500),type of Family (χ2=2.96 ,p=.085),history of comorbidity (χ2=3.14,p=.076) history of health check-up(χ2=3.38,p=.065).

The association was found to be significant for selected variables in the experimental group compared to the control group thus, the stated research hypothesis H_5 is accepted.

Comparably a study aimed to investigate the relationship between health perception and health predictors among the elderly. In this study, 376 older adults from four different countries (Hungary, *n* =86; Italy, *n* =133; Portugal, *n* =95; and Spain, *n* =62) were analyzed. All subjects completed the EQ-5D-5L to assess their quality-adjusted life years. QOL is dependent on the subject's age and physical fitness, as increasing age was associated with decreased strength. [64]

Thus the current study findings were also found to be significant with selected variables.

Summary

This chapter also dealt with the discussion of the significant findings of the study about other studies. This helped the Investigator to prove that the findings were true and that the multimodal intervention was effective in enhancing the favorable perception and better quality of life.

CHAPTER VIII

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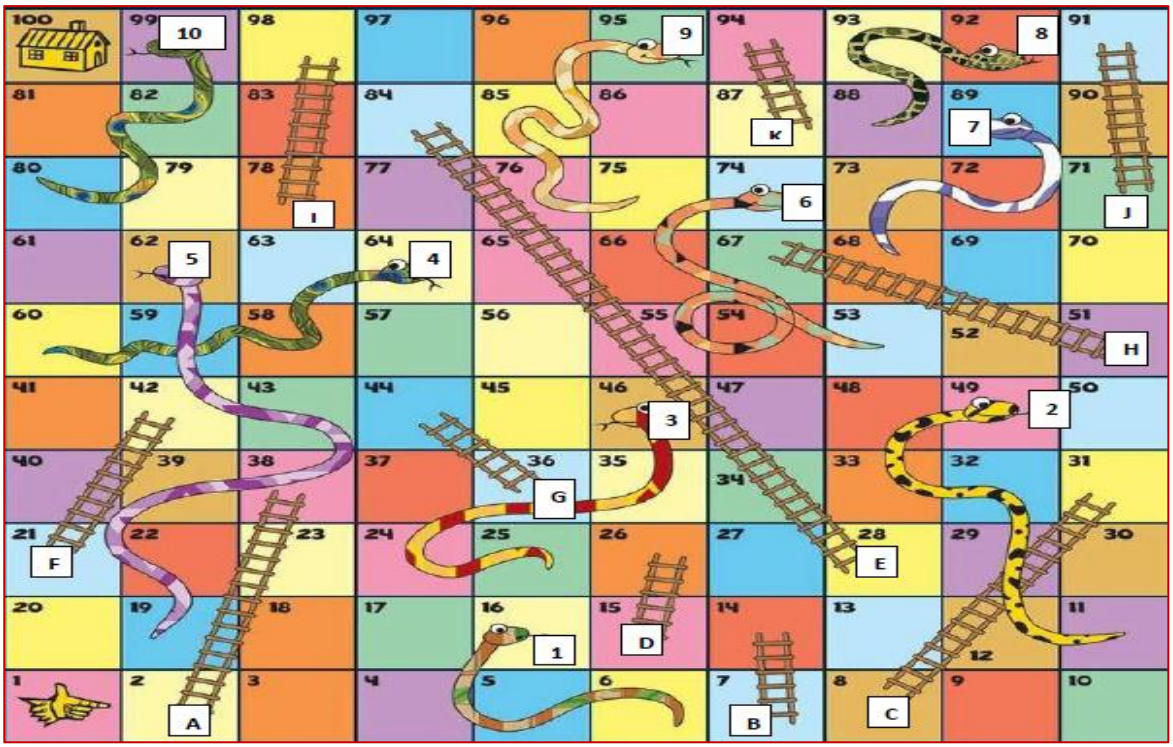
MULTIMODAL INTERVENTION

ANNEXURE XXI

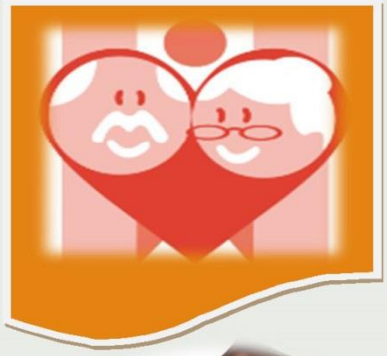
SNAKE AND LADDER GAME

HEALTH PROMOTION STRATEGIES



SNAKE (Unhealthy strategies)				LADDER (Health promotion strategies)			
1	Sugar and fat-containing foods are consumed in excess.	6	No harmonious relationship	A	Excessive consumption of fiber-rich foods, as well as a low-fat, sugar-free diet	G	Consult the doctor regularly for health checkups and follow-ups
2	Personal Hygiene is Inadequate	7	Not seeking medical help if required.	B	Maintains good personal Hygiene	H	Participates in religious and spiritual pursuits.
3	No physical activity.	8	Not following culture or religion.	C	Walks, exercises, and practices yoga regularly.	I	Maintains good communication with everyone.
4	Daily life activities are not being carried out.	9	Make discussions into fights	D	Participate in Day-to-Day Activities	J	Reads books, prays, and listens to music, in Leisure time.
5	Sleep deprivation	10	Possessing unfavorable emotions	E	Proper sleep-wake cycle.	K	Being optimistic in all situations
				F	Maintains positive interactions with family members.		

HEALTH PROMOTION STRATEGIES

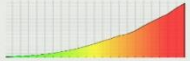


Healthy Life for Healthy Aging

INTRODUCTION

Old age is a privilege for second childhood and a new stage of opportunity and strength.

In 2050,



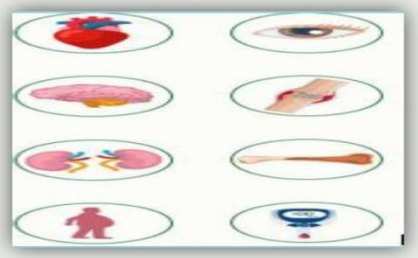
- 1 in 5 people will be 60 years older
- 80% of older people will be living in low- and middle-income countries

Definition: Geriatric as, >65years of the age in developed countries and >60years in developing countries.

"International Day for Elderly" is celebrated every year on **1st October**.

A man's life is normally divided into five stages.

Common geriatric problems:



HEALTH PROMOTION

Enabling people to increase control over their health and empowering to adapt healthy behaviours

- WHO

Health Promotion Strategies

1. **Physical Activity**
2. **Lifestyle & Healthy Diet**
3. **Socialization**
4. **Fall prevention**
5. **Stress management**
6. **Pain management**
7. **Medication & follow up**
8. **Spirituality & Schemes**

1. Physical Activity

Benefits :

150 min: Moderate intensity activity per week

20-30 min in a week for 3days

2. Healthy Diet

Eating a well-balanced diet is an important overcome the nutritional problems.

Benefits

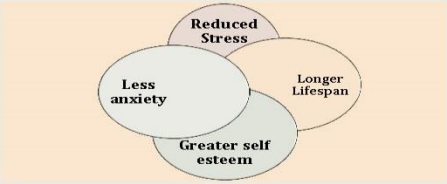
- Healthy Organ & Brain function
- Managing chronic illnesses
- Strengthening the immune system
- Muscle and bone health

Tips: Healthy Senior Diet

- Eat plenty of fruit and vegetables
- Choose calcium for bone health
- Go "good fat" not "no fat"
- Sources of protein
- Eat more fibre rich foods
- Avoid refined carbs & sugars
- Maintain hydration

3. Socialization

Good connections improve health and increase longevity by keeping mentally, physically and emotionally fit.



Ways to Cultivate: Healthy Social Life

1. Build and maintain positive relationships
2. Do volunteer work in social activities
3. Move to a retirement community
4. Caring for a pet, hobby.

4. Fall Prevention

As per CDC,

By 2030

- 49 miliion falls and 12 million injuries

Fall prevention Strategies :

1. Talk to your doctor
2. Do strength and balance exercises
3. Have your feet and eyes checked
4. Make home safer

5.Stress Management

Stress is an everyday part of our lives & reaction to a situation where you feel under pressure.

Strategies to cope with Stress

- Regular exercise
- Participate in social activities
- Do relaxation techniques
- Meditation, massage

6. Pain Management

An unpleasant sensory & emotional experience

Pain management measures

1. Massage therapy
2. Warm and cold compress
3. Spiritual support
4. Music therapy

7. Medication & Follow Up

1. Take Medicine as Prescribed—with Input from Your Health Care Provider
2. Keep a Medication List
3. Be Aware of side effects

8. Spirituality & Schemes

Holistic approach to improve quality of life for a positive wellness.

Schemes

1. Pradhan Mantri Vaya Vandana Scheme
2. Indira Gandhi National Old Age Pension Scheme (IGNOAPS)
3. National Programme for the Health Care of Elderly (NPHCE)
4. Varishta Mediclaim Policy
5. Rashtriya Vayoshri Yojana
6. Varishta Pension Bima Yojana
7. Senior Citizens' Welfare Fund
8. Pradhan Mantri Jan Arogya Yojana

FAMILY CARE GIVER

1. Assist with Personal care & health care
2. Maintain a healthful environment
3. Food and Medicine administration
4. Keep updated about what is happening in your life.
5. Visit as often as you can along with children and partner.

Elder abuse

Infliction of harm on an older person

- *National helpline numbers:* to reach out redressal of grievances lodged by senior citizens-**1090(Bangalore), 14567(common to all states).**

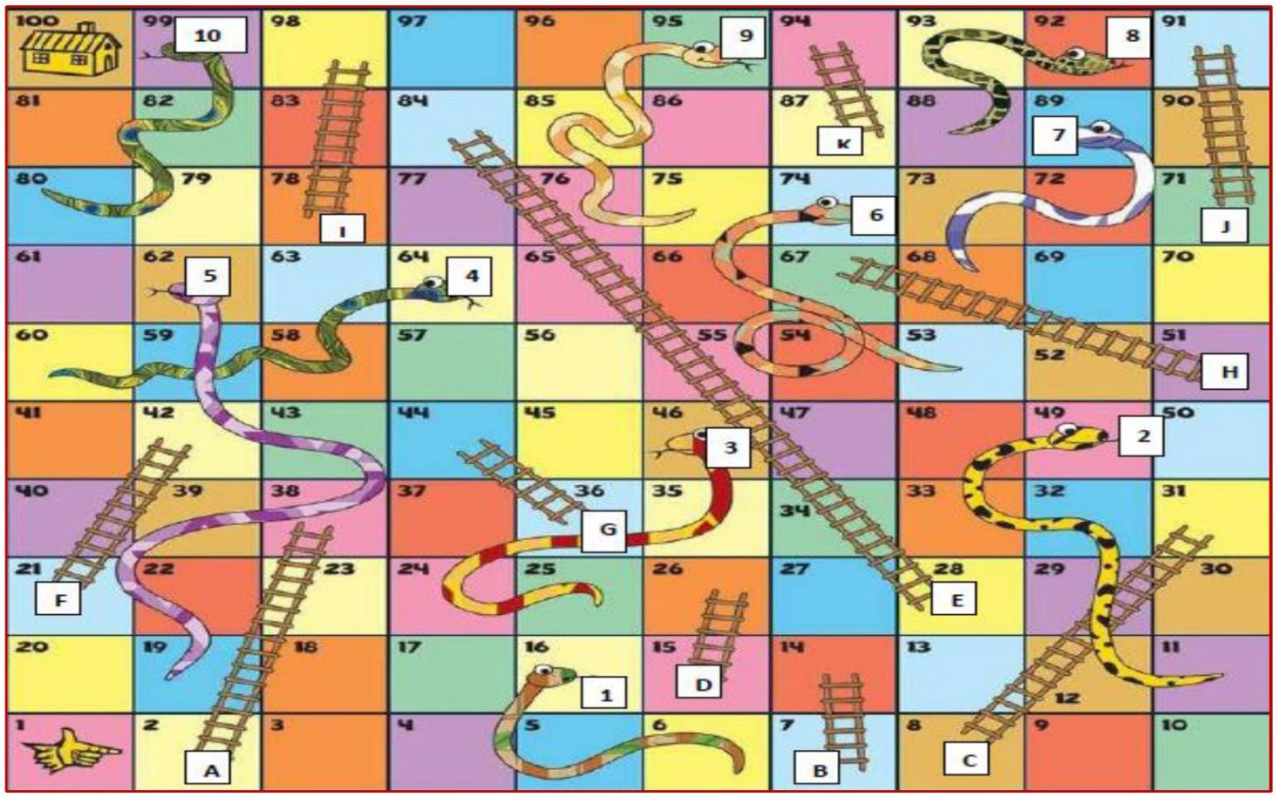
ROLE OF NURSE

- Assess and screen for health problems
- Promote health & wellness
- Encourage active lifestyle
- Strengthening self-care capacities
- Prevent disability
- Counseling, Communication,
- Improve Health & control of diseases
- Increasing life expectancy among the elderly.

"TO CARE FOR THOSE WHO ONCE CARED FOR US IS ONE OF THE HIGHEST HONOURS"

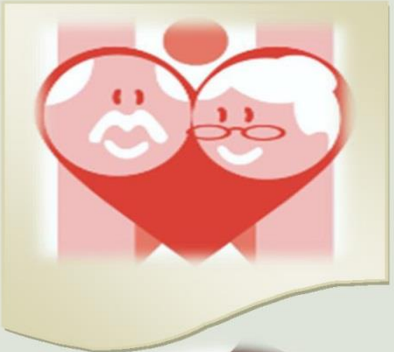
ಹಾವು ಮತ್ತು ಏಣಿ ಆಟ

ಆರೋಗ್ಯ ಪ್ರಚಾರ ತಂತ್ರಗಳು



ಹಾವು (ಆರೋಗ್ಯ ಕುಸಿತ ಚಟುವಟಿಕೆಗಳು)				ಏಣಿ (ಆರೋಗ್ಯಕರ ಪ್ರಚಾರ ಚಟುವಟಿಕೆಗಳು)			
1	ನಕ್ಕರೆ ಮತ್ತು ಕೊಬ್ಬನ್ನು ಒಳಗೊಂಡಿರುವ ಆಹಾರವನ್ನು ಹೆಚ್ಚು ಸೇವಿಸುವುದು	6	ನದನ್ಯರ ನಡುವೆ ಸಾಮರನ್ಯದ ನಂಬಂಧವಿಲ್ಲದಿರುದು.	A	ಹೆಚ್ಚಿನ ನಾರು, ಕಡಿಮೆ ಕೊಬ್ಬು, ನಕ್ಕರೆ, ಉಪ್ಪು ರಹಿತ ಒಳಗೊಂಡಿರುವ ಆಹಾರಗಳ ಅತಿಯಾದ ಬಳಕೆ.	G	ಆರೋಗ್ಯ ತಪಾಸಣೆ ಮತ್ತು ಅನುನರಣೆಗಾಗಿ ನಿಯಮಿತವಾಗಿ ವೈದ್ಯರನ್ನು ನಂವರ್ಕಿಸಿಸುವುದು.
2	ವೈಯಕ್ತಿಕ ನೈರ್ಮಲ್ಯವು ಅನಮರ್ಪಕವಾಗಿ ಇಟ್ಟುಕೊಳ್ಳುದು	7	ವೈದ್ಯಕೀಯ ನಹಾಯದ ಅಗತ್ಯವಿದ್ದಾಗ, ಪಡೆಯುವುದಿಲ್ಲದಿರುದು	B	ನ್ವಚ್ಛವಾದ ವೈಯಕ್ತಿಕ ಪರಿನರವನ್ನು ನಿರ್ವಹಿನುವುದು.	H	ಧಾರ್ಮಿಕ ಮತ್ತು ಅಧ್ಯಾತ್ಮಿಕ ಅನ್ವೇಷಣೆಗಳಲ್ಲಿ ಭಾಗವಹಿನುವುದು.
3	ಯಾವುದೇ ದೈಹಿಕ ಚಟುವಟಿಕೆಗಳಿಲ್ಲದಿರುವುದು	8	ನಂನ್ಕೃತಿ ಅಥವಾ ಧರ್ಮದ ಚಟುವಟಿಕೆಗಳನ್ನು ನಿರ್ವಹಿನುತ್ತಿಲ್ಲದಿರುದು	C	ನಿಯಮಿತವಾಗಿ ನಡೆಯುವುದು, ವ್ಯಾಯಾಮ ಮತ್ತು ಯೋಗವನ್ನು ಅಭ್ಯಾನ ಮಾಡುವುದು.	I	ಎಲ್ಲರೊಂದಿಗೆ ಉತ್ತಮ ನಂವಹನವನ್ನು ಇಟ್ಟುಕೊಳ್ಳುವುದು.
4	ದೈನಂದಿನ ಜೀವನದ ಚಟುವಟಿಕೆಗಳನ್ನು ನಿರ್ವಹಿನುತ್ತಿಲ್ಲದಿರುದು	9	ಚರ್ಚೆಗಳನ್ನು ಹೋರಾಟಗಳಾಗಿ ವರಿವರ್ತಿಸಿಸುವುದು	D	ದಿನನಿತ್ಯದ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ಭಾಗವಹಿನುವುದು.	J	ಬಿಡುವಿನ ವೇಳೆಯಲ್ಲಿ ವ್ಯಾರ್ಥನೆ ಮಾಡುವುದು, ನಂಗೀತ ಕೇಳುವುದು ಪುನ್ತಕಗಳನ್ನು ಓದುವುದು, ಇತ್ಯಾದಿ.
5	ನಿದ್ದೆಯ ಅಭಾವ	10	ಪ್ರತಿಕೂಲವಾದ ಭಾವನೆಗಳನ್ನು ಹೊಂದಿರುವುದು.	E	ನರಿಯಾದ ನಿದ್ರೆ-ಎಚ್ಚರ ಚಕ್ರವನ್ನು ಅನುನರಿನುವುದು.	K	ಎಲ್ಲಾ ನಂದರ್ಭಗಳಲ್ಲೂ ಆಶಾವಾದಿಯಾಗಿರುವುದು
				F	ಕುಟುಂಬದ ನದನ್ಯರೊಂದಿಗೆ ನಕಾರಾತ್ಮಕ ನಂವಹನವನ್ನು ನಿರ್ವಹಿನುತ್ತದೆ.		

ಆರೋಗ್ಯ ಪ್ರಚಾರ ಕ್ರಮಗಳು



"ಆರೋಗ್ಯಕರ ವೃದ್ಧಾಪ್ಯಕ್ಕೆ ಆರೋಗ್ಯಕರ ಜೀವನ"

ಪರಿಚಯ

ವೃದ್ಧಾಪ್ಯವು ಎರಡನೇ ಬಾಲ್ಯಕ್ಕೆ ಒಂದು ಸವಲತ್ತು ಅವಕಾಶ ಮತ್ತು ಶಕ್ತಿಯ ಹೊಸ ಹಂತವಾಗಿದೆ.

2050,

- 5 ಜನರಲ್ಲಿ ಒಬ್ಬರಿಗೆ 60 ವರ್ಷ ವಯಸ್ಸಾಗಿರುತ್ತದೆ
- 80% ವಯಸ್ಸಾದ ಜನರು ಕಡಿಮೆ ಮತ್ತು ಮಧ್ಯಮ ಆದಾಯದ ದೇಶಗಳಲ್ಲಿ ವಾಸಿಸುತ್ತಿದ್ದಾರೆ

ವ್ಯಾಖ್ಯಾನ: ವೃದ್ಧಾಪ್ಯವನ್ನು ಅಭಿವೃದ್ಧಿ ಹೊಂದಿದ ದೇಶಗಳಲ್ಲಿ > 65 ವರ್ಷಗಳು ಮತ್ತು ಅಭಿವೃದ್ಧಿಶೀಲ ರಾಷ್ಟ್ರಗಳಲ್ಲಿ > 60 ವರ್ಷಗಳು ಎಂದು ಪರಿಗಣಿಸಲಾಗುತ್ತದೆ.

"ಅಂತಾರಾಷ್ಟ್ರೀಯ ಹಿರಿಯರ ದಿನ"ವನ್ನು ಪ್ರತಿ ವರ್ಷ **ಅಕ್ಟೋಬರ್ 1** ರಂದು ಆಚರಿಸಲಾಗುತ್ತದೆ.

ಸಾಮಾನ್ಯ ವೃದ್ಧಾಪ್ಯ ಸಮಸ್ಯೆಗಳು:

ಆರೋಗ್ಯ ಪ್ರಚಾರ

ಆರೋಗ್ಯದ ಮೇಲೆ ನಿಯಂತ್ರಣವನ್ನು ಹೆಚ್ಚಿಸಲು ಮತ್ತು ಆರೋಗ್ಯಕರ ನಡವಳಿಕೆಗಳನ್ನು ಅಳವಡಿಸಿಕೊಳ್ಳವುದು

ಆರೋಗ್ಯ ಪ್ರಚಾರ ತಂತ್ರಗಳು

1. ದೈಹಿಕ ಚಟುವಟಿಕೆ
2. ಜೀವನಶೈಲಿ ಮತ್ತು ಆರೋಗ್ಯಕರ ಆಹಾರ
3. ಸಮಾಜೀಕರಣ
4. ಪತನ ತಡೆಗಟ್ಟುವಿಕೆ
5. ಒತ್ತಡ ನಿರ್ವಹಣೆ
6. ನೋವು ನಿರ್ವಹಣೆ
7. ಔಷಧಿ ಮತ್ತು ಅನುಸರಣೆ

1. ದೈಹಿಕ ಚಟುವಟಿಕೆ

ವಯಸ್ಸಾದವರಿಗೆ ಅತ್ಯಗತ್ಯ ಮತ್ತು ದೀರ್ಘಕಾಲದ ಕಾಯಿಲೆಗಳ ಹೊರೆಯನ್ನು ಮತ್ತು ಅಕಾಲಿಕ ಮರಣವನ್ನು ತಡೆಯುತ್ತದೆ

ಪ್ರಯೋಜನಗಳು

150 ನಿಮಿಷ: ಪ್ರತಿ ವಾರ ಮಧ್ಯಮ ತೀವ್ರತೆಯ ಚಟುವಟಿಕೆ

2.ಆರೋಗ್ಯಕರ ಆಹಾರ ಕ್ರಮ

ನಮತೋಲಿತ ಆಹಾರವನ್ನು ಸೇವಿಸುವುದು ಪೌಷ್ಟಿಕಾಂಶದ ಸಮಸ್ಯೆಗಳಿಗೆ ಸಂಬಂಧಿಸಿದ ಸಮಸ್ಯೆಗಳನ್ನು ಜಯಿಸಲು ಮುಖ್ಯವಾಗಿದೆ.

ಪ್ರಯೋಜನಗಳು

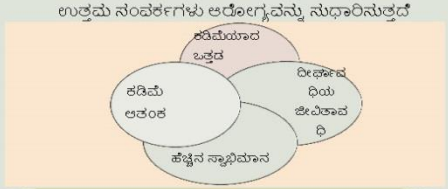
- ಆರೋಗ್ಯಕರ ಅಂಗ ಮತ್ತು ಮೆದುಳಿನ ಕಾರ್ಯ
- ದೀರ್ಘಕಾಲದ ಕಾಯಿಲೆಗಳನ್ನು ನಿರ್ವಹಿಸುವುದು
- ಪ್ರತಿರಕ್ಷಣಾ ವ್ಯವಸ್ಥೆಯನ್ನು ಬಲಪಡಿಸುವುದು
- ಸ್ನಾಯು ಮತ್ತು ಮೂಳೆಗಳ ಆರೋಗ್ಯವನ್ನು ಕಾಪಾಡುತ್ತದೆ

ಸಲಹೆಗಳು: ಆರೋಗ್ಯಕರ ಹಿರಿಯ ಆಹಾರ

- ನಾರಿನಂಶ ಹಣ್ಣು ಮತ್ತು ತರಕಾರಿಗಳನ್ನು ಸೇವಿಸಿ
- ಮೂಳೆ ಆರೋಗ್ಯಕ್ಕಾಗಿ ಕ್ಯಾಲ್ಸಿಯಂ ಅನ್ನು ಆರಿಸಿ
- ಹೆಚ್ಚು ಪ್ರೋಟೀನ್, ನಾರು ಭರಿತ ಆಹಾರವನ್ನು ಸೇವಿಸಿ
- ಎಚ್ಚು ನಕ್ಕರೆ ಉಪ್ಪು ವರ್ಧಾರ್ಥಗಳನ್ನು ತಪ್ಪಿಸಿ
- ಅಧಿಕ ನೀರು ಸೇವಿಸಿ.

3. ಸಮಾಜೀಕರಣ

ಉತ್ತಮ ಸಂವರ್ಕಗಳು ಆರೋಗ್ಯವನ್ನು ಸುಧಾರಿಸುತ್ತದೆ



ಬೆಳೆಸುವ ಮಾರ್ಗಗಳು: ಆರೋಗ್ಯಕರ ಸಾಮಾಜಿಕ ಜೀವನ

1. ಧನಾತ್ಮಕ ಸಂಬಂಧಗಳನ್ನು ನಿರ್ಮಿಸಿ ಮತ್ತು ನಿರ್ವಹಿಸಿ
2. ಸಾಮಾಜಿಕ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ಸ್ವಯಂಸೇವಕರಾಗಿ ಕೆಲಸ ಮಾಡಿ
3. ನಿವೃತ್ತಿ ಸಮುದಾಯಕ್ಕೆ ಸೇರಿಕೊಳ್ಳಿ, ಸಾಕುಪ್ರಾಣಿಗಳನ್ನು ನೋಡಿಕೊಳ್ಳುವುದು

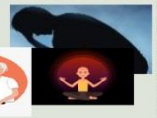
4. ಪತನ ತಡೆಗಟ್ಟುವಿಕೆ

49 ಮಿಲಿಯನ್ ಪತನ ಮತ್ತು 12 ಮಿಲಿಯನ್ ಗಾಯಗಳು - **ಸಿಡಿಸಿ**

ಪತನ ತಡೆಗಟ್ಟುವ ತಂತ್ರಗಳು:

1. ಶಕ್ತಿ ಮತ್ತು ಸಮತೋಲನ ವ್ಯಾಯಾಮಗಳನ್ನು ಮಾಡಿ
2. ನಿಮ್ಮ ಪಾದಗಳು ಮತ್ತು ಕಣ್ಣುಗಳನ್ನು ಪರೀಕ್ಷಿಸಿ
3. ..ಮನೆಯನ್ನು ಸುರಕ್ಷಿತವಾಗಿ ನೋಡಿಕೊಳ್ಳುವುದು.

5. ಒತ್ತಡ ನಿರ್ವಹಣೆ



ಒತ್ತಡವು ನಮ್ಮ ಜೀವನದ ದೈನಂದಿನ ಭಾಗವಾಗಿದೆ.

ಒತ್ತಡವನ್ನು ನಿಭಾಯಿಸಲು ತಂತ್ರಗಳು

- ✓ ನಿಯಮಿತ ವ್ಯಾಯಾಮ
- ✓ ಸಾಮಾಜಿಕ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ಭಾಗವಹಿ
- ✓ ವಿಶ್ರಾಂತಿ ತಂತ್ರಗಳನ್ನು ಮಾಡಿ
- ✓ ಧ್ಯಾನ, ಮಸಾಜ್

6. ನೋವು ನಿರ್ವಹಣೆ

ಅಹಿತಕರ ಸಂವೇದನಾ ಮತ್ತು ಭಾವನಾತ್ಮಕ ಅನುಭವ.

ನೋವು ನಿರ್ವಹಣೆ ಕ್ರಮಗಳು

1. ಮನಾಜ್ ಥೆರಪಿ
2. ಬೆಚ್ಚಗಿನ ಮತ್ತು ತಣ್ಣನೆಯ ನಂಕುಚನವನ್ನು ತೆಗೆದುಕೊಳ್ಳಿ 3. ಅಧ್ಯಾತ್ಮಿಕ ಬೆಂಬಲ 4. ನಂಗೀತ ಚಿಕಿತ್ಸೆ

7. ಔಷಧಿ ಮತ್ತು ಅನುಸರಣೆ

1. ನಿಮ್ಮ ಆರೋಗ್ಯ ರಕ್ಷಣೆ ನೀಡುಗರಿಂದ ಸೂಚಿಸಿದಂತೆ ಔಷಧವನ್ನು ತೆಗೆದುಕೊಳ್ಳಿ
2. ಔಷಧಿಗಳ ಪಟ್ಟಿಯನ್ನು ಇರಿಸಿ
3. ಔಷಧಿಯ ಅಡ್ಡ ಪರಿಣಾಮಗಳ ಬಗ್ಗೆ ಎಚ್ಚರವಿರಲಿ.

8.ಆಧ್ಯಾತ್ಮಿಕತೆ ಮತ್ತು ಆರೋಗ್ಯ ಯೋಜನೆಗಳು

ನಕಾರಾತ್ಮಕ ಕ್ಷೇಮಕ್ಕಾಗಿ ಜೀವನದ ಗುಣಮಟ್ಟವನ್ನು ಸುಧಾರಿಸಲು ನಮಗ್ರ ವಿಧಾನ.

ಆರೋಗ್ಯ ಯೋಜನೆಗಳು

1. ಪ್ರಧಾನ ಮಂತ್ರಿ ವಯ ವಂದನಾ ಯೋಜನೆ
2. ಇಂದಿರಾ ಗಾಂಧಿ ರಾಷ್ಟ್ರೀಯ ವೃದ್ಧಾಪ್ಯ ಪಿಂಚಣಿ ಯೋಜನೆ (IGNOAPS)
3. ಹಿರಿಯರ ಆರೋಗ್ಯ ರಕ್ಷಣೆಗಾಗಿ ರಾಷ್ಟ್ರೀಯ ಕಾರ್ಯಕ್ರಮ
4. ವರಿಷ್ಠ ಮೆಡಿಸ್ಕೈಮ್ ಪಾಲಿಸಿ
5. ರಾಷ್ಟ್ರೀಯ ವಯೋಶ್ರೀ ಯೋಜನೆ
6. ವರಿಷ್ಠ ಪಿಂಚಣಿ ಬಿಮಾ ಯೋಜನೆ
7. ಹಿರಿಯ ನಾಗರಿಕರ ಕಲ್ಯಾಣ ನಿಧಿ
8. ಪ್ರಧಾನ ಮಂತ್ರಿ ಜನ ಆರೋಗ್ಯ ಯೋಜನೆ

1. ವೈಯಕ್ತಿಕ ಸ

ಕುಟುಂಬ ಆರೈಕೆ ನೀಡುವವರ ಪಾತ್ರ

2. ಆರೋಗ್ಯಕರ ವಾತಾವರಣವನ್ನು ಕಾಪಾಡುವುದು
3. ಆಹಾರ ಮತ್ತು ಔಷಧ ನೀಡುವುದು
4. ಜೀವನದಲ್ಲಿ ಏನಾಗುತ್ತಿದೆ ಎಂಬುದರ ಕುರಿತು ನವೀಕರಿಸಿ.
5. ಮಕ್ಕಳು ಮತ್ತು ಪಾಲುದಾರರೊಂದಿಗೆ ನೀವು ಸಾಧ್ಯವಾದಷ್ಟು ಹೆಚ್ಚಾಗಿ ಭೇಟಿ ನೀಡಿ

ಹಿರಿಯರ ನಿಂದನೆ

ವಯಸ್ಸಾದ ವ್ಯಕ್ತಿಯ ಮೇಲೆ ಹಾನಿಯನ್ನುಂಟುಮಾಡುವುದು.

ಹಿರಿಯ ನಾಗರಿಕರಿಗಾಗಿ ರಾಷ್ಟ್ರೀಯ ಸಹಾಯವಾಣಿ: ಹಿರಿಯ ನಾಗರಿಕರು ಸಲ್ಲಿಸಿದ ಕುಂದುಕೊರತೆಗಳ ಪರಿಹಾರವನ್ನು ತಲುಪಲು-**1090(ಬೆಂಗಳೂರು), 14567(ಎಲ್ಲಾ ರಾಜ್ಯಗಳಿಗೆ)**

ಶುಶ್ರೂಷಕಿಪಾತ್ರ

1.ಆರೋಗ್ಯ ಸಮಸ್ಯೆಗಳಿಗೆ ಮೌಲ್ಯಮಾಪನ

•2. ಆರೋಗ್ಯ ಮತ್ತು ಕ್ಷೇಮವನ್ನು ಉತ್ತೇಜಿಸಿ

3.ಸಕ್ರಿಯ ಜೀವನಶೈಲಿಯನ್ನು ಪ್ರೋತ್ಸಾಹಿಸಿ

•4. ಸ್ವ-ಆರೈಕೆ ಸಾಮರ್ಥ್ಯಗಳನ್ನು ಬಲಪಡಿಸುವುದು

•5. ಅಂಗವೈಕಲ್ಯವನ್ನು ತಡೆಯಿರಿ

6.ಕೌನ್ಸಲಿಂಗ್, ಸಂವಹನ ನಡೆಸುವುದು,

• 7.ಆರೋಗ್ಯವನ್ನು ಸುಧಾರಿಸಿ ಮತ್ತು ರೋಗಗಳ ನಿಯಂತ್ರಣ

• 8.ವಯಸ್ಸಾದವರಲ್ಲಿ ಜೀವಿತಾವಧಿಯನ್ನು ಹೆಚ್ಚಿಸುವುದು.

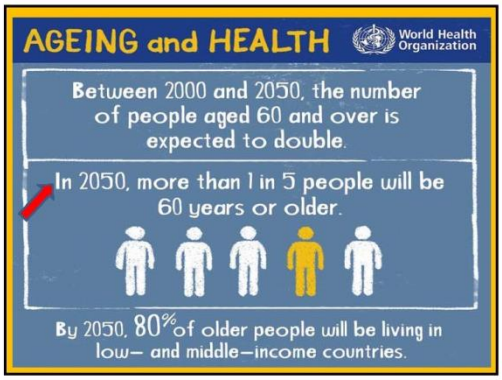
"ಒಮ್ಮೆ ನಮ್ಮನ್ನು ಕಾಳಜಿ ವಹಿಸಿದವರನ್ನು ನೋಡಿಕೊಳ್ಳುವುದು ಅತ್ಯುನ್ನತ ಗೌರವಗಳಲ್ಲಿ ಒಂದಾಗಿದೆ"

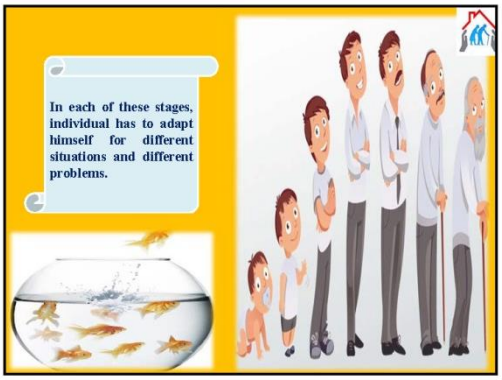

HEALTH PROMOTION STRATEGIES AMONG GERIATRIC
Great Senior Living


"one of the highest honors" is "to care for those who once cared for us."

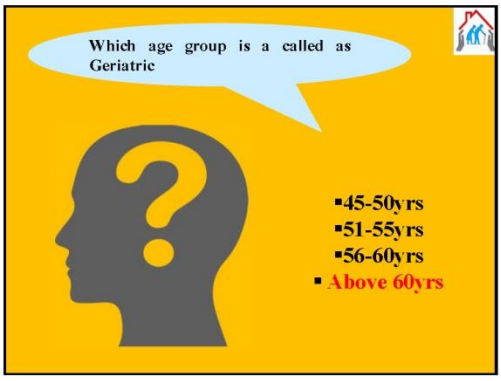

INTRODUCTION
Old age is a gift for a second childhood and a new stage of strength and potential.


Elderly-fastest growing population

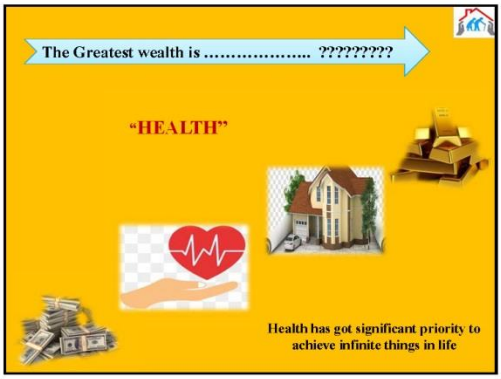

AGEING and HEALTH
World Health Organization
Between 2000 and 2050, the number of people aged 60 and over is expected to double.
In 2050, more than 1 in 5 people will be 60 years or older.
By 2050, 80% of older people will be living in low- and middle-income countries.


In each of these stages, individual has to adapt himself for different situations and different problems.

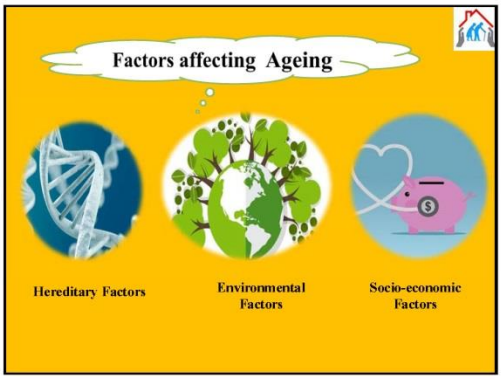

Health promotion and illness prevention are becoming more prominent.


Which age group is a called as Geriatric
▪45-50yrs
▪51-55yrs
▪56-60yrs
▪ Above 60yrs

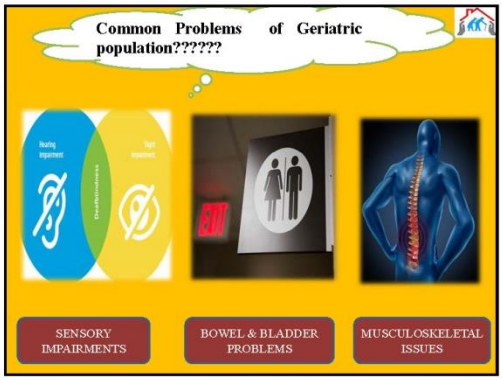

"International Day for Elderly" (UN) is celebrated every year on 1st October.
OCTOBER
1

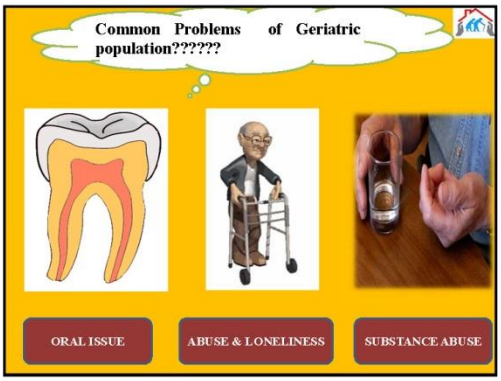

The Greatest wealth is …….. ????????
"HEALTH"
Health has got significant priority to achieve infinite things in life

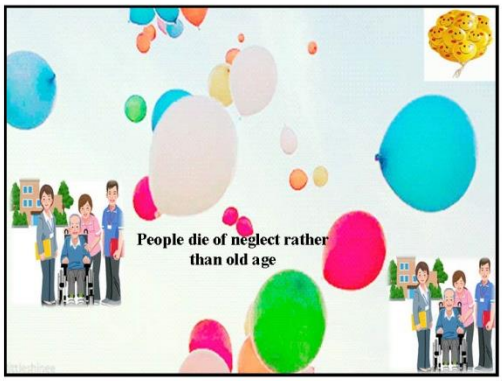

Successful Aging: Health promotional interventions play a pivotal role.

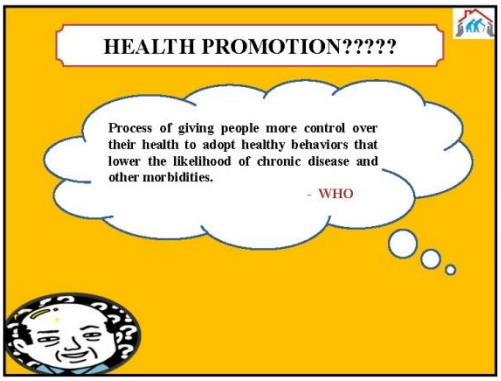

Factors affecting Ageing
Hereditary Factors
Environmental Factors
Socio-economic Factors


Common Problems of Geriatric population??????
CHRONIC HEALTH CONDITIONS & COGNITIVE ISSUE
RISK FOR INJURY
MALNUTRITION


Common Problems of Geriatric population??????
SENSORY IMPAIRMENTS
BOWEL & BLADDER PROBLEMS
MUSCULOSKELETAL ISSUES

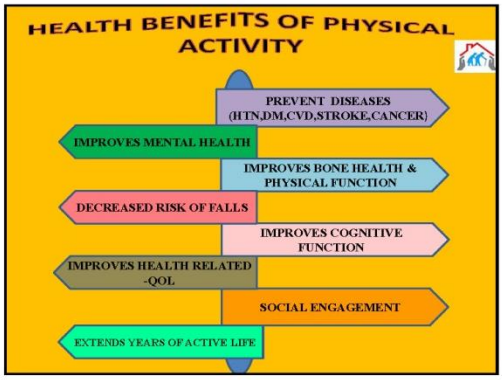

Common Problems of Geriatric population??????
ORAL ISSUE
ABUSE & LONELINESS
SUBSTANCE ABUSE


People die of neglect rather than old age

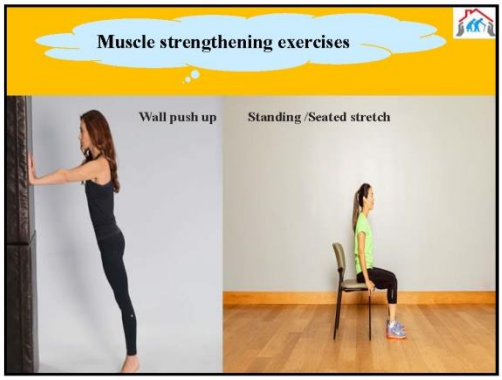

HEALTH PROMOTION?????
Process of giving people more control over their health to adopt healthy behaviors that lower the likelihood of chronic disease and other morbidities.
- WHO

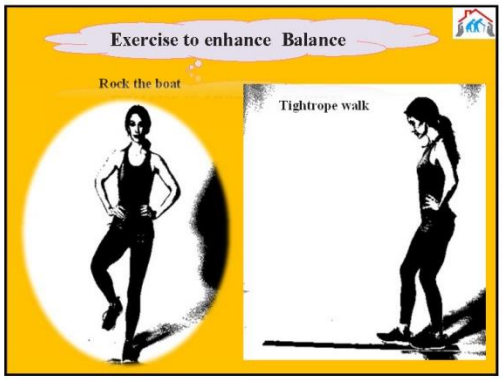

Health Promotion Strategies
1. Physical Activity
2. Lifestyle & Healthy Diet
3. Socialization
4. Fall prevention
5. Stress management
6. Pain management
7. Medication & follow up
8.Spirituality & Schemes


1. STAY ACTIVE – Healthy Aging
Physical activity is about adding life.


HEALTH BENEFITS OF PHYSICAL ACTIVITY
PREVENT DISEASES (HTN,DM,CVD,STROKE,CANCER)
IMPROVES MENTAL HEALTH
IMPROVES BONE HEALTH & PHYSICAL FUNCTION
DECREASED RISK OF FALLS
IMPROVES COGNITIVE FUNCTION
IMPROVES HEALTH RELATED -QOL
SOCIAL ENGAGEMENT
EXTENDS YEARS OF ACTIVE LIFE

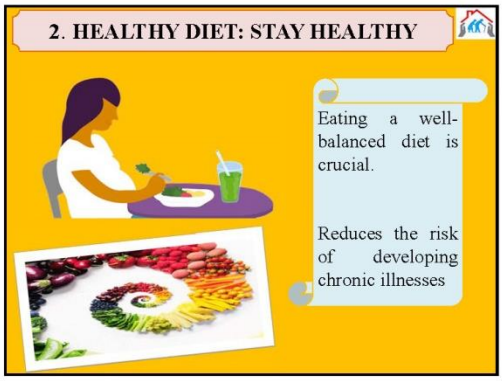

WHO Recommendations
✓ 150 minutes – moderate intensity aerobic activity per week
✓ Balance exercise

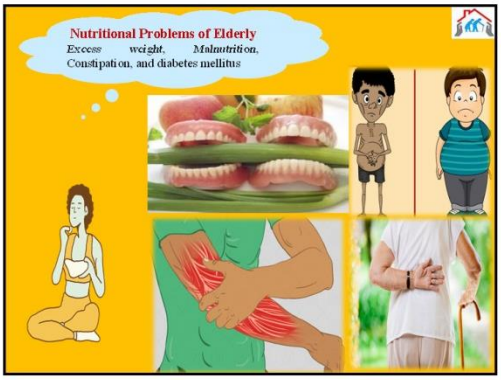

Muscle strengthening exercises
Wall push up
Standing /Seated stretch

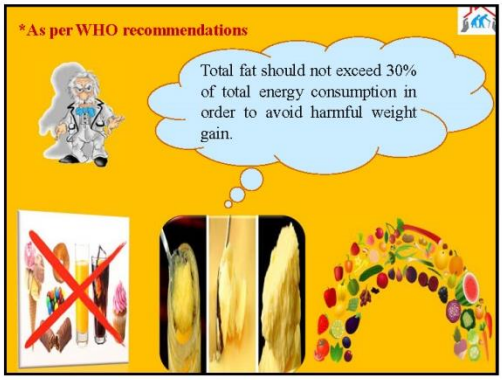

Exercise to enhance Balance
Rock the boat
Tightrope walk

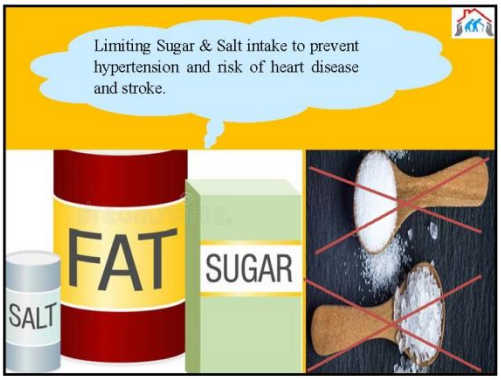

Exercises
Walking
Arm exercise
Side leg exercise
Hand & Finger Exercise(Squeeze,Pinch,Stretch,Twist)
Marching in Place

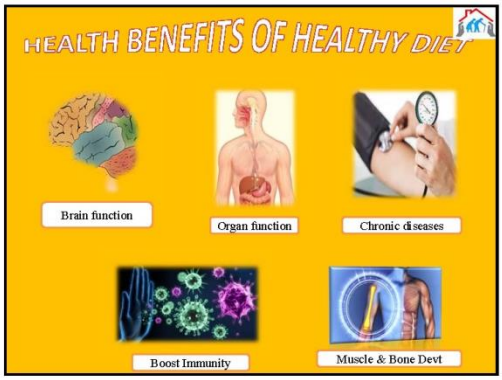

KEEP
ACTIVE
AND
STAY
HEALTHY
LET'S JOIN OUR HANDS TO MAKE
"ACTIVE PEOPLE -HEALTHY AGING &
NATION"


2. HEALTHY DIET: STAY HEALTHY
Eating a well-balanced diet is crucial.
Reduces the risk of developing chronic illnesses


Nutritional Problems of Elderly
Excess weight, Malnutrition,
Constipation, and diabetes mellitus

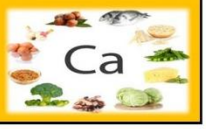

*As per WHO recommendations
Total fat should not exceed 30% of total energy consumption in order to avoid harmful weight gain.


Limiting Sugar & Salt intake to prevent hypertension and risk of heart disease and stroke.
FAT
SUGAR
SALT


HEALTH BENEFITS OF HEALTHY DIET
Brain function
Organ function
Chronic diseases
Boost Immunity
Muscle & Bone Devt

HEALTHY SENIOR DIET

1. Consume variety of Fruits and Vegetables
2. Calcium & Protein for muscle & Bone health
3. Fiber-Rich meals
4. Reduce intake of processed carbohydrates and sweets.
5. Maintain Hydration
6. Vitamins and minerals: Calcium, Magnesium, Vitamin D, Vitamin B12, and Potassium

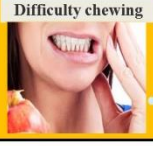


OVERCOME EATING OBSTACLES- AMONG ELDERLY

Boost a low appetite

Natural flavour enhancers like olive oil, butter, garlic, onions, ginger, and spices.

Difficulty chewing



Smoothies containing fresh fruit, yoghurt, and protein powder & steamed vegetables.

Deal with a dry mouth

Every day, consume 8–10 glasses of water

3. Stay Socially Active : Live Longer

Good connections and social support can improve health and longevity.

According to several studies, older persons who participate in social activities perform better on cognitive tasks.

HEALTH BENEFITS OF SOCIALIZATION

Reduced Stress

Longer lifespan

More fitness

Greater Self-esteem

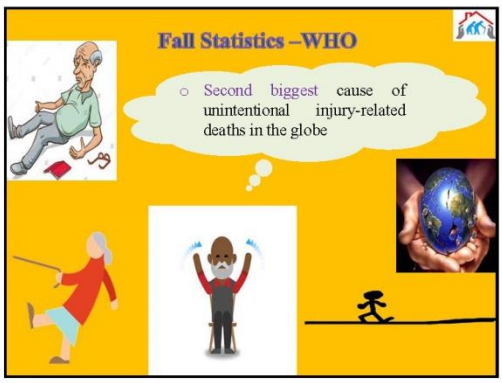
Reduced risk of depression

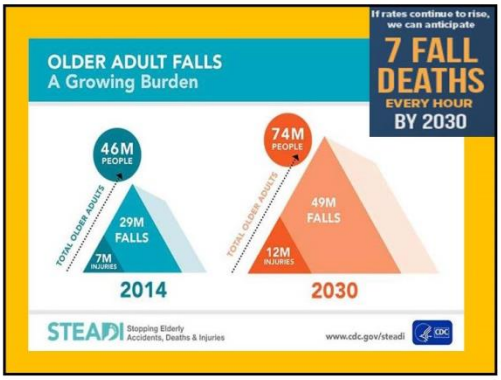
Less anxiety

Ways to Maintain a Healthy Social Life: Geriatric

1. Maintain good relations
2. Participate in voluntary social activities.
3. Caring for a pet or engaging in hobbies and interests.


4. Fall Prevention
Falls and fall-related injuries are widespread and dangerous concern.
An accident that causes a person to fall
Healthy Aging In Place


Fall Statistics –WHO
Second biggest cause of unintentional injury-related deaths in the globe


If rates continue to rise, we can anticipate
7 FALL DEATHS EVERY HOUR BY 2030
OLDER ADULT FALLS
A Growing Burden
46M PEOPLE
29M FALLS
7M INJURIES
2014
74M PEOPLE
49M FALLS
12M INJURIES
2030
STEADI Stopping Elderly Accidents, Deaths & Injuries
www.cdc.gov/steadi


Consequences of a Fall
Broken bones, like wrist, arm, ankle, and hip fractures.
Head injuries


Fall Prevention Strategies
SCREEN
ASSESS
INTERVENE
Identify patients at risk
Identify modifiable risk factors
Effective communication skills
www.cdc.gov
STEADI Stopping Elderly Accidents, Deaths & Injuries


OLDER ADULT FALLS
A Preventable Problem
CDC, healthcare providers, and older adults and their caretakers can work together to prevent falls.
1. SCREEN
Screen for fall risk using these 3 questions:
Have you fallen in the past year?
Do you feel unsteady when standing or walking?
Do you worry about falling?
2. REVIEW
Review and manage medications linked to falls.
3. RECOMMEND
Recommend vitamin D for improved bone, muscle, and nerve health.
STEADI Stopping Elderly Accidents, Deaths & Injuries
www.cdc.gov/steadi

Fall Prevention Strategies

Talk to Your Doctor

Do Strength and Balance Exercises

Have Your Eyes & Feet Checked

Make Your Home Safer

* Asner CDC Guidelines - 2021

ACTIVITY

The 4-Stage Balance Test

Patient _____

Date _____

Time _____ ☐AM ☐PM

Instructions to the patient:

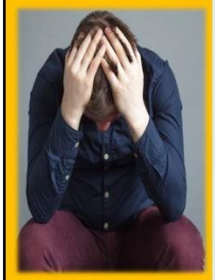
- I'm going to show you four positions.
- Try to stand in each position for 10 seconds.
- You can hold your arms out, or move your body to help keep your balance, but don't move your feet.
- For each position I will say, **"Ready, begin."** Then, I will start timing. After 10 seconds, I will say, **"Stop."**

	① Stand with your feet side-by-side.	Time: _____seconds
	② Place the instep of one foot so it is touching the big toe of the other foot.	Time: _____seconds
	③ Tandem stand: Place one foot in front of the other, heel touching toe.	Time: _____seconds
	④ Stand on one foot.	Time: _____seconds

5. STRESS MANAGEMENT

- Stress is a common occurrence in our lives and a natural reaction to a stressful event.

WHO STATISTICS



- Mental and neurological illnesses account for 6.6 percent of all disability in older individuals.
- Around 15% of persons aged 60 and up suffer from a mental illness.

SOURCES OF STRESS

- After retirement, lifestyle and financial circumstances
- Taking care of grandchildren
- Taking care of a sick spouse
- Beloved ones die
- Physical impairment and chronic illness

STRATEGIES FOR MANAGING STRESS

1. Look after yourself
2. Exercise on a regular basis
3. Engage in social activities
4. Discuss your emotions
5. Use relaxing methods
6. Massage and meditation
7. Seek expert assistance

6. PAIN MANAGEMENT

An unpleasant sensory and emotional experience triggered by sensory cues and influenced by personal recollection, expectations, and emotions.

- ✓ 1 in 5 elderly have pain -WHO

NON DRUG PAIN MANAGEMENT

Massage therapy

Warm and cold compress

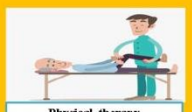
Repositioning

Spiritual support

Music therapy

Meditation

NON DRUG PAIN MANAGEMENT



Physical therapy

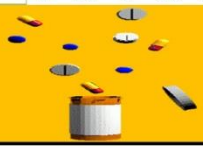
Occupational therapy

Emotional support

Education about illness

7.Medication Management

- Determine the severity of your pain.
- If pain is persistent on a regular basis, you should take medication on a regular basis.



Conti……

Take Medicine as Prescribed—with Input from Your Health Care Provider

Keep a Medication List

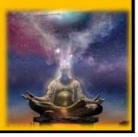
Be Aware of Potential Drug Interactions and Side Effects

Review Medications with Your Health Care Provider

8. SPIRITUALITY

Spirituality is considered to be the very essence of being which allows a person to experience transcendent meaning in life which gives holistic approach to wellness.

A spiritual connection can boost seniors wellness, especially senior living community supports faith practices.



IMPORTANCE OF SPIRITUALITY

Spirituality can improve quality for life for seniors

Spirituality is a significant part of many people's lives

Spirituality is a significant to lead peaceful life

Individual's spiritual practice improve health outcomes

SCHEMES FOR GERIATRIC

1. Pradhan Mantra Vaya Vandana scheme
2. Indira Gandhi National Old Age Pension Scheme (IGNOAPS)
3. National Programme for the Health Care of Elderly (NPHCE)
4. Varishta Mediclaim policy
5. Rashtriya Vayoshri Yojana
6. Varishta Pension Bima Yojana
7. Senior Citizens' Welfare Fund
8. Vayoshreshtha Samman
9. Reverse Mortgage Scheme
10. Pradhan Mantri Jan Arogya Yojana

ELDER ABUSE

Infliction of harm on an older person

National toll-free *helpline numbers for senior citizens*: to reach out to the abandoned *elderly* and redressal of grievances lodged by senior citizens-

- **1090 (Bangalore),**
- **14567(common to all states)**

FAMILY CARE GIVER ROLE

1. Maintain a safe, clean and healthful environment for the patient.
2. Care of the patient welfare socially, intellectually, spiritually, physically and emotionally.
3. Food and Medicine preparation administration.
4. Spend a few minutes to keep your seniors updated about what's happening in your life.
5. Visit as often as you can. Bring your children and partner to visit your senior loved one.

Role of NURSE in Geriatric care

- Assess and screen for health problems
- Promote health & wellness,
- encourage active lifestyle,
- Strengthening self-care capacities
- prevent disability & secondary impairments
- Engages in counseling, communication, collaboration.
- Improve Health control of communicable diseases and
- Increasing life expectancy among the elderly

CONCLUSION

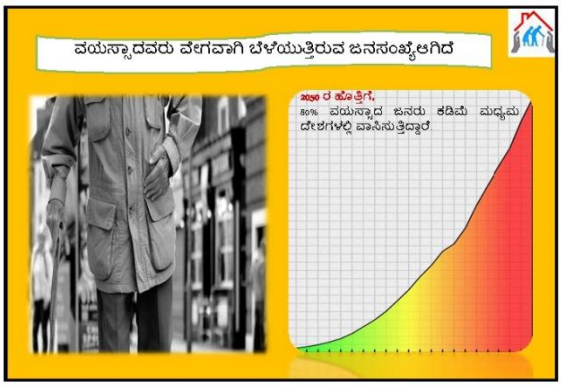
Health promotion measures plays a vital role in improving health of geriatric by promoting healthy strategies to achieve successful aging

"Adding colours to life in silver years

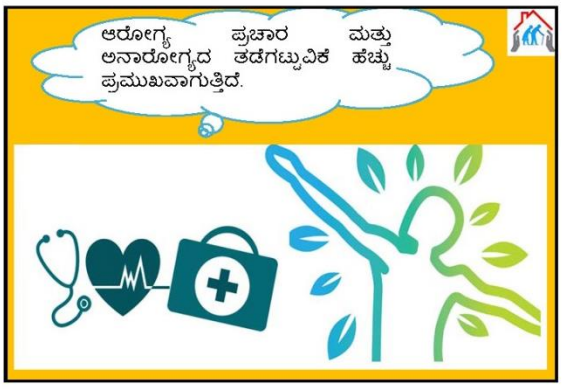

ವಯೋವೃದರು
ಆರೋಗ್ಯ ಪ್ರಚಾರದ ಕ್ರಮಗಳು

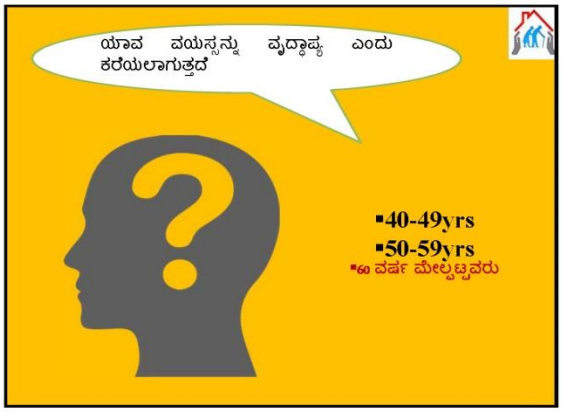

"ಒಂದು ಅತ್ಯುನ್ನತ ಗೌರವ"
ಎಂದರೆ "ಒಮ್ಮೆ ನಮ್ಮನ್ನು
ಕಾಳಜಿ ವಹಿಸಿದವರಿಗೆ ಕಾಳಜಿ
ವಹಿಸುವುದು."


ಪರಿಚಯ
ವೃದ್ಯಾವ್ಯವು ಎರಡನೇ ಬಾಲ್ಯದ ಉಡುಗೊರೆಯಾಗಿದೆ ಶಕ್ತಿ ಮತ್ತು ಸಾಮರ್ಥ್ಯದ
ಹೊಸ ಹಂತವಾಗಿದೆ.

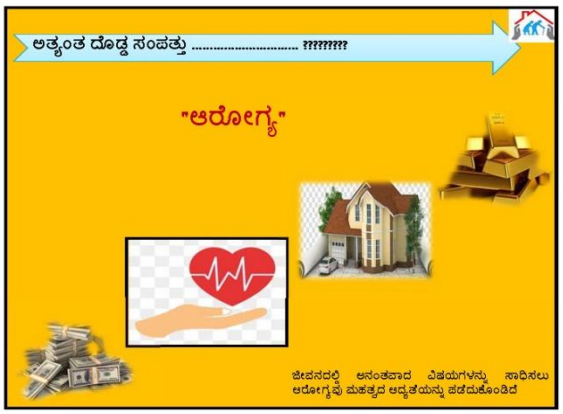

ವಯಸ್ಸಾದವರು ವೇಗವಾಗಿ ಬೆಳೆಯುತ್ತಿರುವ ಜನಸಂಖ್ಯೆಯಾಗಿದೆ


ಪ್ರತಿಯೊಂದು
ಹಂತಗಳಲ್ಲಿ,
ವ್ಯಕ್ತಿಯುವಿಭಿನ್ನ
ಸನ್ನಿವೇಶಗಳು
ಮತ್ತು
ಸಮಸ್ಯೆಗಳಿಗೆ
ತನ್ನನ್ನು ತಾನೇ
ಹೊಂದಿಕೊಳ್ಳ
ಬೇಕಾಗುತ್ತದೆ.


ಆರೋಗ್ಯ ಪ್ರಚಾರ ಮತ್ತು
ಅನಾರೋಗ್ಯದ ತಡೆಗಟ್ಟುವಿಕೆ ಹೆಚ್ಚು
ಪ್ರಮುಖವಾಗುತ್ತಿದೆ.


ಯಾವ ವಯಸ್ಸನ್ನು ವೃದ್ಧಾಪ್ಯ ಎಂದು ಕರೆಯಲಾಗುತ್ತದೆ
▪40-49yrs
▪50-59yrs
▪60 ವರ್ಷ ಮೇಲ್ಪಟ್ಟವರು


"ಅಂತಾರಾಷ್ಟ್ರೀಯ ಹಿರಿಯರ ದಿನ" ಪ್ರತಿ ವರ್ಷ
ಅಕ್ಟೋಬರ್ 1 ರಂದು
ಆಚರಿಸಲಾಗುತ್ತದೆ".
OCTOBER
1


ಅತ್ಯಂತ ದೊಡ್ಡ ಸಂಪತ್ತು ..... ????????
"ಆರೋಗ್ಯ"
ಜೀವನದಲ್ಲಿ ಅನಂತವಾದ ವಿಷಯಗಳನ್ನು ಸಾಧಿಸಲು ಆರೋಗ್ಯವು ಮಹತ್ವದ ಆದ್ಯತೆಯನ್ನು ಪಡೆದುಕೊಂಡಿದೆ


ಯಶಸ್ವಿ ವೃದ್ಧಾಪ್ಯಕ್ಕೆ :
ಆರೋಗ್ಯ ಪ್ರಜಾರದ ಕ್ರಮಗಳು
ಪ್ರಮುಖ ಪಾತ್ರವಹಿಸುತ್ತವೆ.

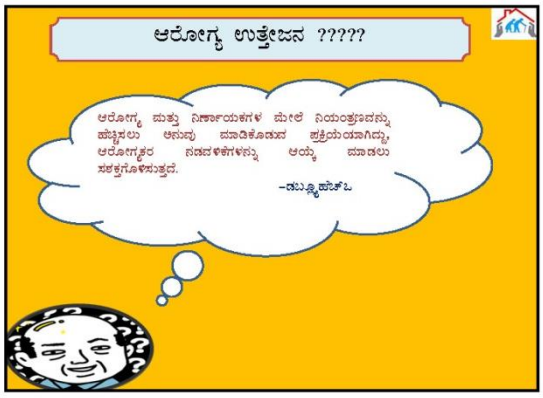

ಪರಿಣಾಮ ಬೀರುವ ಅಂಶಗಳು
ಆನುವಂಶಿಕ ಅಂಶಗಳು
ಪರಿಸರ ಅಂಶಗಳು
ಸಾಮಾಜಿಕ-ಆರ್ಥಿಕ ಅಂಶಗಳು

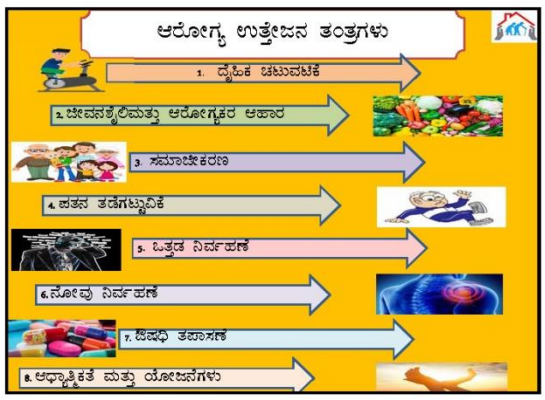

ವೃದ್ಧಾಪ್ಯ ಜನರು ಎದುರಿಸುತ್ತಿರುವ ಸಮಸ್ಯೆಗಳು???????
ದೀರ್ಘಕಾಲೀನ ಆರೋಗ್ಯ ಮತ್ತು ಆರಿವಿನ ಸಮಸ್ಯೆ
ಗಾಯದ ಅಪಾಯ
ಅಪೌಷ್ಟಿಕತೆ


ವೃದ್ಧಾಪ್ಯ ಜನರು ಎದುರಿಸುತ್ತಿರುವ ಸಮಸ್ಯೆಗಳು!!!!!!!
Hearing Impairment
Deafblindness
Sight Impairment
EXIT
ಸಂವೇದನಾ ಸಮಸ್ಯೆಗಳು
ಕರುಳು ಮತ್ತು ಮೂತ್ರಕೋಶದ ಸಮಸ್ಯೆಗಳು
ಸ್ನಾಯು ಎಲುಬು ಸಮಸ್ಯೆಗಳು

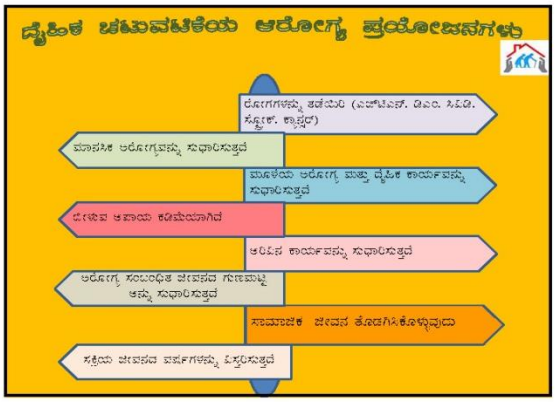

ವೃದ್ಧಾಪ್ಯ ಜನರು ಎದುರಿಸುತ್ತಿರುವ ಸಮಸ್ಯೆಗಳು!!!!!!!
ಮೌಖಿಕ ಸಮಸ್ಯೆ
ಹಿರಿಯರ ನಿಂದನೆ ಮತ್ತು ಒಂಟಿತನ
ಮಾದಕ ವಸ್ತು ದುರುಪಯೋಗ


ಜನರು ವೃದ್ಧಾಪ್ಯದಿಂದ ಸಾಯುವುದಿಲ್ಲ, ಅವರು ನಿರ್ಲಕ್ಷ್ಯದಿಂದ ಸಾಯುತ್ತಾರೆ,
ಆದ್ದರಿಂದ ಪ್ರೀತಿ, ಗೌರವ, ಸಹಾನುಭೂತಿ, ಸಂತೋಷದಿಂದ ನೋಡಿಕೊಳ್ಳಬೇಕು


ಆರೋಗ್ಯ ಉತ್ತೇಜನ ?????
ಆರೋಗ್ಯ ಮತ್ತು ನಿರ್ಣಾಯಕಗಳ ಮೇಲೆ ನಿಯಂತ್ರಣವನ್ನು ಹೆಚ್ಚಿಸಲು ಅನುವು ಮಾಡಿಕೊಡುವ ಪ್ರಕ್ರಿಯೆಯಾಗಿದ್ದು, ಆರೋಗ್ಯಕರ ನಡವಳಿಕೆಗಳನ್ನು ಆಯ್ಕೆ ಮಾಡಲು ಸಕ್ಷಮಗೊಳಿಸುತ್ತದೆ.
–ಡಬ್ಲ್ಯೂಹೆಚ್ಒ

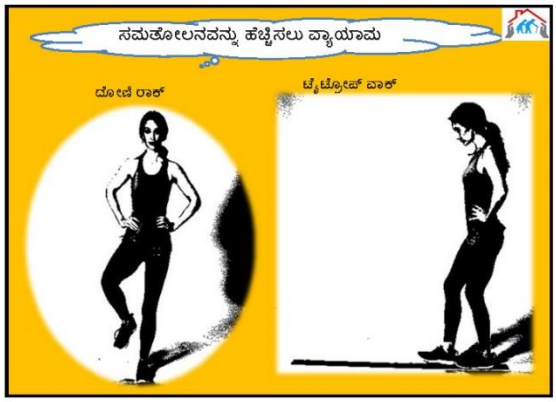

ಆರೋಗ್ಯ ಉತ್ತೇಜನ ತಂತ್ರಗಳು
1. ದೈಹಿಕ ಚಟುವಟಿಕೆ
2. ಜೀವನಶೈಲಿಮತ್ತು ಆರೋಗ್ಯಕರ ಆಹಾರ
3. ಸಮಾಜೀಕರಣ
4. ಪತನ ತಡೆಗಟ್ಟುವಿಕೆ
5. ಒತ್ತಡ ನಿರ್ವಹಣೆ
6. ನೋವು ನಿರ್ವಹಣೆ
7. ಔಷಧಿ ತಪಾಸಣೆ
8. ಆಧ್ಯಾತ್ಮಿಕತೆ ಮತ್ತು ಯೋಜನೆಗಳು

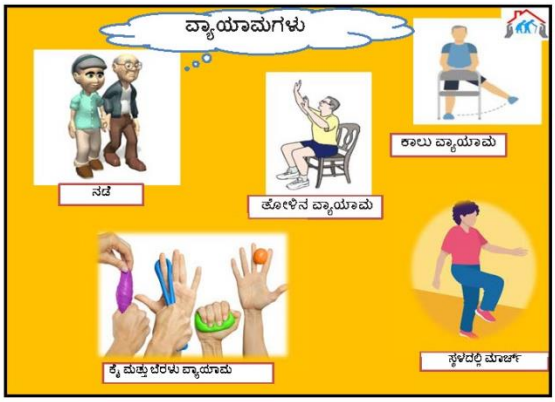

1. ಸಕ್ರಿಯವಾಗಿರಿ:
ಆರೋಗ್ಯಕರ ಹಿರಿಯ ಜೀವನಕ್ಕೆ
ದೈಹಿಕ ಚಟುವಟಿಕೆಯು
ಜೀವನವನ್ನು ಹೆಚ್ಚಿಸುತ್ತದೆ.


ದೈಹಿಕ ಚಟುವಟಿಕೆಯ ಆರೋಗ್ಯ ಪ್ರಯೋಜನಗಳು
ರೋಗಗಳನ್ನು ತಡೆಯಿರಿ (ಎಚ್‌ಐವಿ, ಡಿಎಂ, ಸಿವಿಡಿ, ಸ್ಟ್ರೋಕ್, ಕ್ಯಾನ್ಸರ್)
ಮಾನಸಿಕ ಆರೋಗ್ಯವನ್ನು ಸುಧಾರಿಸುತ್ತದೆ
ಮೂಳೆಯ ಆರೋಗ್ಯ ಮತ್ತು ದೈಹಿಕ ಕಾರ್ಯವನ್ನು ಸುಧಾರಿಸುತ್ತದೆ
ದೀರ್ಘಾವಧಿಯ ಆಪಾಯ ಕಡಿಮೆಯಾಗಿದೆ
ಅರಿವಿನ ಕಾರ್ಯವನ್ನು ಸುಧಾರಿಸುತ್ತದೆ
ಆರೋಗ್ಯ ಸಂಬಂಧಿತ ಜೀವನದ ಗುಣಮಟ್ಟವನ್ನು ಸುಧಾರಿಸುತ್ತದೆ
ಸಾಮಾಜಿಕ ಜೀವನ ತೊಡಗಿಸಿಕೊಳ್ಳುವುದು
ಸಕ್ರಿಯ ಜೀವನದ ವರ್ಷಗಳನ್ನು ವಿಸ್ತರಿಸುತ್ತದೆ


WHO ಶಿಫಾರಸುಗಳು
150 ನಿಮಿಷಗಳು - ವಾರಕ್ಕೆ ಮಧ್ಯಮ ಚಟುವಟಿಕೆ
ಸಮತೋಲನ ವ್ಯಾಯಾಮ


ಸ್ನಾಯು ಬಲಪಡಿಸುವ ವ್ಯಾಯಾಮಗಳು
ಗೋಡೆ ತ್ಪುಷ್ಪು
ನಿಂತಿರುವ / ಕುಳಿತಿರುವ ಹಿಗ್ಗಿಸುವಿಕೆ

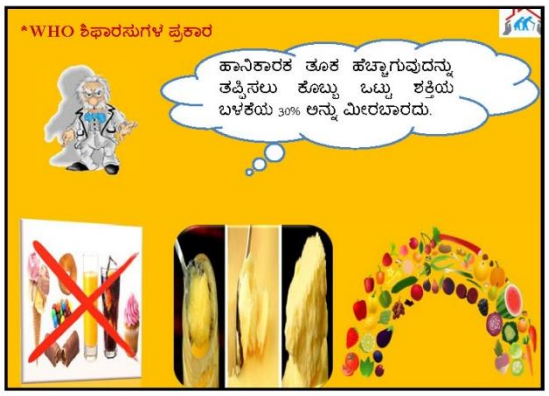

ಸಮತೋಲನವನ್ನು ಹೆಚ್ಚಿಸಲು ವ್ಯಾಯಾಮ
ಟೋಣೆ ರಾಕ್
ಟೈಟ್ರೋಪ್ ವಾಕ್

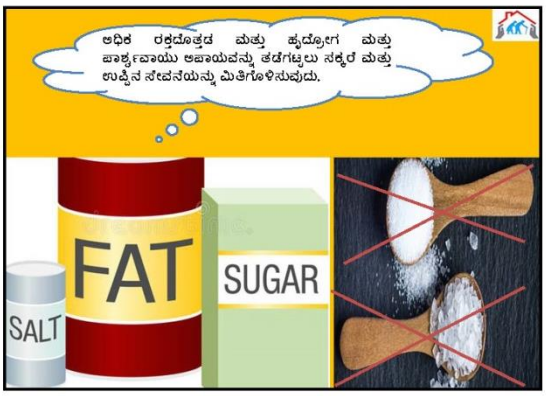

ವ್ಯಾಯಾಮಗಳು
ನಡೆ
ತೋಳಿನ ವ್ಯಾಯಾಮ
ಕಾಲು ವ್ಯಾಯಾಮ
ಕೈ ಮತ್ತು ಬೆರಳು ವ್ಯಾಯಾಮ
ಸ್ಥಳದಲ್ಲಿ ಮಾರ್ಚ್


KEEP
ACTIVE
AND
STAY
HEALTHY
ನಾವು ಕೈಗಳನ್ನು ಸೇರಿಕೊಳ್ಳೋಣ
"ಸಕ್ರಿಯ ಜನರು-ಆರೋಗ್ಯಕರ ವಯಸ್ಸು ಮತ್ತು ರಾಷ್ಟ್ರ"


2. ಆರೋಗ್ಯಕರ ಆಹಾರ: ಆರೋಗ್ಯವಾಗಿರಲು
ಸಮತೋಲಿತ ಆಹಾರವನ್ನು ಸೇವಿಸುವುದು ಬಹಳ ಮುಖ್ಯ
ದೀರ್ಘಕಾಲದ ಕಾಯಿಲೆಗಳನ್ನು ಅಭಿವೃದ್ಧಿಪಡಿಸುವ ಅಪಾಯವನ್ನು ಕಡಿಮೆ ಮಾಡುತ್ತದೆ

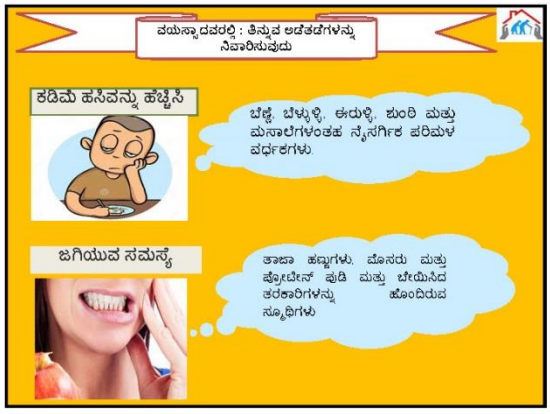

ಹಿರಿಯರ ಪೌಷ್ಟಿಕಾಂಶದ ಸಮಸ್ಯೆಗಳು
ಅಧಿಕ ತೂಕ, ಅಪೌಷ್ಟಿಕತೆ, ಮಲಬದ್ಧತೆ ಮತ್ತು ಮಧುಮೇಹ


*WHO ಶಿಫಾರಸುಗಳ ಪ್ರಕಾರ
ಹಾನಿಕಾರಕ ತೂಕ ಹೆಚ್ಚಾಗುವುದನ್ನು ತಪ್ಪಿಸಲು ಕೊಬ್ಬು ಒಟ್ಟು ಶಕ್ತಿಯ ಬಳಕೆಯ 30% ಅನ್ನು ಮೀರಬಾರದು.


ಅಧಿಕ ರಕ್ತದೊತ್ತಡ ಮತ್ತು ಹೃದ್ರೋಗ ಮತ್ತು ಪಾರ್ಶ್ವವಾಯು ಅಪಾಯವನ್ನು ತಡೆಗಟ್ಟಲು ಸಕ್ಕರೆ ಮತ್ತು ಉಪ್ಪಿನ ಸೇವನೆಯನ್ನು ಮಿತಿಗೊಳಿಸುವುದು.
FAT
SUGAR
SALT


ಆರೋಗ್ಯಕರ ಆಹಾರದ ಪ್ರಯೋಜನಗಳು
ಮೆದುಳಿನ ಕಾರ್ಯ
ಅಂಗ ಕಾರ್ಯ
ದೀರ್ಘಕಾಲದ ರೋಗಗಳು
ರೋಗನಿರೋಧಕ ಶಕ್ತಿಯನ್ನು ಹೆಚ್ಚಿಸಿ
ಸ್ನಾಯು ಮತ್ತು ಮೂಳೆ ಅಭಿವೃದ್ಧಿ


ಆರೋಗ್ಯಕರ ಹಿರಿಯ ಆಹಾರ
1. ವಿವಿಧ ಹಣ್ಣುಗಳು ಮತ್ತು ತರಕಾರಿಗಳನ್ನು ಸೇವಿಸಿ
2. ಸ್ನಾಯು ಮತ್ತು ಮೂಳೆಗಳ ಆರೋಗ್ಯಕ್ಕಾಗಿ ಕ್ಯಾಲ್ಸಿಯಂ ಮತ್ತು ಪ್ರೋಟೀನ್
3. ನಾರು ಭರಿತ ಊಟ. ಹೆಚ್ಚು ನೀರು ಸೇವನೆ
4. ಸಿಹಿತಿಂಡಿಗಳ ಸೇವನೆಯನ್ನು ಕಡಿಮೆ ಮಾಡಿ
5. ಜೀವಸತ್ವಗಳು ಮತ್ತು ಖನಿಜಗಳು ಸೇವಿಸುವುದು
Ca


ವಯಸ್ಸಾದವರಲ್ಲಿ : ತಿನ್ನುವ ಅಡೆತಡೆಗಳನ್ನು ನಿವಾರಿಸುವುದು
ಕಡಿಮೆ ಹಸಿವನ್ನು ಹೆಚ್ಚಿಸಿ
ಬೆಳ್ಳಿ, ಬೆಳ್ಳುಳ್ಳಿ, ಈರುಳ್ಳಿ, ಶುಂಠಿ ಮತ್ತು ಮಸಾಲೆಗಳಂತಹ ನೈಸರ್ಗಿಕ ಪರಿಮಳ ವರ್ಧಕಗಳು.
ಜಗಿಯುವ ಸಮಸ್ಯೆ
ತಾಜಾ ಹಣ್ಣುಗಳು, ಮೊಸರು ಮತ್ತು ಪ್ರೋಟೀನ್ ಪುಡಿ ಮತ್ತು ಬೇಯಿಸಿದ ತರಕಾರಿಗಳನ್ನು ಹೊಂದಿರುವ ಸ್ಮೂಥಿಗಳು

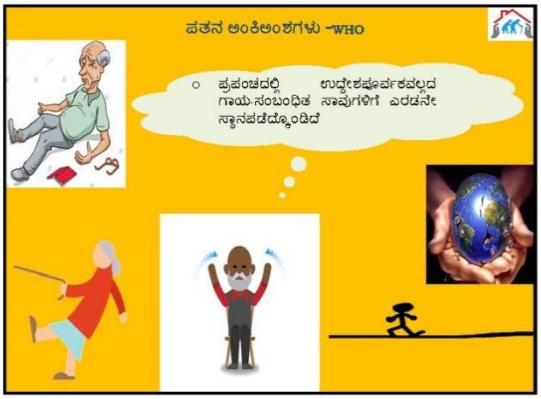

ಒಣಗಿದ ಬಾಯಿ
ಪ್ರತಿದಿನ 8-10 ಲೋಟ ನೀರು ಕುಡಿಯಿರಿ.

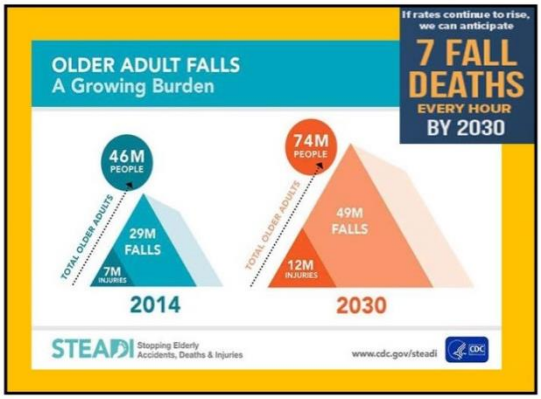

3. ಸಾಮಾಜಿಕ ಸಕ್ರಿಯರಾಗಿರಿ: ದೀರ್ಘಾಯುಷ್ಯರಾಗಿರಿ
ಉತ್ತಮ ಸಂಪರ್ಕಗಳು ಮತ್ತು ಸಾಮಾಜಿಕ ಬೆಂಬಲವು ಆರೋಗ್ಯವನ್ನು ಸುಧಾರಿಸುತ್ತದೆ
ಸಾಮಾಜಿಕ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ತೊಡಗಿರುವ ವಯಸ್ಸಾದ ಜನರು ಅರಿವಿನ ಕಾರ್ಯಗಳಲ್ಲಿ ಉತ್ತಮವಾಗಿ ಕಾರ್ಯನಿರ್ವಹಿಸುತ್ತಾರೆ ಎಂದು ಅಧ್ಯಯನಗಳ ಸಂಖ್ಯೆ ಕಂಡುಹಿಡಿದಿದೆ.


ಸಾಮಾಜಿಕ ಆರೋಗ್ಯದ ಲಾಭಗಳು
ಕಡಿಮೆ ಒತ್ತಡ
ದೀರ್ಘಾಯುಷ್ಯ
ದೈಹಿಕ ಸದೃಢತೆ
ಹೆಚ್ಚಿನ ಸ್ವಾಭಿಮಾನ
ಖಿನ್ನತೆಯ ಅಪಾಯವನ್ನು ಕಡಿಮೆ ಮಾಡುತ್ತದೆ
ಕಡಿಮೆ ಆತಂಕ

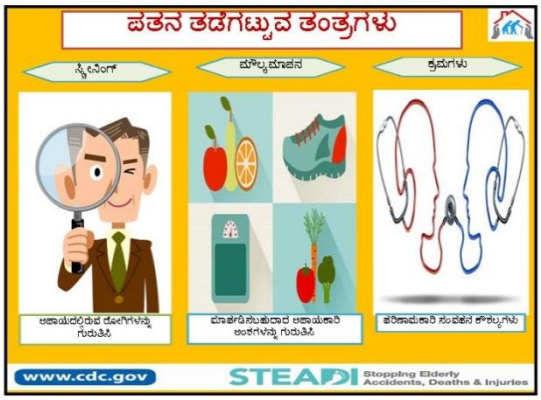

ಆರೋಗ್ಯಕರ ಸಾಮಾಜಿಕ ಜೀವನವನ್ನು ಕಾಪಾಡಿಕೊಳ್ಳುವ ಮಾರ್ಗಗಳು
1.ಉತ್ತಮ ಸಂಬಂಧಗಳನ್ನು ಕಾಪಾಡಿಕೊಳ್ಳಿ
2. ಸ್ವಯಂಪ್ರೇರಿತ ಸಾಮಾಜಿಕ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ಭಾಗವಹಿಸಿ.
3.ಸಾಕುಪ್ರಾಣಿಗಳನ್ನು ನೋಡಿಕೊಳ್ಳುವುದು ಅಥವಾ ಹವ್ಯಾಸಗಳು ಆಸಕ್ತಿಗಳಲ್ಲಿ ತೊಡಗಿಸಿಕೊಳ್ಳುವುದು


4. ಪತನ ತಡೆಗಟ್ಟುವಿಕೆ
ಪತನ ಮತ್ತು ಪತನಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ಗಾಯಗಳು ಅಪಾಯಕಾರಿ, ಒಬ್ಬ ವ್ಯಕ್ತಿಯು ಬೀಳಲು ಕಾರಣವಾಗುವ ಅಪಘಾತ.
Healthy Aging in Place


ಪತನ ಅಂಕಿಅಂಶಗಳು -WHO
ಪ್ರಪಂಚದಲ್ಲಿ ಉದ್ದೇಶಪೂರ್ವಕವಲ್ಲದ ಗಾಯ-ಸಂಬಂಧಿತ ಸಾವುಗಳಿಗೆ ಎರಡನೇ ಸ್ಥಾನವಿದೆ


If rates continue to rise, we can anticipate
7 FALL DEATHS EVERY HOUR BY 2030
OLDER ADULT FALLS
A Growing Burden
46M PEOPLE
TOTAL OLDER ADULTS
29M FALLS
7M INJURIES
2014
74M PEOPLE
TOTAL OLDER ADULTS
49M FALLS
12M INJURIES
2030
STEADI Stopping Elderly Accidents, Deaths & Injuries
www.cdc.gov/steadi


ಪತನದ ಪರಿಣಾಮಗಳು
ಮಣಿಕಟ್ಟು, ತೋಳು, ಪಾದದ ಮತ್ತು ಸೊಂಟದ ಮುರಿತಗಳಂತಹ ಮುರಿದ ಮೂಳೆಗಳು.
ತಲೆಗೆ ಗಾಯಗಳು


ಪತನ ತಡೆಗಟ್ಟುವ ತಂತ್ರಗಳು
ಸ್ಕ್ರೀನಿಂಗ್
ಮೌಲ್ಯಮಾಪನ
ಕ್ರಮಗಳು
ಅಪಾಯದಲ್ಲಿರುವ ರೋಗಿಗಳನ್ನು ಗುರುತಿಸಿ
ಮಾರ್ಪಡಿಸಬಹುದಾದ ಅಪಾಯಕಾರಿ ಅಂಶಗಳನ್ನು ಗುರುತಿಸಿ
ಪರಿಣಾಮಕಾರಿ ಸಂವಹನ ಕೌಶಲ್ಯಗಳು
www.cdc.gov
STEADI Stopping Elderly Accidents, Deaths & Injuries


ತಡೆಗಟ್ಟುವ ತಂತ್ರಗಳು
ನಿಮ್ಮ ವೈದ್ಯರೊಂದಿಗೆ ಮಾತನಾಡಿ
ಬಲ ಮತ್ತು ಸಮತೋಲನ ವ್ಯಾಯಾಮಗಳನ್ನು ಮಾಡಿ
ನಿಮ್ಮ ಕಣ್ಣುಗಳು ಮತ್ತು ಪಾದಗಳನ್ನು ಪರೀಕ್ಷಿಸಿ
ನಿಮ್ಮ ಮನೆಯನ್ನು ಸುರಕ್ಷಿತಗೊಳಿಸು
ಸಿಡಿಸಿ ಮಾರ್ಗಸೂಚಿಗಳ ಪ್ರಕಾರ - 2021


ACTIVITY
The 4-Stage Balance Test
Patient
Date
Time
AM PM
Instructions to the patient:
I'm going to show you four positions.
Try to stand in each position for 10 seconds.
You can hold your arms out, or move your body to help keep your balance, but don't move your feet.
For each position I will say, "Ready, begin." Then, I will start timing. After 10 seconds, I will say, "Stop."
① Stand with your feet side-by-side.
Time: seconds
② Place the instep of one foot so it is touching the big toe of the other foot.
Time: seconds
③ Tandem stand: Place one foot in front of the other, heel touching toe.
Time: seconds
④ Stand on one foot.
Time: seconds

5. ಒತ್ತಡ ನಿರ್ವಹಣೆ

- ಒತ್ತಡವು ನಮ್ಮ ಜೀವನದಲ್ಲಿ ನೈಸರ್ಗಿಕ ಪ್ರತಿಕ್ರಿಯೆಯಾಗಿದೆ.

ಡಬ್ಲ್ಯೂಎಚ್ಓ -ಅಂಕಿಅಂಶಗಳು

- ಮಾನಸಿಕ ಮತ್ತು ನರವೈಜ್ಞಾನಿಕ ಕಾಯಿಲೆಗಳು ವಯಸ್ಕಾದ ವ್ಯಕ್ತಿಗಳಲ್ಲಿ ಎಲ್ಲಾ ಅಂಗವೈಕಲ್ಯದಲ್ಲಿ 66 ಪ್ರತಿಶತವನ್ನು ಹೊಂದಿವೆ.
- ೬೦ ಮತ್ತು ಅದಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ವಯಸ್ಸಿನ ಸುಮಾರು 15% ಜನರು ಮಾನಸಿಕ ಅಸ್ವಸ್ಥತೆಯಿಂದ ಬಳಲುತ್ತಿದ್ದಾರೆ.

ಒತ್ತಡದ ಮೂಲಗಳು

- ನಿವೃತ್ತಿಯ ನಂತರ, ಜೀವನಶೈಲಿ ಮತ್ತು ಆರ್ಥಿಕ ಪರಿಸ್ಥಿತಿಗಳು
- ಮೊಮ್ಮಕ್ಕಳನ್ನು ನೋಡಿಕೊಳ್ಳುವುದು
- ಅನಾರೋಗ್ಯದ ಸಂಗಾತಿಯನ್ನು ನೋಡಿಕೊಳ್ಳುವುದು
- ಪ್ರೀತಿಪಾತ್ರರು ಸಾಯುತ್ತಾರೆ
- ದೈಹಿಕ ದುರ್ಬಲತೆ ಮತ್ತು ದೀರ್ಘಕಾಲದ ಅನಾರೋಗ್ಯ

ಒತ್ತಡವನ್ನು ನಿರ್ವಹಿಸುವ ತಂತ್ರಗಳು

1. ವ್ಯಾಯಾಮ ಮಾಡಿ
2. ಸಾಮಾಜಿಕ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ತೊಡಗಿಸಿಕೊಳ್ಳಿ
3. ನಿಮ್ಮ ಭಾವನೆಗಳನ್ನು ಚರ್ಚಿಸಿ
4. ವಿಶ್ರಾಂತಿ ವಿಧಾನಗಳನ್ನು ಬಳಸಿ
5. ಮನಸಾಜ್ ಮತ್ತು ಧ್ಯಾನ
6. ತಜ್ಞರ ಸಹಾಯವನ್ನು ಪಡೆಯಿರಿ

6. ನೋವು ನಿರ್ವಹಣೆ

ಅಹಿತಕರ ಸಂವೇದನಾ ಮತ್ತು ಭಾವನಾತ್ಮಕ ಅನುಭವವು ಮತ್ತು ವೈಯಕ್ತಿಕ ಸ್ಮರಣೆ, ನಿರೀಕ್ಷೆಗಳು ಮತ್ತು ಭಾವನೆಗಳಿಂದ ಪ್ರಭಾವಿತವಾಗಿರುತ್ತದೆ.

- ✓ 5 ರಲ್ಲಿ 1 ಹಿರಿಯರು ನೋವಿನಿಂದ ಬಳಲುತ್ತಿದ್ದಾರೆ

-WHO

ಔಷಧವಲ್ಲದ ನೋವು ನಿರ್ವಹಣೆ

ಮಸಾಜ್ ಥೆರಪಿ

ಬೆಚ್ಚಗಿನ ಮತ್ತು ತಣ್ಣನೆಯ ಸಂಕುಚಿತ

ಮರುಸ್ಥಾನೀಕರಣ

ಅಧ್ಯಾತ್ಮಿಕ ಬೆಂಬಲ

ಸಂಗೀತ ಚಿಕಿತ್ಸೆ

ಧ್ಯಾನ

ಔಷಧವಲ್ಲದ ನೋವು ನಿರ್ವಹಣೆ

ದೈಹಿಕ ಚಿಕಿತ್ಸೆ

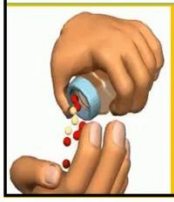
ಔದ್ಯೋಗಿಕ ಚಿಕಿತ್ಸೆ

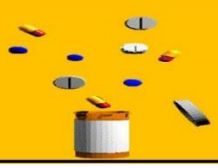
ಭಾವನಾತ್ಮಕ ಬೆಂಬಲ

ಅನಾರೋಗ್ಯದ ಬಗ್ಗೆ ಶಿಕ್ಷಣ

7.ಔಷಧಿ ನಿರ್ವಹಣೆ

- ನಿಮ್ಮ ನೋವಿನ ತೀವ್ರತೆಯನ್ನು ನಿರ್ಧರಿಸಿ.
- ನೋವು ನಿಯಮಿತವಾಗಿ ನಿರಂತರವಾಗಿದ್ದರೆ, ನಿಯಮಿತವಾಗಿ ಔಷಧಿಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳಬೇಕು.





ಮುಂದಾವರಿಸಿದ .....

ನಿಮ್ಮ ರೋಗ್ಯ ಸೇವ ಒದಗಿಸುವವರಿಂದ ಇನ್ ಫುಟ್ ನೊಂದಿಗೆ ಶಿಫಾರಸು ಮಾಡಲಾದ ಔಷಧವನ್ನು ತೆಗೆದುಕೊಳ್ಳಿ

ಔಷಧೋಪಚಾರ ಪಟ್ಟಿಯನ್ನು ಇರಿಸಿ

ಸಂಭಾವ್ಯ ಔಷಧ ಸಂಯಹನಗಳು ಮತ್ತು ಅಡ್ಡ ಪರಿಣಾಮಗಳ ಬಗ್ಗೆ ತಿಳಿದಿರಲಿ

ನಿಮ್ಮ ಎಲ್ಲಾ ಆರೋಗ್ಯ ಪೂರೈಕೆದಾರರೊಂದಿಗೆ ಔಷಧೋಪಚಾರಗಳನ್ನು ಪರಿಶೀಲಿಸಿ

8. ಆಧ್ಯಾತ್ಮಿಕತೆ

ಆಧ್ಯಾತ್ಮಿಕತೆಯನ್ನು ಅಸ್ತಿತ್ವದ ಮೂಲತತ್ವವೆಂದು ಪರಿಗಣಿಸಲಾಗುತ್ತದೆ. ಆರೋಗ್ಯಕರ ಜೀವನಕ್ಕೆ ಸಮಗ್ರ ವಿಧಾನವನ್ನು ನೀಡುತ್ತದೆ

ಆಧ್ಯಾತ್ಮಿಕ ಸಂಪರ್ಕವು ಹಿರಿಯರ ಸ್ವಾಸ್ಥ್ಯವನ್ನು ಹೆಚ್ಚಿಸುತ್ತದೆ. ವಿಶೇಷವಾಗಿ ಹಿರಿಯ ದೇಶ ಸಮುದಾಯವು ನಂಬಿಕೆ ಆಚರಣೆಗಳನ್ನು ಬೆಂಬಲಿಸುತ್ತದೆ.

ಆಧ್ಯಾತ್ಮಿಕತೆಯ ಪ್ರಾಮುಖ್ಯತೆ

ಆಧ್ಯಾತ್ಮಿಕತೆಯು ಹಿರಿಯರಿಗೆ ಜೀವನದ ಗುಣಮಟ್ಟವನ್ನು ಸುಧಾರಿಸಬಹುದು

ಆಧ್ಯಾತ್ಮಿಕತೆಯು ಅನೇಕ ಜನರ ಜೀವನದ ಮಹತ್ವದ ಭಾಗವಾಗಿದೆ

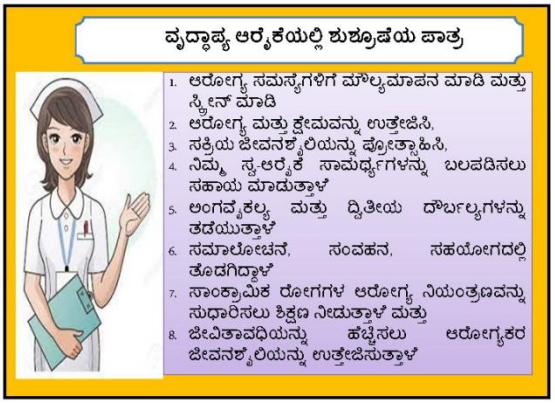
ಶಾಂತಿಯುತ ಜೀವನವನ್ನು ನಡೆಸಲು ಆಧ್ಯಾತ್ಮಿಕತೆಯು ಮಹತ್ವದ್ದಾಗಿದೆ

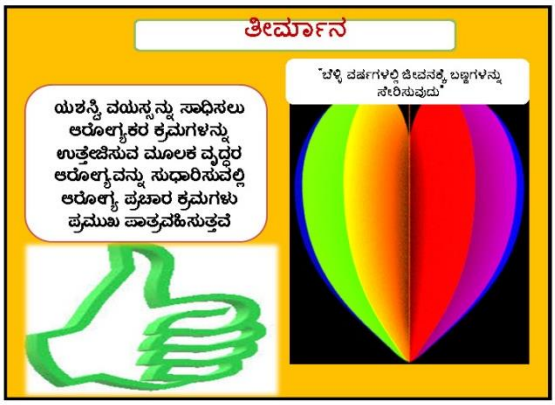
ವ್ಯಕ್ತಿಯ ಆಧ್ಯಾತ್ಮಿಕ ಅಭ್ಯಾಸವು ಆರೋಗ್ಯ ಫಲಿತಾಂಶಗಳನ್ನು ಸುಧಾರಿಸುತ್ತದೆ

ವೃದ್ಧಾಪ್ಯ ಯೋಜನೆಗಳು

1. ಪ್ರಧಾನಮಂತ್ರ ವಯ ವಂದನಾ ಯೋಜನೆ
2. ಇಂದಿರಾ ಗಾಂಧಿ ರಾಷ್ಟ್ರೀಯ ವೃದ್ಧಾಪ್ಯ ಪಿಂಚಣಿ ಯೋಜನೆ (ಐಜಿಎನ್ಒಎಪಿಎಸ್)
3. ವೃದ್ಧರ ಆರೋಗ್ಯ ರಕ್ಷಣೆಗಾಗಿ ರಾಷ್ಟ್ರೀಯ ಕಾರ್ಯಕ್ರಮ (ಎನ್ ಪಿಎಚ್ ಸೆಇ)
4. ವರಿಶ್ತಾ ಮೆಡಿಕ್ಲೇಮ್ ನೀತಿ
5. ರಾಷ್ಟ್ರೀಯ ವಾಯೋಶ್ರಿ ಯೋಜನೆ
6. ವರಿಶ್ತಾ ಪಿಂಚಣಿ ಬಿಮಾ ಯೋಜನೆ
7. ಹಿರಿಯ ನಾಗರಿಕರ ಕಲ್ಯಾಣ ನಿಧಿ
8. ವಯೋಶ್ರೇಷ್ಠ ಸಮ್ಮಾನ್
9. ಹಿಮ್ಮುಖ ಅಡಮಾನ ಯೋಜನೆ
10. ಪ್ರಧಾನಮಂತ್ರಿ ಜನ ಆರೋಗ್ಯ ಯೋಜನೆ

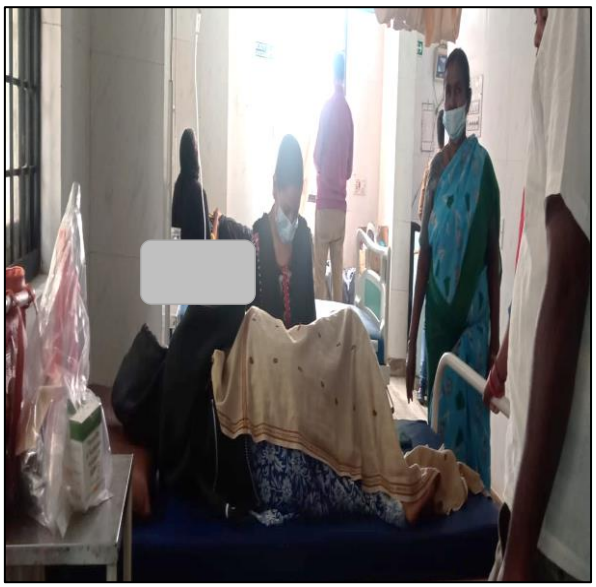

ಕುಟುಂಬದ ಸದಸ್ಯರ ಆರೈಕೆಯ : ಜವಾಬ್ದಾರಿಗಳು
1. ರೋಗಿಗೆ ಸುರಕ್ಷಿತ, ಸ್ವಚ್ಛ ಮತ್ತು ಆರೋಗ್ಯಕರ ವಾತಾವರಣವನ್ನು ಕಾಪಾಡಿಕೊಳ್ಳಿ.
2. ರೋಗಿಯ ಯೋಗಕ್ಷೇಮವನ್ನು ಸಾಮಾಜಿಕವಾಗಿ, ಬೌದ್ಧಿಕವಾಗಿ, ಆಧ್ಯಾತ್ಮಿಕವಾಗಿ, ದೈಹಿಕವಾಗಿ ಮತ್ತು ಭಾವನಾತ್ಮಕವಾಗಿ ನೋಡಿಕೊಳ್ಳಿ.
3. ಔಷಧಿ ಆಹಾರ ವಿತರಣೆಗಾಗಿ ಆಹಾರ ಮತ್ತು ಔಷಧ ತಯಾರಿ.
4. ನಿಮ್ಮ ಜೀವನದಲ್ಲಿ ಏನಾಗುತ್ತಿದೆ ಎಂಬುದರ ಕುರಿತು ನಿಮ್ಮ ಹಿರಿಯರನ್ನು ನವೀಕರಿಸಲು ಕೆಲವು ನಿಮಿಷಗಳನ್ನು ಕಳೆಯಿರಿ.
5. ನಿಮಗೆ ಸಾಧ್ಯವಾದಷ್ಟು ಭೇಟಿ ನೀಡಿ. ನಿಮ್ಮ ಹಿರಿಯ ಪ್ರೀತಿಪಾತ್ರರನ್ನು ಭೇಟಿ ಮಾಡಲು ನಿಮ್ಮ ಮಕ್ಕಳು ಮತ್ತು ಪಾಲುದಾರರನ್ನು ಕರೆತನ್ನಿ.

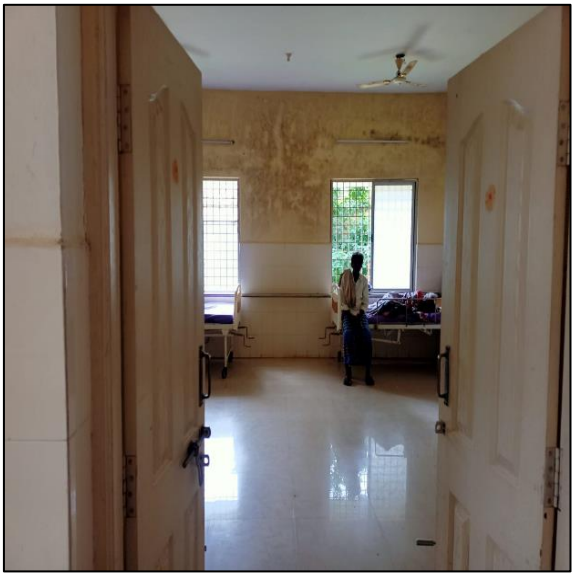

ವೃದ್ಧಾಪ್ಯ ಆರೈಕೆಯಲ್ಲಿ ಶುಶ್ರೂಷೆಯ ಪಾತ್ರ
1. ಆರೋಗ್ಯ ಸಮಸ್ಯೆಗಳಿಗೆ ಮೌಲ್ಯಮಾಪನ ಮಾಡಿ ಮತ್ತು ಸ್ಕ್ರೀನ್ ಮಾಡಿ
2. ಆರೋಗ್ಯ ಮತ್ತು ಕ್ಷೇಮವನ್ನು ಉತ್ತೇಜಿಸಿ,
3. ಸಕ್ರಿಯ ಜೀವನಶೈಲಿಯನ್ನು ಪ್ರೋತ್ಸಾಹಿಸಿ,
4. ನಿಮ್ಮ ಸ್ವ-ಆರೈಕೆ ಸಾಮರ್ಥ್ಯಗಳನ್ನು ಬಲಪಡಿಸಲು ಸಹಾಯ ಮಾಡುತ್ತಾಳೆ
5. ಅಂಗವೈಕಲ್ಯ ಮತ್ತು ದ್ವಿತೀಯ ದೌರ್ಬಲ್ಯಗಳನ್ನು ತಡೆಯುತ್ತಾಳೆ
6. ಸಮಾಲೋಚನೆ, ಸಂವಹನ, ಸಹಯೋಗದಲ್ಲಿ ತೊಡಗಿದ್ದಾಳೆ
7. ಸಾಂಕ್ರಾಮಿಕ ರೋಗಗಳ ಆರೋಗ್ಯ ನಿಯಂತ್ರಣವನ್ನು ಸುಧಾರಿಸಲು ಶಿಕ್ಷಣ ನೀಡುತ್ತಾಳೆ ಮತ್ತು
8. ಜೀವಿತಾವಧಿಯನ್ನು ಹೆಚ್ಚಿಸಲು ಆರೋಗ್ಯಕರ ಜೀವನಶೈಲಿಯನ್ನು ಉತ್ತೇಜಿಸುತ್ತಾಳೆ


ತೀರ್ಮಾನ
ಯಶಸ್ವಿ ವಯಸ್ಸನ್ನು ಸಾಧಿಸಲು ಆರೋಗ್ಯಕರ ಕ್ರಮಗಳನ್ನು ಉತ್ತೇಜಿಸುವ ಮೂಲಕ ವೃದ್ಧರ ಆರೋಗ್ಯವನ್ನು ಸುಧಾರಿಸುವಲ್ಲಿ ಆರೋಗ್ಯ ಪ್ರಚಾರ ಕ್ರಮಗಳು ಪ್ರಮುಖ ಪಾತ್ರವಹಿಸುತ್ತವೆ
"ಬೆಳೆ ವರ್ಷಗಳಲ್ಲಿ ಜೀವನಕ್ಕೆ ಬಣ್ಣಗಳನ್ನು ಸೇರಿಸುವುದು"

ANNEXURE XXII

PHOTO GALLERY OF STUDY CARRIED OUT





	MASTER SHEET OF SOCIO-DEMOGRAPHIC VARIABLES & BIOPHYSIOLOGICAL PARAMETERS (EXPERIMENTAL GROUP)																			
Sampl	Sociodemographic Variables										Biophysiological Parameters									
sl.no	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	B1	B2	B3	B4	B5	B6	B7	B8	B9	B10
1	A	A	B	A	A	B	B	A	A	B	A	A	B	B	A	A	B	B	A	B
2	A	A	A	A	A	A	A	B	A	A	A	B	A	A	B	A	B	B	B	C
3	B	A	A	B	B	A	B	A	A	A	B	A	A	B	B	A	A	A	A	C
4	A	B	A	B	C	A	B	B	B	B	A	B	B	B	A	B	B	A	C	B
5	B	B	B	B	A	B	B	B	A	A	B	A	B	A	A	A	A	A	A	C
6	B	A	B	A	B	B	A	B	B	B	A	A	A	B	B	B	A	A	C	B
7	A	B	B	A	A	A	A	A	A	A	A	B	B	A	B	A	A	A	A	B
8	A	A	A	C	C	A	B	B	A	B	C	A	A	B	A	A	A	A	C	B
9	B	B	A	A	C	A	B	B	B	A	B	B	A	A	A	A	A	A	C	B
10	B	B	A	B	A	A	B	B	A	A	B	A	A	A	B	A	A	B	C	B
11	A	A	A	A	A	B	B	B	B	A	A	A	A	B	A	A	A	B	C	C
12	A	B	B	B	A	B	A	B	A	B	B	A	B	A	A	B	A	B	A	B
13	A	B	B	A	C	B	B	A	A	A	C	B	B	B	B	B	B	A	A	B
14	B	B	B	A	A	A	B	B	A	B	A	A	A	B	B	A	A	A	C	C
15	A	A	A	B	B	A	B	B	B	A	B	B	A	A	A	B	A	A	B	C
16	A	A	B	B	A	B	A	B	A	A	B	B	B	A	B	A	A	A	B	B
17	A	B	A	A	A	A	A	B	B	B	C	A	A	A	A	B	A	A	A	B
18	B	B	B	A	A	A	B	B	B	A	B	B	A	A	A	A	A	A	B	B
19	B	B	B	B	C	B	A	A	B	B	A	B	A	B	A	A	B	A	B	B
20	B	A	A	B	A	B	B	B	A	B	C	A	B	B	B	B	A	A	C	B
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22	A	B	A	A	B	A	B	B	A	A	B	A	B	B	B	B	A	A	C	B
23	A	A	A	B	A	A	A	B	A	A	B	B	A	A	A	A	B	B	A	C
24	A	B	B	A	A	B	B	B	B	B	A	B	A	B	B	B	A	B	B	B
25	B	A	B	B	C	A	B	B	A	A	B	A	A	A	B	B	A	B	A	C
26	A	B	A	B	C	B	A	A	B	B	C	B	A	A	B	A	A	A	B	B
27	A	A	A	A	B	A	A	A	A	B	A	A	A	B	A	A	A	A	B	B
28	A	A	B	A	A	A	B	B	B	B	B	B	A	A	B	A	B	A	C	C
29	B	B	B	B	C	A	B	B	A	A	B	A	B	A	A	A	B	A	B	C
30	B	B	A	B	A	A	B	B	A	A	B	A	A	B	B	B	B	A	C	C
31	B	B	A	A	A	A	B	A	A	A	A	A	B	A	A	A	A	A	B	C
32	A	A	B	C	A	B	B	B	A	B	A	A	A	A	A	B	A	A	A	A
33	A	B	B	B	A	A	B	B	B	B	A	B	B	B	B	A	A	A	C	A
34	A	A	A	A	A	B	A	B	A	A	B	A	A	A	B	B	A	A	B	A
35	B	B	B	B	A	A	B	A	B	A	B	B	A	A	B	A	A	B	A	A
36	B	A	A	A	A	A	B	B	A	B	A	A	A	A	A	B	A	B	A	A
37	A	B	A	A	C	A	B	B	A	B	A	A	A	A	B	A	B	A	B	A
38	B	A	B	B	A	A	A	B	A	A	A	B	A	A	A	B	A	A	B	C
39	A	A	B	A	A	B	B	A	A	A	A	B	A	B	A	A	A	B	C	A
40	B	B	A	C	A	A	A	B	B	A	B	B	B	A	B	B	A	B	C	A
41	A	B	B	A	C	A	B	B	B	A	B	A	B	A	A	A	A	A	B	A
42	A	A	B	A	A	B	B	A	A	A	B	A	A	A	B	B	A	A	C	C
43	A	B	B	A	A	A	B	B	A	B	B	B	A	A	B	A	B	A	B	C
44	B	A	A	C	A	A	B	A	A	A	A	A	A	A	B	B	A	A	C	C
45	A	A	B	C	A	A	B	B	A	B	B	B	A	B	B	A	B	A	C	A
46	B	B	B	A	A	A	B	A	B	A	B	A	A	B	A	A	B	A	A	A
47	A	A	B	A	A	A	B	A	A	B	A	B	A	A	A	A	B	A	A	A
48	A	A	A	A	A	A	B	B	B	B	B	B	B	A	B	A	A	A	B	A
49	A	B	B	A	A	A	B	A	A	A	B	A	A	A	A	A	A	A	B	A
50	A	A	B	A	A	A	B	B	A	B	A	B	A	B	B	A	A	A	C	A
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53	A	A	B	C	C	B	B	A	B	A	A	B	A	A	A	B	A	A	B	A
54	A	A	B	A	A	B	B	B	B	B	A	B	B	B	A	B	B	B	C	C
55	A	A	B	A	A	A	B	B	A	A	B	A	A	A	B	B	A	A	B	A
56	A	B	B	B	A	A	B	B	A	A	B	B	B	A	A	B	A	B	B	A
57	A	A	B	A	A	A	B	A	B	B	A	B	A	A	B	A	B	A	B	A
58	A	B	B	A	A	B	B	B	A	B	C	A	A	B	A	B	B	A	C	A
59	A	A	B	C	A	A	B	B	A	A	A	B	A	A	B	A	B	A	B	A
60	A	A	B	A	A	A	B	B	A	B	A	B	A	A	A	A	A	A	A	A

	MASTER SHEET OF SOCIO-DEMOGRAPHIC VARIABLES & BIOPHYSIOLOGICAL PARAMETERS (Control group)																			
Sampl	Sociodemographic Variables										Biophysiological Parameters									
sl.no	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	B1	B2	B3	B4	B5	B6	B7	B8	B9	B10
1	A	A	B	A	A	A	A	B	B	A	A	A	B	A	B	A	B	A	C	A
2	B	B	A	B	B	B	B	B	A	A	B	B	A	B	B	A	A	B	A	C
3	A	A	B	C	A	A	A	A	B	A	C	B	A	B	B	A	B	A	A	A
4	A	B	A	A	C	B	B	B	A	B	A	A	A	A	B	A	A	A	B	C
5	B	B	B	C	A	A	B	B	A	A	A	B	B	A	B	A	A	A	B	C
6	A	A	B	B	A	A	B	A	A	A	B	A	A	B	B	A	B	A	A	A
7	B	A	B	A	B	B	A	B	B	B	C	A	A	A	A	B	A	B	C	B
8	A	B	A	B	A	B	A	B	A	A	A	B	A	B	B	A	A	A	B	C
9	B	A	B	A	C	A	B	A	A	A	B	A	B	B	A	B	B	A	A	A
10	A	B	A	B	A	B	B	A	B	B	C	B	A	A	B	A	A	A	C	B
11	B	A	B	C	B	A	A	B	B	A	C	A	B	A	B	B	A	B	A	C
12	A	B	A	A	A	B	B	B	A	B	A	B	B	B	A	A	B	A	A	A
13	B	A	A	A	C	A	B	B	B	A	A	A	A	B	B	A	A	A	B	C
14	A	B	B	A	B	B	A	A	A	A	B	B	A	A	B	A	A	A	C	C
15	B	A	B	C	A	A	B	B	A	A	B	A	B	B	B	A	B	A	B	A
16	A	B	B	A	A	A	B	A	A	A	C	B	A	A	A	B	A	A	A	C
17	A	B	B	B	C	A	A	B	B	B	A	A	A	A	B	A	A	B	B	C
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21	A	A	A	A	B	A	B	B	B	A	B	B	B	B	A	A	B	B	C	A
22	B	B	B	A	A	A	B	B	A	A	C	A	A	B	B	A	A	A	A	C
23	B	B	A	B	C	A	B	A	B	B	A	B	B	B	A	A	A	A	B	C
24	A	A	B	A	A	B	A	B	A	B	B	A	B	A	B	A	B	A	C	A
25	A	A	B	A	A	A	B	A	B	A	C	B	A	A	A	B	A	A	A	C
26	B	B	A	B	A	A	B	B	A	A	C	A	A	A	A	B	B	B	B	A
27	A	A	A	A	C	A	B	B	B	A	A	A	B	B	B	A	A	A	A	A
28	B	B	B	B	A	B	A	B	A	A	B	B	A	A	A	B	B	A	B	C
29	A	B	B	A	C	A	B	A	A	B	B	B	B	B	B	B	B	A	C	B
30	B	A	B	B	C	B	B	A	A	A	B	A	A	A	B	A	A	A	A	A
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33	A	B	A	A	A	A	B	A	B	A	B	A	A	A	B	B	A	B	A	C
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40	A	B	B	B	A	A	B	B	A	B	B	B	A	B	A	B	A	A	B	B
41	A	B	B	A	A	A	B	A	A	A	B	A	A	B	B	A	B	A	C	A
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53	A	B	B	A	A	A	B	B	A	A	A	B	A	B	B	B	A	A	B	B
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55	A	B	B	A	A	A	B	B	A	A	A	B	A	B	A	A	A	A	C	C
56	A	B	B	A	A	A	B	B	A	A	A	B	A	B	B	A	B	A	B	B
57	A	B	B	A	B	A	B	B	A	A	A	A	A	B	B	A	A	A	B	C
58	A	B	B	A	A	A	B	B	A	A	A	B	A	B	A	A	A	A	C	C
59	A	B	B	A	A	A	B	B	A	A	A	B	A	A	B	A	A	A	B	B
60	A	A	B	A	B	A	A	B	A	A	A	B	A	B	B	A	A	B	C	B

Perception of Geriatric clients reagrding Health Promotional outcomes (Experimental Group)

	Perception pretest																		Post test I																		Post test II																	
Sample	1	2	3	4	5	**T**	6	7	8	9	10	11	**T**	12	13	14	15	**T**	**Total**	1	2	3	4	5	**T**	6	7	8	9	10	11	**T**	12	13	14	15	**T**	**Total**	1	2	3	4	5	**T**	6	7	8	9	10	11	**T**	12	13	14	15	**T**	**Total**
1	1	2	2	1	1	7	2	1	3	2	3	1	12	1	2	1	1	5	**24**	2	2	3	5	2	14	2	2	2	1	3	2	12	5	4	2	4	15	**41**	1	2	3	5	2	13	4	2	3	2	1	4	16	5	4	2	5	16	**45**
2	5	2	4	1	2	14	3	1	3	4	3	1	15	5	3	1	2	11	**40**	5	4	4	4	2	19	2	4	4	4	4	1	19	5	4	4	5	18	**56**	5	4	4	4	2	19	2	4	4	4	4	1	19	5	3	1	5	14	**52**
3	1	4	2	2	2	11	2	4	3	5	4	3	21	5	2	3	2	12	**44**	1	4	3	2	2	12	2	4	3	4	4	3	20	3	3	3	2	11	**43**	1	4	2	4	2	13	4	4	3	5	4	3	23	5	2	3	2	12	**48**
4	1	2	2	4	1	10	2	5	3	2	1	4	17	5	2	5	5	17	**44**	1	4	2	4	1	12	5	5	3	2	2	4	21	5	3	5	5	18	**51**	1	4	2	4	1	12	5	5	3	2	2	4	21	5	4	5	5	19	**52**
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Perception of Geriatric clients regarding Health Promotional outcomes (Control Group

Perception pretest																			Post test I																			Post test II																		
1	2	3	4	5	**T**	6	7	8	9	10	11	**T**	12	13	14	15	**T**	**Total**	1	2	3	4	5	**T**	6	7	8	9	10	11	**T**	12	13	14	15	**T**	**Total**	1	2	3	4	5	**T**	6	7	8	9	10	11	**T**	12	13	14	15	**T**	**Total**
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QUALITY OF LIFE REGARDING HEALTH PROMOTIONAL OUTCOMES AMONG GERIATRIC CLIENTS (EXPERIMENTAL GROUP)

PRETEST

SAMPLE	1	2	I- SA	10	20	I-SA	3	4	5	11	II-AU	12	13	15	19	III-PP	14	16	17	18	SP	6	IV-SP	20	7	8	9	DDD	21	22	23	24	INT	PRE-T
1	2	1	**10**	3	1	**7**	1	2	2	1	**6**	2	2	1	1	**6**	2	1	2	2	**7**	1	2	1	2	1	2	**9**	2	2	2	4	**10**	**45**
2	2	2	**10**	1	1	**6**	1	4	4	5	**14**	3	5	2	1	**11**	1	4	2	1	**8**	4	2	1	1	2	1	**11**	4	2	2	2	**10**	**60**
3	4	4	**14**	1	1	**10**	1	5	1	4	**11**	2	4	3	3	**12**	1	3	3	2	**9**	1	2	2	1	2	2	**10**	4	1	4	2	**11**	**63**
4	2	1	**9**	1	2	**6**	1	1	2	1	**5**	2	1	2	2	**7**	2	2	1	2	**7**	5	1	1	2	2	1	**12**	1	1	2	2	**6**	**43**
5	5	5	**15**	1	1	**12**	1	4	4	4	**13**	2	4	1	2	**9**	1	2	1	2	**6**	4	1	1	2	4	2	**14**	3	2	4	4	**13**	**67**
6	2	2	**10**	1	2	**7**	1	4	3	2	**10**	1	4	2	2	**9**	1	2	2	1	**6**	1	2	2	2	2	1	**10**	2	2	2	3	**9**	**51**
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11	5	5	**15**	3	1	**14**	2	1	2	4	**9**	2	4	1	2	**9**	1	2	1	2	**6**	4	1	1	2	4	2	**14**	3	2	4	4	**13**	**65**
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POST TEST I

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POST TEST II

SAMPLE	1	2	10	20	I- SA	3	4	5	11	II- AU	12	13	15	19	III-PP	14	16	17	18	IV- SP	6	7	8	9	V-DDD	21	22	23	24	VI-INT	POS-II Tot
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QUALITY OF LIFE REGARDING HEALTH PROMOTIONAL OUTCOMES AMONG GERIATRIC CLIENTS (CONTROL GROUP)

PRETEST

SAMPLE	1	2	10	20	I- SA	3	4	5	11	II-AU	12	13	15	19	III-PP	14	16	17	18	IV- SP	6	7	8	9	V-DD	21	22	23	24	VI-IN	Pre Total
1	1	2	2	1	**6**	3	1	2	1	**7**	3	1	1	1	**6**	1	3	2	1	**7**	3	1	4	1	**9**	2	2	1	2	4	**39**
2	5	4	5	2	**16**	3	2	3	2	**10**	1	2	4	3	**10**	2	3	4	4	**13**	3	2	5	4	**14**	4	3	2	3	**12**	**75**
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	5	5	5	2	**17**	1	1	1	2	**5**	2	1	1	1	**5**	1	2	1	2	**6**	2	1	1	2	**6**	1	3	1	1	**6**	**45**
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17	4	4	4	2	**14**	2	1	2	2	**7**	3	2	1	1	**7**	2	2	1	1	**6**	5	5	5	5	**20**	1	2	1	2	**6**	**60**
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21	1	2	2	1	**6**	1	1	2	1	**5**	3	2	1	1	**7**	1	1	2	1	**5**	3	4	1	4	**12**	2	1	2	2	**7**	**42**
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27	1	2	1	1	**5**	1	1	2	3	**7**	1	2	1	1	**5**	1	3	2	4	**10**	3	4	1	1	**9**	2	2	2	2	**8**	**44**
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POST TEST I

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POST TEST II

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10	2	2	5	2	**11**	2	2	2	2	**8**	1	3	2	3	**9**	3	2	4	3	**12**	2	1	4	4	**11**	1	2	1	2	**6**	**57**
11	2	2	3	3	**10**	2	2	3	3	**10**	2	2	1	2	**7**	2	2	2	3	**9**	4	3	2	2	**11**	4	2	4	2	**12**	**59**
12	2	4	1	2	**9**	1	3	2	2	**8**	2	2	4	3	**11**	2	2	2	3	**9**	4	2	1	4	**11**	2	2	2	2	**8**	**56**
13	1	2	1	1	**5**	1	1	1	1	**4**	3	1	1	2	**7**	1	2	1	2	**6**	4	2	1	2	**9**	2	3	2	2	**9**	**40**
14	2	1	2	1	**6**	3	2	2	2	**9**	2	2	1	2	**7**	2	1	2	1	**6**	2	2	2	1	**7**	1	2	1	1	**5**	**40**
15	4	2	1	4	**11**	1	2	2	3	**8**	2	2	3	3	**10**	1	3	2	4	**10**	3	3	3	4	**13**	2	3	3	2	**10**	**62**
16	1	2	2	2	**7**	1	1	1	2	**5**	1	2	2	1	**6**	1	2	1	1	**5**	1	1	2	2	**6**	1	3	1	2	**7**	**36**
17	4	1	1	1	**7**	2	2	1	3	**8**	3	2	1	4	**10**	2	2	1	2	**7**	5	3	1	2	**11**	1	4	1	2	**8**	**51**
18	2	1	1	2	**6**	2	3	1	1	**7**	2	3	2	3	**10**	2	3	2	4	**11**	2	2	3	1	**8**	2	2	2	2	**8**	**50**
19	5	2	5	1	**13**	3	1	3	2	**9**	3	2	1	4	**10**	1	2	3	4	**10**	5	4	1	2	**12**	4	3	4	2	**13**	**67**
20	4	1	4	1	**10**	3	4	2	3	**12**	4	4	3	2	**13**	3	4	5	3	**15**	4	5	4	5	**18**	3	2	4	2	**11**	**79**
21	4	2	1	4	**11**	3	2	2	1	**8**	2	2	3	1	**8**	1	1	2	4	**8**	3	1	1	4	**9**	2	2	3	2	**9**	**53**
22	2	4	1	4	**11**	4	2	4	4	**14**	2	4	2	4	**12**	2	2	4	4	**12**	2	4	4	2	**12**	4	2	4	4	**14**	**75**
23	4	1	1	1	**7**	2	2	1	3	**8**	1	2	1	3	**7**	2	4	1	4	**11**	1	3	4	4	**12**	4	4	4	2	**14**	**59**
24	2	1	1	2	**6**	1	3	2	2	**8**	2	2	4	3	**11**	2	1	2	3	**8**	4	2	1	4	**11**	2	2	2	2	**8**	**52**
25	1	2	2	2	**7**	1	1	1	2	**5**	1	2	2	1	**6**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	1	2	**7**	**38**
26	1	2	2	2	**7**	1	1	1	2	**5**	1	2	2	1	**6**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	1	2	**7**	**38**
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28	2	2	5	2	**11**	2	2	2	2	**8**	1	3	2	3	**9**	3	2	4	3	**12**	2	1	4	1	**8**	1	2	1	2	**6**	**54**
29	4	1	1	1	**7**	2	2	1	3	**8**	3	2	1	2	**8**	2	2	1	2	**7**	2	3	1	2	**8**	1	2	1	2	**6**	**44**
30	1	2	2	2	**7**	1	1	1	2	**5**	1	2	2	1	**6**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	1	2	**7**	**38**
31	5	2	1	1	**9**	3	1	3	2	**9**	3	2	1	4	**10**	1	2	3	4	**10**	5	4	1	2	**12**	4	3	4	2	**13**	**63**
32	2	4	2	1	**9**	1	1	3	2	**7**	1	2	2	3	**8**	2	1	4	4	**11**	3	2	2	4	**11**	4	3	2	3	**12**	**58**
33	1	2	2	2	**7**	1	1	1	2	**5**	1	2	2	1	**6**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	1	2	**7**	**38**
34	1	2	2	2	**7**	1	1	3	2	**7**	3	2	2	1	**8**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	2	2	**8**	**43**
35	1	2	2	2	**7**	1	1	3	2	**7**	3	2	2	1	**8**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	2	2	**8**	**43**
36	2	1	1	2	**6**	1	3	2	2	**8**	2	2	4	3	**11**	2	1	2	3	**8**	4	2	1	4	**11**	2	1	2	2	**7**	**51**
37	4	4	4	2	**14**	4	1	4	2	**11**	1	2	2	4	**9**	4	4	3	1	**12**	4	4	2	2	**12**	4	3	3	2	**12**	**70**
38	2	1	2	1	**6**	1	2	3	2	**8**	1	3	2	3	**9**	2	1	2	4	**9**	3	2	2	4	**11**	4	3	2	3	**12**	**55**
39	1	2	2	2	**7**	1	1	1	2	**5**	1	1	1	1	**4**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	1	2	**7**	**36**
40	2	2	1	2	**7**	2	2	2	2	**8**	1	2	2	3	**8**	3	2	1	3	**9**	2	1	2	2	**7**	1	2	1	2	**6**	**45**
41	1	1	1	1	**4**	2	2	1	3	**8**	1	2	1	1	**5**	2	2	1	2	**7**	3	3	1	2	**9**	1	4	1	2	**8**	**41**
42	4	1	4	1	**10**	3	4	2	3	**12**	4	4	3	2	**13**	3	4	5	3	**15**	4	5	4	5	**18**	3	2	4	2	**11**	**79**
43	5	2	5	1	**13**	3	1	3	2	**9**	3	2	1	4	**10**	1	2	1	4	**8**	5	4	1	2	**12**	4	3	4	1	**12**	**64**
44	1	2	2	2	**7**	1	1	1	2	**5**	1	2	2	1	**6**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	1	2	**7**	**38**
45	4	2	1	4	**11**	1	2	2	3	**8**	2	2	3	1	**8**	1	1	2	4	**8**	3	1	1	4	**9**	2	2	3	2	**9**	**53**
46	1	2	2	2	**7**	1	1	1	2	**5**	1	2	2	1	**6**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	1	2	**7**	**38**
47	4	4	1	1	**10**	2	2	1	1	**6**	3	2	1	4	**10**	2	2	1	2	**7**	5	3	1	2	**11**	1	4	1	2	**8**	**52**
48	2	4	1	2	**9**	1	3	2	2	**8**	1	2	1	3	**7**	2	1	2	1	**6**	2	2	1	2	**7**	1	2	1	2	**6**	**43**
49	2	2	1	2	**7**	3	1	3	2	**9**	3	2	1	4	**10**	1	2	3	4	**10**	5	4	1	2	**12**	4	3	4	2	**13**	**61**
50	4	4	1	1	**10**	1	2	3	2	**8**	2	4	2	3	**11**	2	4	4	4	**14**	3	2	4	4	**13**	4	3	2	3	**12**	**68**
51	2	4	1	2	**9**	3	2	2	2	**9**	2	1	3	1	**7**	1	1	2	2	**6**	3	1	1	1	**6**	1	1	3	2	**7**	**44**
52	5	2	1	1	**9**	2	1	2	1	**6**	1	3	2	3	**9**	3	2	4	3	**12**	2	1	4	4	**11**	1	2	1	2	**6**	**53**
53	2	4	1	1	**8**	2	2	1	3	**8**	3	2	1	4	**10**	2	2	1	2	**7**	5	3	1	2	**11**	1	4	1	2	**8**	**52**
54	1	2	2	1	**6**	1	3	2	2	**8**	2	2	1	3	**8**	2	1	2	1	**6**	1	2	1	4	**8**	2	2	1	2	**7**	**43**
55	2	2	1	2	**7**	3	1	3	2	**9**	3	2	1	4	**10**	1	2	3	4	**10**	5	4	1	2	**12**	4	3	2	3	**12**	**60**
56	1	2	2	2	**7**	1	1	3	2	**7**	1	2	2	3	**8**	3	2	3	4	**12**	1	3	2	3	**9**	1	3	1	2	**7**	**50**
57	2	4	1	2	**9**	2	2	2	3	**9**	2	2	3	1	**8**	1	1	2	4	**8**	3	1	1	4	**9**	1	2	1	2	**6**	**49**
58	1	2	2	2	**7**	1	1	1	2	**5**	1	2	2	1	**6**	1	2	3	1	**7**	1	1	2	2	**6**	1	3	1	2	**7**	**38**
59	4	4	1	1	**10**	2	2	1	3	**8**	3	2	1	4	**10**	2	2	1	2	**7**	5	3	1	2	**11**	2	2	2	4	**10**	**56**
60	2	3	1	1	**7**	1	2	2	2	**7**	2	2	1	3	**8**	2	1	2	2	**7**	1	2	2	2	**7**	2	2	2	2	**8**	**44**

ANNEXURES

ANNEXURE –I

Doctoral Research Advisory Committee Approval

Gmail

vani. R vani.R <vanivanir1988@gmail.com>

Approval letter from external expert VANI.R, PhD scholar

1 message

vani. R vani.R <vanivanir1988@gmail.com> Tue, Oct 27, 2020 at 3:00 PM
To: co.rd@sduu.ac.in

Forwarded message ---------
From: **Dr. Priya Reshma Aranha** <priyareshma@yenepoya.edu.in>
Date: Tue, Oct 13, 2020 at 3:18 PM
Subject: Re: Revised research proposal of Vani.R -acceptance request
To: Ph. D Programmes <mphil.phdprogrammes@sduu.ac.in>

Dear sir, I have suggested a correction in the research design. With that the revised research proposal of Mrs. Vani could be accepted.

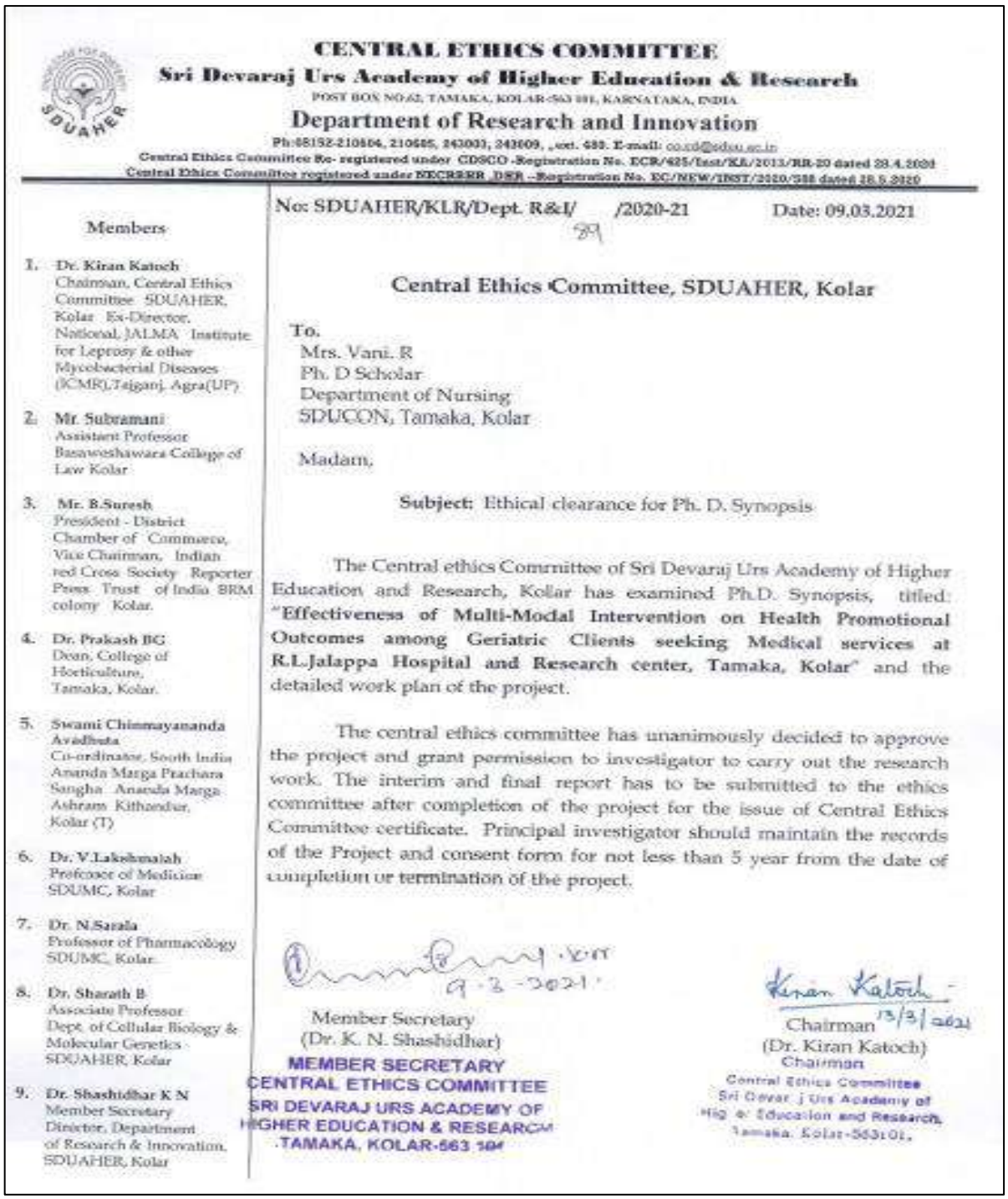
On Mon, Oct 12, 2020 at 4:09 PM Ph. D Programmes <mphil.phdprogrammes@sduu.ac.in> wrote:

> Madam,
> Vani.R, Ph.D. Scholar in Interdisciplinary Nursing submitted research proposal on the topic"**"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services and their Caretakers at selected Tertiary care Hospital, Kolar".**
> As per Doctoral committee suggestions, corrections were undertaken and submitted to you for approval. (Doctoral committee proceedings enclosed).
> The necessary corrections were incorporated, the research proposal was revised and submitted for your acceptance.
> Kindly send a **letter of acceptance** of the revised research proposal which is required essentially for the purpose of obtaining **Central ethics committee approval**.
> Thanks and regards,
> Dr C D Dayanand,
> Centre for PhD program

--
With warm Regards

ANNEXURE –II

Central Ethics Committee Approval



CENTRAL ETHICS COMMITTEE

Sri Devaraj Urs Academy of Higher Education & Research

POST BOX NO.62, TAMAKA, KOLAR-563 101, KARNATAKA, INDIA

Department of Research and Innovation

Ph:08152-210804, 210805, 243001, 243009, , ext. 488. E-mail: co.rd@sduu.ac.in

Central Ethics Committee Re- registered under CDSCO -Registration No. ECR/425/Inst/KA/2013/RR-20 dated 28.4.2020

Central Ethics Committee registered under NECRRRR ,DHR --Registration No. EC/NEW/INST/2020/588 dated 28.5.2020

Members

1. **Dr. Kiran Katoch**
   Chairman, Central Ethics Committee SDUAHER, Kolar Ex-Director, National JALMA Institute for Leprosy & other Mycobacterial Diseases (ICMR),Tajganj, Agra(UP)
2. **Mr. Subramani**
   Assistant Professor Basaweshawara College of Law Kolar
3. **Mr. B.Suresh**
   President - District Chamber of Commerce, Vice Chairman, Indian red Cross Society Reporter Press Trust of India BRM colony Kolar.
4. **Dr. Prakash BG**
   Dean, College of Horticulture, Tamaka, Kolar.
5. **Swami Chinmayananda Avadhuta**
   Co-ordinator, South India Ananda Marga Prachara Sangha Ananda Marga Ashram Kithandur, Kolar (T)
6. **Dr. V.Lakshmaiah**
   Professor of Medicine SDUMC, Kolar
7. **Dr. N.Sarala**
   Professor of Pharmacology SDUMC, Kolar.
8. **Dr. Sharath B**
   Associate Professor Dept. of Cellular Biology & Molecular Genetics SDUAHER, Kolar
9. **Dr. Shashidhar K N**
   Member Secretary Director, Department of Research & Innovation, SDUAHER, Kolar

No: SDUAHER/KLR/Dept. R&I/ /2020-21 Date: 09.03.2021

89

Central Ethics Committee, SDUAHER, Kolar

To,
Mrs. Vani. R
Ph. D Scholar
Department of Nursing
SDUCON, Tamaka, Kolar

Madam,

Subject: Ethical clearance for Ph. D. Synopsis

The Central ethics Committee of Sri Devaraj Urs Academy of Higher Education and Research, Kolar has examined Ph.D. Synopsis, titled: "**Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar**" and the detailed work plan of the project.

The central ethics committee has unanimously decided to approve the project and grant permission to investigator to carry out the research work. The interim and final report has to be submitted to the ethics committee after completion of the project for the issue of Central Ethics Committee certificate. Principal investigator should maintain the records of the Project and consent form for not less than 5 year from the date of completion or termination of the project.

9-3-2021

Member Secretary
(Dr. K. N. Shashidhar)

MEMBER SECRETARY
CENTRAL ETHICS COMMITTEE
SRI DEVARAJ URS ACADEMY OF
HIGHER EDUCATION & RESEARCH
TAMAKA, KOLAR-563 101

Kiran Katoch 13/3/2021

Chairman
(Dr. Kiran Katoch)
Chairman
Central Ethics Committee
Sri Devaraj Urs Academy of
Higher Education and Research,
Tamaka, Kolar-563101.

ANNEXURE –III

Clinical trials Registry of India (CTRI) approved letter

CLINICAL TRIALS REGISTRY - INDIA
ICMR - National Institute of Medical Statistics

PDF of Trial
CTRI Website URL - http://ctri.nic.in

Clinical Trial Details (PDF Generation Date :- Sat, 15 Jun 2024 13:59:11 GMT)

CTRI Number	CTRI/2021/07/034632 [Registered on: 06/07/2021] - **Trial Registered Prospectively**
Last Modified On	15/05/2024
Post Graduate Thesis	Yes
Type of Trial	Interventional
Type of Study	Process of Care Changes
Study Design	Randomized, Parallel Group Trial
Public Title of Study	"Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients.
Scientific Title of Study	"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center,Tamaka,Kolar".

Secondary IDs if Any

Secondary ID	Identifier
NIL	NIL

Details of Principal Investigator or overall Trial Coordinator (multi-center study)

Details of Principal Investigator	
Name	VANI R
Designation	ASSISTANT PROFESSOR
Affiliation	SRI DEVARAJ URS COLLEGE OF NURSING
Address	11TH CROSS, NEAR BABA VIDYA SAMASTAE, KARANJIKATTE,KHADRIPURA ROAD, KOLAR-563101 SRI DEVARAJ URS COLLEGE OF NURSING, TAMAKA,KOLAR-563103 Kolar KARNATAKA 563101 India
Phone	9620213112
Fax	-
Email	vanivanir1988@gmail.com

Details Contact Person (Scientific Query)

Details Contact Person (Scientific Query)	
Name	Dr Zeanath Cariena J
Designation	PROFESSOR & CNO at SDUCON/RLJH&RC
Affiliation	Rajiv Gandhi University of Health sciences, Karnataka
Address	SRI DEVARAJ URS COLLEGE OF NURSING TAMAKA KOLAR SRI DEVARAJ URS COLLEGE OF NURSING TAMAKA KOLAR Kolar KARNATAKA 563101 India
Phone	9880609853

ANNEXURE –IV

Letter requesting permission for conducting Pilot study

From,
Mrs. Vani.R
Assistant Professor/PhD Scholar
SDUCON, SDUAHER
TAMAKA, KOLAR.

To,
The Medical superintendent
ETCM Hospital, Kolar

Through the Research supervisor,

Respected Sir/Madam,

Subject: Requesting permission for conduct of **Pilot study data collection**- reg

With respect to the above, I Mrs.Vani.R, Assistant Professor at Sri Devaraj Urs College of nursing and doing PhD in SDUAHER,Tamaka,Kolar. As a part of My PhD Research project entitled as **"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research centre, Tamaka, Kolar"** Would like to conduct pilot study among Elderly seeking medical services from your esteemed hospital.

Hence, I request your good self to kindly consider and do the needful in conduct of research study.

Thanking You

Yours faithfully

Mrs.Vani.R

Sir/Madam,
Kindly consider for needful approval & permission/

28/06/2022

9/7/22

Medical Superintendent
E.T.C.M. HOSPITAL
KOLAR - 563101.

From,
Mrs. Vani.R
Assistant Professor/ PhD Scholar
SDUCON, SDUAHER
TAMAKA, KOLAR.

To,
The Medical superintendent
Hope HEALTH CARE HOSPITAL, KOLAR

Through the Research supervisor,

Respected Sir/Madam,

Subject: Requesting permission for conduct of **Pilot study data collection**– reg.

With respect to the above, I Mrs.Vani.R, Assistant Professor at Sri Devaraj Urs College of nursing and doing PhD in SDUAHER,Tamaka,Kolar. As a part of My PhD Research project entitled as **"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research centre, Tamaka, Kolar"** Would like to conduct pilot study among Elderly seeking medical services from your esteemed hospital.

Hence I request your good self to kindly consider and do the needful in conduct of research study.

Thanking You

Yours faithfully

Mrs.Vani.R

Sir/madam,
Kindly consider for needful
Approval. /
28/6/2022

Dr. YESHWANT WHITLEY
M.B.B.S., M.S., DNB (Surg)
KMC No.41774
HOPE HOSPITAL
Kuruburapet, KOLAR-563101.

ANNEXURE –V

Letter requesting permission for conducting Main study

From,
Mrs. Vani.R
Assistant Professor/ PhD Scholar
SDUCON, SDUAHER
TAMAKA, KOLAR.

To,
The Medical superintendent
R.L. JALAPPA HOSPITAL & RESEARCH CENTRE
TAMAKA, KOLAR

Through the Research supervisor,

Respected Sir/Madam,

Subject: Requesting permission for conduct of **Main study data collection**- reg.

With respect to the above, I Mrs.Vani.R, Assistant Professor at Sri Devaraj Urs College of nursing and doing PhD in SDUAHER,Tamaka,Kolar. As a part of My PhD Research project entitled as **"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research centre, Tamaka, Kolar"** Would like to conduct pilot study among Elderly seeking medical services from your esteemed hospital.

Hence, I request your good self to kindly consider and do the needful in conduct of research study.

Thanking You

Yours faithfully

Mrs.Vani.R

Sir/ Madam,
Kindly consider for needful approval & permission
22/06/2022

permitted
Medical Superintendent
RLJH & RC
TAMAKA, KOLAR-563101

From,
Mrs. Vani.R
Assistant Professor/PhD Scholar
SDUCON, SDUAHER
TAMAKA, KOLAR.

To,
The Medical superintendent
SNR DISTRICT HOSPITAL, KOLAR

Through the Research supervisor,

Respected Sir/Madam,

Subject: Requesting permission for conduct of **Main study data collection**- reg.

With respect to the above, I Mrs.Vani.R, Assistant Professor at Sri Devaraj Urs College of nursing and doing PhD in SDUAHER,Tamaka,Kolar. As a part of My PhD Research project entitled as **"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research centre, Tamaka, Kolar"** Would like to conduct pilot study among Elderly seeking medical services from your esteemed hospital.

Hence, I request your good self to kindly consider and do the needful in conduct of research study.

Thanking You

Yours faithfully

Mrs.Vani.R

Sir/Madam,
Kindly Consider for needful
Approval & permission
29/6/2022

Permitted

Kindly consider for approval

Senior Specialist/Deputy Chief Medical Officer
S. N. R. Dist. Hospital
KOLAR-563 101.

DISTRICT SURVEILLANCE OFFICER
District Surveillance Unit
Kolar District, KOLAR-563101

ANNEXURE –VI

Letter requesting opinions and suggestions of experts for establishing content validity of research tool and Multimodal Intervention

LETTER REQUESTING OPINION AND SUGGESTIONS OF EXPERTS TO VALIDATE THE TOOL & INTERVENTION

From,

Mrs. Vani.R

PhD Scholar –SDUAHER

Assistant Professor

Community Health Nursing

Sri Devaraj Urs College of Nursing

Tamaka, Mangaluru-575002.

Through: Research Supervisor

Respected Sir/Madam,

Subject: Requesting experts to validate the research tool & Intervention.

I, Mrs. Vani.R PhD Scholar at Sri Devaraj Urs Academy Higher Education & Research under the guidance of Dr.Zeanath Cariena.J, Prof & HOD of Dept of MSN & CNO at RLJH&RC, have selected the following title for my research project.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar."

With regard to this, may I kindly request you to validate my tool (scale) for its appropriateness and relevancy and kindly suggest modifications, additions and deletions, if any, in the remark column. I am enclosing objectives of the study and tool. I would be highly obliged and thankful to hear from you.

Herewith enclosed,

- Objectives of the study, Operational definitions, Hypothesis and Research Methodology
- Tool 1: Socio demographic proforma
- Tool 2: Perception questionnaire by using Five point likert scale
- Tool 3:WHO QOL questionnaire - standardized Tool by WHO
- Blueprint of Questionnaire
- Scoring/Grading of responses
- Multi modal Intervention package includes the following :
  - Pamphlet
  - Snake & Ladder Game
  - Content of the educational video
- Criteria checklist for Validation of the tool & Intervention

Thanking you

Place: Kolar

Date:

Yours faithfully

(Mrs. Vani.R)

Sir/madam,

Requesting for your validation

6/5/2022.

[Prof. Leonath C.]

ANNEXURE –VII

CRITERIA CHECK LIST FOR VALIDATION OF TOOL

Dear Experts,

Kindly Review the Questionnaire, give you suggestions regarding accuracy, relevance, and appropriate of the items and content. There are columns namely **Relevant, Not Relevant, Needs Modifications and Remarks.** Kindly place a tick mark in (√) in the relevant column and give your suggestions in the remarks column if found to be not relevant and needs modifications.

Item No	Relevant	Needs Modification	Not Relevant	Remarks
Sec A Part 1: Socio demographic proforma				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
Sec A Part 2: Bio physiological parameters				
13.				
14.				
15.				
16.				

17.				
18.				
19.				
20.				
21.				
22.				
Perception Questionnaire on Health promotion outcomes				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

PAMPHLET

Evaluation criteria check list for validation of pamphlet on health promotion strategies among geriatric clients

Sl.no	Contents	Relevant	Needs modification	Not relevant	Remarks
1.	**Introduction** o Appropriate				
	o Interesting				
	o Specific to the topic				
2.	**Selection of the content :** o Relevance				
	o Accuracy & adequacy of the topic				
	o Simple & clear				
3.	**Organization of the content** o Arranged in logical sequence				
	o Very informative content				
	o Creativity & Interesting				
4.	**Language** o Simple to understand				
	o Comprehension				
	o No repetition of words				
5.	**Practicability and Feasibility** o Content was appropriate to the need				
	o Overall content is creative & interesting				
	o Content will enhance Perception & QOL regarding health promotion measures.				

SNAKE & LADDER GAME

Evaluation criteria check list for validation of snake & ladder game on health promotion strategies among geriatric clients

It's a game developed as a motivational session of learning by playing among geriatric clients by adopting health promotion strategies that helps in improving Perception & QOL. Each snake in this game is considered as the unhealthy habit and climbing the ladder symbolizes the adoption of healthy strategies to enhance QOL.

The components involve;

Snake (Unhealthy strategies)				
SL.NO	**CONTENT**	**APPROPRIATE**	**INAPPROPRIATE**	**REMARKS**
1.	Excessive consumption of sugars, fat containing foods			
2.	Inadequate personal Hygiene			
3.	No physical activity			
4.	Not performing Activities of daily living			
5.	No adequate sleep			
6.	No harmonious relationship with members			
7.	Not seeking medical services in need			
8.	Not a believer of culture, religion			
9.	Lead discussions into conflicts			
10.	Possessing negative feelings			
Ladder (Health Promotion strategies)				
11.	Excessive consumption of foods containing fibers, low fat, sugar diet			
12.	Maintains good personal hygiene			
13.	Performs walking, exercise, yoga regularly			
14.	Engage in ADL's			
15.	Adequate sleep-wake cycle is followed			
16.	Maintains good relationship with family members			
17.	Does regular health checkups and follow-up			
18.	Takes part in religious and spiritual activities			
19.	Maintains good Communication relationship with all			
20.	Spends leisure time by reading books, prayers, music etc…			
21.	Being optimistic in all situations			

EDUCATIONAL VIDEO TEACHING -PPT

Criteria checklist for content validity of educational video teaching through PowerPoint presentation on health promotion outcomes among geriatric clients

Item no.		Relevance		Accuracy		Appropriateness		Remarks
		Agree	Disagree	Agree	Disagree	Agree	Disagree	
1	**Content aspects**							
1.1	Accurate and up to date							
1.2	Logically organized							
1.3	Simple clear							
2	**Presentation aspects**							
2.1	Video begins with a motivating and interesting manner.							
2.2	Video are presented in a simplified manner.							
2.3	Video periodically summarizes important content.							
2.4	Audio visuals are appropriate and correct.							
2.5	Language used is clear and simple.							
2.6	Video meets the objectives and needs of the learner.							
2.7	Video is well planned and organized.							
2.8	Video includes section breaks and section titles.							
2.9	Video is such that it can be played on the available equipment.							
3.0	Color contrast to the content and pictorial representation and appropriateness.							

ANNEXURE VIII

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at selected hospitals, Kolar"

Signature/Seal:

Nam
e:

Designation:

Institution:

Place:

Date:

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal:

Mrs. SHIJI P. J.
Professor
Community Health Nursing Department
Father Muller College of Nursing
Kankanady, Mangaluru

Name:
Dr.Shiji P J

Designation:Professor

Institution:Father Muller College of Nursing

Place: Mangaluru

Date: 01-06-2022

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal: 

Name: DR. HEBSIBA P [DMS, MBA, BIOSTATISTICS, MSN, BSN-RNRM]

Designation: ASSOCIATE PROFESSOR, DEPT. OF MEDICAL SURGICAL NURSING

Institution: SREE GOKULAM NURSING COLLEGE

Place: VENJARAMOODU

Date: 18/06/2022

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal:

Name:
Neetha

Designation:
Associate Professor

Department:
Community health
Nursing

Institution:
Nitte Usha institute of nursing sciences

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal: Principal
Zulekha Nursing College
Bunder, Mangalore - 575001

Name: DR. R. KANAGAVALLI

Designation: PRINCIPAL

Institution: ZULEKHA NURSING COLLEGE

Place: MANGALURU

Date: 22-06-2022

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs. Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal: 

Name:
Dr. Syed Imran

Designation: Associate Professor
PGD(clinical ethics),PCC(Palliative care), PhD (N)

Institution: **College of Applied Medical Sciences, University of Jeddah, KSA**

Place: **Jeddah**

Date:
22.06.2022

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal: 9/6/22
Dr. Pradeep. T.S.
Asst. Professor, KMC No. 90529
Dept. of Community Medicine
SDUMC, Kolar-563103

Name: Dr. PRADEEP. T. S.

Designation: ASST. PROFESSOR,

Institution: SDUMC, SDUAHER

Place: KOLAR

Date: 9/6/22

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal: 31/8/22

Name: Mr. Ravishankar. S

Designation: Mr. S. Ravishankar
Asst. Professor, Statistics
Dept. of Community Medicine
SDUMC, Kolar-563103

Institution:

Place: Kolar

Date: 31/8/22

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal: 8/6/22 Head of the Department
Dept. of Paediatric Nursing
Sri Devaraj Urs College of Nursing
Tamaka, Kolar - 563 101.

Name: Dr. Lavanya Subhadra

Designation: Vice Principal & HOD

Institution: Sri Devaraj Urs College of Nursing,

Place: Tamaka, Kolar - 563103

Date: 08/06/22

CONTENT VALIDATION CERTIFICATE

I hereby certify that, the tool and Multimodal Intervention package content constructed by Mrs.Vani.R, Ph.D. Scholar of Sri Devaraj Urs Academy of Higher Education And Research, Tamaka, Kolar-563103 to be used for the study entitled has been validated by me.

"Effectiveness of Multi-Modal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services at R.L.Jalappa Hospital and Research center, Tamaka, Kolar"

Signature/Seal: Malathi

Name: Dr Malathi

Designation: Associate professor
Dept of community health Nsg

Institution: Sri. Devaraj Urs college of Nursing

Place: Tamaka Kolar

Date: 08/06/22

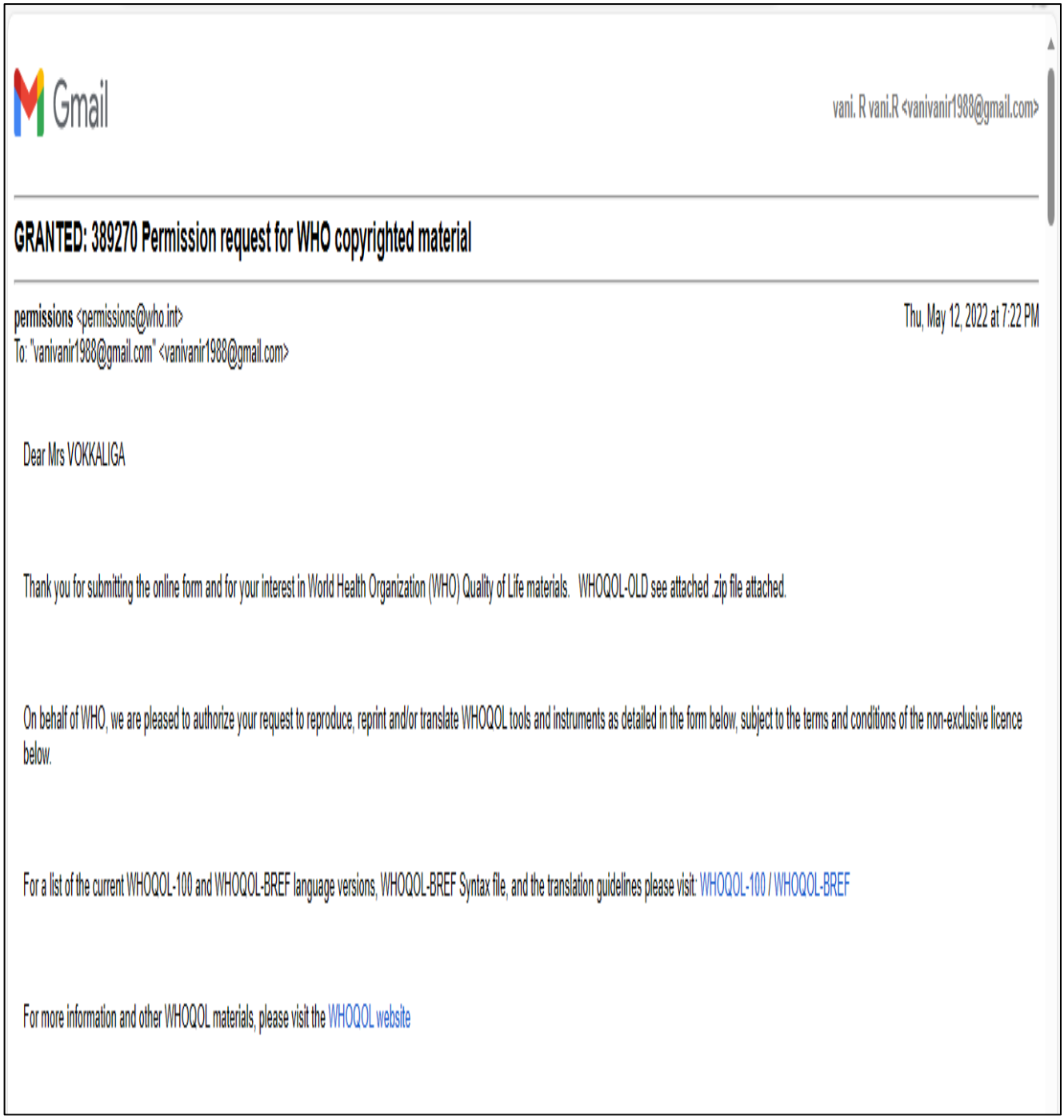
ANNEXURE IX

LIST OF EXPERTS

Sl.no	EXPERTS	
1.	Dr.Hebsiba.P Associate Professor Dept. of MSN Sree Gokulam Nursing College Venjaramoodu	**7.** Mr. Ravishankar .S Asst.Professor, Statistician Dept. of Community Medicine SDUMC, Tamaka, Kolar
2.	Dr.R.Kanagavalli Principal Zulekha Nursing College Mangaluru	**8.** Dr. Lavanya Subhashini Vice principal & HOD SDUCON, Tamaka, Kolar
3.	Dr.Shiji.P.J Professor Dept. of Community Health Nursing Father Muller College of Nursing Managluru.	**9.** Dr. Malathi K.V Associate Professor Dept. of Community Health Nursing SDUCON, Tamaka, Kolar
4.	Dr.Neetha Associate Professor Dept. of Community Health Nursing Nitte Usha Institute of Nursing Sciences Managluru.	**10**. Dr.Varsha reddy Geriatrician RLJH&RC Hospital Tamaka, Kolar.
5.	Dr.Syed Imran Associate Professor Dept. of Psychiatry Nursing College of applied Medical Sciences University of Jeddah, Saudi Arabia.	**11**. Dr.Gururaja Rao Consultant & Counsellor SDUCON Tamaka, Kolar.
6.	Dr.Pradeep T.S Asst.Professor Dept. of Community Medicine SDUMC, Tamaka, Kolar	

ANNEXURE X

Permission obtained for Tool from WHO



Gmail

vani. R vani.R <vanivanir1988@gmail.com>

GRANTED: 389270 Permission request for WHO copyrighted material

permissions <permissions@who.int> Thu, May 12, 2022 at 7:22 PM
To: "vanivanir1988@gmail.com" <vanivanir1988@gmail.com>

Dear Mrs VOKKALIGA

Thank you for submitting the online form and for your interest in World Health Organization (WHO) Quality of Life materials. WHOQOL-OLD see attached .zip file attached.

On behalf of WHO, we are pleased to authorize your request to reproduce, reprint and/or translate WHOQOL tools and instruments as detailed in the form below, subject to the terms and conditions of the non-exclusive licence below.

For a list of the current WHOQOL-100 and WHOQOL-BREF language versions, WHOQOL-BREF Syntax file, and the translation guidelines please visit: WHOQOL-100 / WHOQOL-BREF

For more information and other WHOQOL materials, please visit the WHOQOL website

ANNEXURE XI

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Title: : **"**Effectiveness of Multi-Modal Intervention regarding Health Promotion on Perception and Quality of Life among Geriatric Clients seeking Medical services at selected Hospitals, Kolar**"**.

Geriatric clients are invited to take part in a research study. Before you decide to participate in this study, it is important for you to understand why this research is being carried out and your role in the project. Please take time to read the following information carefully and discuss it with your friends and relatives if you wish before you decide to participate or not in this study. Don't hesitate to ask us if there is anything that is not clear here or for more information. Take as much as time you need to decide to participate in this study.

What is the purpose of the study?

This is purely a research study and your participation may not bring any direct benefit to you.

The present study aims to conduct validated Multimodal intervention Educational for Geriatric clients to promote health outcomes.

Does participants have to take part in the study?

The investigator invites you to participate in the study and will be given a copy of this information sheet and adequate time to read through this, think and ask any questions before making a decision. If you decide to enrol in the study, you will be asked to sign a consent form. You are free to withdraw from the study at any time without giving any reason. A decision not to take part or later withdraw from the study whenever you choose will not affect your right or your profession.

What is your role in this project?

After you sign in the informed consent, the investigator shall ask questions on the basic details of the age, gender, education, occupation, area of residence, Health check-up & details of Bio physiological parameters. Perception and Quality of Life of geriatric clients will be assessed by using perception & WHOQOL tool for approximately 30 minutes followed by Multimodal intervention.

After one month the first post-test and second month second post-test will be conducted to assess the change in perception and QOL.

What is the duration of Training?

The study duration will be for a period of two months. The training consists of Multimodal educational intervention will be given to the participants.

What are the benefits of participating in the study?

Multimodal Intervention shall bring a change in the level of perception and Quality of Life in promoting health outcomes. You are not entitled for any monetary or other benefits for participating in the study.

Are there any risks involved in participating in the study?

Multimodal Intervention is totally non-invasive, safe and will not harm you in anyway. There are absolutely no risks or any inconvenience for participating in this study.

Confidentiality of information

The data collected will be coded using unique code numbers which will be known only to the investigating team. Only this code will be indicated in all assessment sheets. Your name will not be disclosed outside the hospital or appear on any reports or publications resulting from the study. The data generated from this research will be anonymous, with no indication of the identity of individuals involved. The results of the Intervention carried out, however, will be revealed and explained to you.

What will happen to the samples (data) you have given?

The data obtained will be analysed for scientific purpose. The results obtained from this study may be published in national and international scientific journals. Results may also be

presented in scientific conferences /seminars. We will publish the results in scientific journals so that other interested people may learn from our research. However, we assure you that your identity will not be revealed anywhere, in any form and to anybody. If you withdraw from the study after the samples have been collected, then your data will not be used for this study. Such data will be in safe custody till the completion of the project and will be deleted from records thereafter.

Who is organizing/ conducting the study?

The research is being conducted by Ms. Vani.R, Ph.D. Scholar in the Department of Nursing under the guidance of Dr. Zeanath Cariena.J, Professor & HOD of Medical Surgical Nursing – SDUCON, CNO RLJH & RC.

Who has reviewed this study?

The Ph.D. doctoral committee of the SDUAHER (Deemed to be University) has cleared the proposal for its scientific content. The study has been approved by the Central Ethics Committee,SDUAHER for ethical aspects / standards.

If you need any more information about this study, you may please contact the following at any time of the study.

Ms. Vani.R
+919620213112
Email: vanivanir1988@gmail.com

Dr. Zeanath Cariena.J
+919880609853
Email: zeanathcj@gmail.com

Medical Superintendent
Dr.Sheela
Medical Superintendent
R.L.Jalappa Hospital, Kolar.
+918152243003

Thank you for taking time to read this information. If you decide to consider taking part in this study, you will be given a copy of this leaflet for your information.

Signature of the investigator

Acknowledgement: Copy of this document received

Signature/Thumb impression of Participant:

Written Informed Consent Form

Study Title: "Effectiveness of Multi-Modal Intervention regarding Health Promotion on Perception and Quality of Life among Geriatric Clients seeking Medical services at selected Hospitals, Kolar**"**.

Code Number:

I confirm that I have read and understood the information given to me about this study and my role in it. I had opportunities to ask questions and my questions have been answered to my satisfaction.
or
I confirm that all information about this study and my role in it has been read / explained to me by a member of the investigating team in a language that I understand. I had opportunities to ask questions and my questions have been answered to my satisfaction.

b) I understand that my participation in this study is voluntary and that I am free to withdraw from the study at any time, without giving any reason and legal rights being affected.

c) I understand that my identity will not be revealed in any document or publication.

d) I agree not to restrict the use/publication of any data or results that arise from this study provided such use is only for scientific purposes.

e) I am aware that by agreeing to my participation in this investigation, I will have to give more time for training and assessments by the investigating team and that these assessments will not interfere with the benefits that I am entitled to or my daily routine.

f) I give my consent, voluntarily to take part in this study. I also agree for the investigator to record the observation/interview sessions whenever they are held.

Signature (or thumb impression) of the study participants /Legally Acceptable Representative:

Study participant signature/Thumb impression: _____

Signature/Thumb impression of Witnesses: _____

Study Investigator's Signature: _____

ANNEXURE XII

ಭಾಗವಹಿಸುವವರಿಗೆ ಮಾಹಿತಿ- ಹಿರಿಯ ಗ್ರಾಹಕರಿಗೆ

ಶೀರ್ಷಿಕೆ: : ''ಆರ್.ಎಲ್.ಜಾಲಪ್ಪ ಆಸ್ಪತ್ರೆ ಮತ್ತು ಸಂಶೋಧನಾ ಕೇಂದ್ರ, ಟಮಕಾ, ಕೋಲಾರದಲ್ಲಿ ವೈದ್ಯಕೀಯ ಸೇವೆಗಳನ್ನು ಪಡೆಯುವ ವೃದ್ಧಾಪ್ಯ ರೋಗಿಗಳಲ್ಲಿ ಆರೋಗ್ಯ ಪ್ರಚಾರದ ಫಲಿತಾಂಶಗಳ ಕುರಿತು ಬಹು-ಮಾದರಿ ಹಸ್ತಕ್ಷೇಪದ ಪರಿಣಾಮಕಾರಿತ್ವ''.

ಸಂಶೋಧನಾ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಜೆರಿಯಾಟ್ರಿಕ್ ಕ್ಲೈಂಟ್‌ಗಳನ್ನು ಆಹ್ವಾನಿಸಲಾಗಿದೆ. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನೀವು ನಿರ್ಧರಿಸುವ ಮೊದಲು, ಈ ಸಂಶೋಧನೆಯನ್ನು ಏಕೆ ನಡೆಸಲಾಗುತ್ತಿದೆ ಮತ್ತು ಯೋಜನೆಯಲ್ಲಿ ನಿಮ್ಮ ಪಾತ್ರವನ್ನು ಅರ್ಥಮಾಡಿಕೊಳ್ಳುವುದು ನಿಮಗೆ ಮುಖ್ಯವಾಗಿದೆ. ದಯವಿಟ್ಟು ಈ ಕೆಳಗಿನ ಮಾಹಿತಿಯನ್ನು ಎಚ್ಚರಿಕೆಯಿಂದ ಓದಲು ಸಮಯ ತೆಗೆದುಕೊಳ್ಳಿ ಮತ್ತು ನೀವು ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಅಥವಾ ಭಾಗವಹಿಸದಿರಲು ನಿರ್ಧರಿಸುವ ಮೊದಲು ನಿಮ್ಮ ಸ್ನೇಹಿತರು ಮತ್ತು ಸಂಬಂಧಿಕರೊಂದಿಗೆ ಚರ್ಚಿಸಿ. ಇಲ್ಲಿ ಸ್ಪಷ್ಟವಾಗದ ಏನಾದರೂ ಇದ್ದರೆ ಅಥವಾ ಹೆಚ್ಚಿನ ಮಾಹಿತಿಗಾಗಿ ನಮ್ಮನ್ನು ಕೇಳಲು ಹಿಂಜರಿಯಬೇಡಿ. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನೀವು ನಿರ್ಧರಿಸಲು ಅಗತ್ಯವಿರುವಷ್ಟು ಸಮಯವನ್ನು ತೆಗೆದುಕೊಳ್ಳಿ.

ಅಧ್ಯಯನದ ಉದ್ದೇಶವೇನು?

ಇದು ಸಂಪೂರ್ಣವಾಗಿ ಸಂಶೋಧನಾ ಅಧ್ಯಯನವಾಗಿದೆ ಮತ್ತು ನಿಮ್ಮ ಭಾಗವಹಿಸುವಿಕೆ ನಿಮಗೆ ಯಾವುದೇ ನೇರ ಪ್ರಯೋಜನವನ್ನು ತರದಿರಬಹುದು. ಪ್ರಸ್ತುತ ಅಧ್ಯಯನವು ಜೆರಿಯಾಟ್ರಿಕ್ ಗ್ರಾಹಕರಿಗೆ ಆರೋಗ್ಯದ ಫಲಿತಾಂಶಗಳನ್ನು ಉತ್ತೇಜಿಸಲು ಮೌಲ್ಯೀಕರಿಸಿದ ಮಲ್ಟಿಮೋಡಲ್ ಇಂಟರ್ವೆನ್ಷನ್ ಎಜುಕೇಷನಲ್ ಅನ್ನು ನಡೆಸುವ ಗುರಿಯನ್ನು ಹೊಂದಿದೆ - ಯಾವುದೇ ಹಾನಿ ಮಾಡಬೇಡಿ.

ಭಾಗವಹಿಸುವವರು ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳಬೇಕೇ?

ತನಿಖಾಧಿಕಾರಿಯು ನಿಮ್ಮನ್ನು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಆಹ್ವಾನಿಸುತ್ತಾನೆ ಮತ್ತು ಈ ಮಾಹಿತಿ ಹಾಳೆಯ ನಕಲನ್ನು ಮತ್ತು ಇದರ ಮೂಲಕ ಓದಲು, ಯೋಚಿಸಲು ಮತ್ತು ನಿರ್ಧಾರ ತೆಗೆದುಕೊಳ್ಳುವ ಮೊದಲು ಯಾವುದೇ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ಸಾಕಷ್ಟು ಸಮಯವನ್ನು ನೀಡಲಾಗುತ್ತದೆ. ನೀವು ಅಧ್ಯಯನಕ್ಕೆ ದಾಖಲಾಗಲು ನಿರ್ಧರಿಸಿದರೆ, ಒಪ್ಪಿಗೆಯ ನಮೂನೆಗೆ ಸಹಿ ಮಾಡಲು ನಿಮ್ಮನ್ನು ಕೇಳಲಾಗುತ್ತದೆ. ಯಾವುದೇ ಕಾರಣವನ್ನು ನೀಡದೆ ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಅಧ್ಯಯನದಿಂದ ಹಿಂದೆ ಸರಿಯಲು ನೀವು ಸ್ವತಂತ್ರರಾಗಿದ್ದೀರಿ. ನೀವು ಆಯ್ಕೆ ಮಾಡಿಕೊಂಡಾಗಲೆಲ್ಲಾ ಅಧ್ಯಯನದಿಂದ ಪಾಲ್ಗೊಳ್ಳದಿರುವ ಅಥವಾ ನಂತರ ಹಿಂತೆಗೆದುಕೊಳ್ಳುವ ನಿರ್ಧಾರವು ನಿಮ್ಮ ಹಕ್ಕು ಅಥವಾ ನಿಮ್ಮ ವೃತ್ತಿಯ ಮೇಲೆ ಪರಿಣಾಮ ಬೀರುವುದಿಲ್ಲ.

ಈ ಯೋಜನೆಯಲ್ಲಿ ನಿಮ್ಮ ಪಾತ್ರವೇನು?

ತಿಳುವಳಿಕೆಯುಳ್ಳ ಸಮ್ಮತಿಗೆ ನೀವು ಸೈನ್ ಇನ್ ಮಾಡಿದ ನಂತರ, ತನಿಖಾಧಿಕಾರಿಯು ವಯಸ್ಸು, ಲಿಂಗ, ಶಿಕ್ಷಣ, ಉದ್ಯೋಗ, ವಾಸಸ್ಥಳದ ಪ್ರದೇಶ, ಆರೋಗ್ಯ ತಪಾಸಣೆ ಮತ್ತು ಬಯೋ ಫಿಸಿಯೋಲಾಜಿಕಲ್ ಪ್ಯಾರಾಮೀಟರ್‌ಗಳ ಮೂಲ ವಿವರಗಳ ಕುರಿತು ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳುತ್ತಾರೆ. ಗ್ರಹಿಕೆ ಮತ್ತು WHO-ಜೀವನದ ಗುಣಮಟ್ಟವನ್ನು ಸುಮಾರು 20-30 ನಿಮಿಷಗಳ ಕಾಲ ಮಲ್ಟಿಮೋಡಲ್ ಮಧ್ಯಸ್ಥಿಕೆಯ ನಂತರ ಗ್ರಹಿಕೆ ಮತ್ತು WHO ಬಳಸಿಕೊಂಡು ಜೀವನದ ಗುಣಮಟ್ಟವನ್ನು ಮೌಲ್ಯಮಾಪನ ಮಾಡಲಾಗುತ್ತದೆ.

30 ನೇ ದಿನ ಮೊದಲ ನಂತರದ ಪರೀಕ್ಷೆಯನ್ನು ನಡೆಸಲಾಗುವುದು ಮತ್ತು 60 ದಿನಗಳ ಎರಡನೇ ನಂತರದ ಪರೀಕ್ಷೆಯನ್ನು ಗ್ರಹಿಕೆ ಮತ್ತು ಜೀವನದ ಗುಣಮಟ್ಟದಲ್ಲಿನ ಬದಲಾವಣೆಯನ್ನು ನಿರ್ಣಯಿಸಲು ನಡೆಸಲಾಗುತ್ತದೆ.

ತರಬೇತಿಯ ಅವಧಿ ಎಷ್ಟು?

ಅಧ್ಯಯನದ ಅವಧಿಯು ಎರಡು ತಿಂಗಳವರೆಗೆ ಇರುತ್ತದೆ. ತರಬೇತಿಯು ಮಲ್ಟಿಮೋಡಲ್ ಶೈಕ್ಷಣಿಕ ಹಸ್ತಕ್ಷೇಪವನ್ನು ಒಳಗೊಂಡಿರುತ್ತದೆ ಭಾಗವಹಿಸುವವರಿಗೆ ನೀಡಲಾಗುವುದು.

ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವ ಪ್ರಯೋಜನಗಳೇನು?

ಮಲ್ಟಿಮೋಡಲ್ ಮಧ್ಯಸ್ಥಿಕೆಯು ಗ್ರಹಿಕೆಯ ಮಟ್ಟದಲ್ಲಿ ಬದಲಾವಣೆಯನ್ನು ತರುತ್ತದೆ ಮತ್ತು ಜೀವನದ ಗುಣಮಟ್ಟವು ಆರೋಗ್ಯವನ್ನು ಉತ್ತೇಜಿಸುವ ಮೂಲಕ ಮತ್ತು ಜೀವನದ ಗುಣಮಟ್ಟವನ್ನು ಸುಧಾರಿಸುವ ಮೂಲಕ ಆರೋಗ್ಯದ ಫಲಿತಾಂಶಗಳನ್ನು ಹೆಚ್ಚಿಸುತ್ತದೆ. ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನೀವು ಯಾವುದೇ ವಿತ್ತೀಯ ಅಥವಾ ಇತರ ಪ್ರಯೋಜನಗಳಿಗೆ ಅರ್ಹರಾಗಿಲ್ಲ.

ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವಲ್ಲಿ ಯಾವುದೇ ಅಪಾಯಗಳಿವೆಯೇ?

ಮಲ್ಟಿಮೋಡಲ್ ಇಂಟರ್ವೆನ್ಷನ್ ಸಂಪೂರ್ಣವಾಗಿ ಆಕ್ರಮಣಕಾರಿಯಲ್ಲದ, ಸುರಕ್ಷಿತವಾಗಿದೆ ಮತ್ತು ಹೇಗಾದರೂ ನಿಮಗೆ ಹಾನಿ ಮಾಡುವುದಿಲ್ಲ. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಯಾವುದೇ ಅಪಾಯಗಳು ಅಥವಾ ಯಾವುದೇ ಅನಾನುಕೂಲತೆ ಇಲ.

ಮಾಹಿತಿಯ ಗೌಪ್ಯತೆ

ಸಂಗ್ರಹಿಸಿದ ಡೇಟಾವನ್ನು ಅನನ್ಯ ಕೋಡ್ ಸಂಖ್ಯೆಗಳನ್ನು ಬಳಸಿ ಕೋಡ್ ಮಾಡಲಾಗುತ್ತದೆ, ಅದು ತನಿಖಾ ತಂಡಕ್ಕೆ ಮಾತ್ರ ತಿಳಿಯುತ್ತದೆ. ಎಲ್ಲಾ ಮೌಲ್ಯಮಾಪನ ಹಾಳೆಗಳಲ್ಲಿ ಈ ಕೋಡ್ ಅನ್ನು ಮಾತ್ರ ಸೂಚಿಸಲಾಗುತ್ತದೆ. ನಿಮ್ಮ ಹೆಸರನ್ನು ಆಸ್ಪತ್ರೆಯ ಹೊರಗೆ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ ಅಥವಾ ಅಧ್ಯಯನದ ಪರಿಣಾಮವಾಗಿ ಯಾವುದೇ ವರದಿಗಳು ಅಥವಾ ಪ್ರಕಟಣೆಗಳಲ್ಲಿ ಕಾಣಿಸಿಕೊಳ್ಳುವುದಿಲ್ಲ. ಈ ಸಂಶೋಧನೆಯಿಂದ ರಚಿಸಲಾದ ಡೇಟಾವು ಅನಾಮಧೇಯವಾಗಿರುತ್ತದೆ, ಒಳಗೊಂಡಿರುವ ವ್ಯಕ್ತಿಗಳ ಗುರುತಿನ ಯಾವುದೇ ಸೂಚನೆಯಿಲ್ಲ. ಆದಾಗ್ಯೂ, ನಡೆಸಿದ ಹಸ್ತಕ್ಷೇಪದ ಫಲಿತಾಂಶಗಳನ್ನು ಬಹಿರಂಗಪಡಿಸಲಾಗುತ್ತದೆ ಮತ್ತು ನಿಮಗೆ ವಿವರಿಸಲಾಗುತ್ತದೆ.

ನೀವು ನೀಡಿದ ಮಾದರಿಗಳಿಗೆ (ಡೇಟಾ) ಏನಾಗುತ್ತದೆ?

ಪಡೆದ ಡೇಟಾವನ್ನು ವೈಜ್ಞಾನಿಕ ಉದ್ದೇಶಕ್ಕಾಗಿ ವಿಶ್ಲೇಷಿಸಲಾಗುತ್ತದೆ. ಈ ಅಧ್ಯಯನದಿಂದ ಪಡೆದ ಫಲಿತಾಂಶಗಳನ್ನು ರಾಷ್ಟ್ರೀಯ ಮತ್ತು ಅಂತರಾಷ್ಟ್ರೀಯ ವೈಜ್ಞಾನಿಕ ನಿಯತಕಾಲಿಕಗಳಲ್ಲಿ ಪ್ರಕಟಿಸಬಹುದು. ಫಲಿತಾಂಶಗಳನ್ನು ವೈಜ್ಞಾನಿಕ ಸಮ್ಮೇಳನಗಳು / ಸೆಮಿನಾರ್‌ಗಳಲ್ಲಿ ಸಹ ಪ್ರಸ್ತುತಪಡಿಸಬಹುದು. ನಾವು ವೈಜ್ಞಾನಿಕ ನಿಯತಕಾಲಿಕಗಳಲ್ಲಿ ಫಲಿತಾಂಶಗಳನ್ನು ಪ್ರಕಟಿಸುತ್ತೇವೆ ಇದರಿಂದ ಇತರ ಆಸಕ್ತ ಜನರು ನಮ್ಮ ಸಂಶೋಧನೆಯಿಂದ ಕಲಿಯಬಹುದು. ಆದಾಗ್ಯೂ, ನಿಮ್ಮ ಗುರುತನ್ನು ಎಲ್ಲಿಯೂ, ಯಾವುದೇ ರೂಪದಲ್ಲಿ ಮತ್ತು ಯಾರಿಗೂ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ ಎಂದು ನಾವು ನಿಮಗೆ ಭರವಸೆ ನೀಡುತ್ತೇವೆ. ಮಾದರಿಗಳನ್ನು ಸಂಗ್ರಹಿಸಿದ ನಂತರ ನೀವು ಅಧ್ಯಯನದಿಂದ ಹಿಂದೆ ಸರಿದರೆ, ನಿಮ್ಮ ಡೇಟಾವನ್ನು ಈ ಅಧ್ಯಯನಕ್ಕೆ ಬಳಸಲಾಗುವುದಿಲ್ಲ. ಯೋಜನೆಯು ಪೂರ್ಣಗೊಳ್ಳುವವರೆಗೆ ಅಂತಹ ಡೇಟಾವನ್ನು ಸುರಕ್ಷಿತ ಕಸ್ಟಡಿಯಲ್ಲಿ ಇರಿಸಲಾಗುತ್ತದೆ ಮತ್ತು ನಂತರ ದಾಖಲೆಗಳಿಂದ ಅಳಿಸಲಾಗುತ್ತದೆ.

ಯಾರು ಅಧ್ಯಯನವನ್ನು ಆಯೋಜಿಸುತ್ತಿದ್ದಾರೆ / ನಡೆಸುತ್ತಿದ್ದಾರೆ?

ಸಂಶೋಧನೆಯನ್ನು ಶ್ರೀಮತಿ ವಾಣಿ.ಆರ್, ಪಿಎಚ್‌ಡಿ ನಡೆಸುತ್ತಿದ್ದಾರೆ. ವೈದ್ಯಕೀಯ ಶಸ್ತ್ರಚಿಕಿತ್ಸಾ ನರ್ಸಿಂಗ್‌ನ ಪ್ರೊಫೆಸರ್ ಮತ್ತು ಎಚ್‌ಒಡಿ ಡಾ. ಝೀನಾತ್ ಕರೀನಾ.ಜೆ ಮಾರ್ಗದರ್ಶನದಲ್ಲಿ ನರ್ಸಿಂಗ್ ವಿಭಾಗದಲ್ಲಿ ವಿದ್ವಾಂಸರು - ಎಸ್ ಡಿ ಯು ಸಿ ಓ ಎನ್, ಸಿ ಎನ್ ಓ ಆರ್ ಎಲ್ ಜೆ ಎಚ್& ಆರ್ ಸಿ.

ಈ ಅಧ್ಯಯನವನ್ನು ಯಾರು ಪರಿಶೀಲಿಸಿದ್ದಾರೆ?

ಪಿಎಚ್.ಡಿ. ಎಸ್ ಡಿ ಯು ಎ ಎಚ್ ಇ ಆರ್ ನ ಡಾಕ್ಟರೇಟ್ ಸಮಿತಿಯು (ವಿಶ್ವವಿದ್ಯಾಲಯವೆಂದು ಪರಿಗಣಿಸಲಾಗಿದೆ) ಅದರ ವೈಜ್ಞಾನಿಕ ವಿಷಯಕ್ಕಾಗಿ ಪ್ರಸ್ತಾವನೆಯನ್ನು ತೆರವುಗೊಳಿಸಿದೆ. ಈ ಅಧ್ಯಯನವನ್ನು ಸೆಂಟ್ರಲ್ ಎಥಿಕ್ಸ್ ಕಮಿಟಿ, ಶ್ರೀ ದೇವರಾಜ್ ಅರ್ಸ್ ಅಕಾಡೆಮಿ ಆಫ್ ಹೈಯರ್ ಎಜುಕೇಶನ್ ಅಂಡ್ ರಿಸರ್ಚ್‌ನಿಂದ ನೈತಿಕ ಅಂಶಗಳು / ಮಾನದಂಡಗಳಿಗಾಗಿ ಅನುಮೋದಿಸಲಾಗಿದೆ.

ಈ ಅಧ್ಯಯನದ ಕುರಿತು ನಿಮಗೆ ಹೆಚ್ಚಿನ ಮಾಹಿತಿ ಬೇಕಾದಲ್ಲಿ, ಅಧ್ಯಯನದ ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ನೀವು ಕೆಳಗಿನವರನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು.

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ಈ ಮಾಹಿತಿಯನ್ನು ಓದಲು ಸಮಯ ತೆಗೆದುಕೊಂಡಿದ್ದಕ್ಕಾಗಿ ಧನ್ಯವಾದಗಳು. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳಲು ನೀವು ನಿರ್ಧರಿಸಿದರೆ, ನಿಮ್ಮ ಮಾಹಿತಿಗಾಗಿ ಈ ಕರಪತ್ರದ ಪ್ರತಿಯನ್ನು ನಿಮಗೆ ನೀಡಲಾಗುತ್ತದೆ.

ತನಿಖಾಧಿಕಾರಿಯ ಸಹಿ:

ಸ್ವೀಕೃತಿ: ಈ ಡಾಕ್ಯುಮೆಂಟ್‌ನ ಪ್ರತಿಯನ್ನು ಸ್ವೀಕರಿಸಲಾಗಿದೆ

ಭಾಗವಹಿಸುವವರ ಸಹಿ/ಹೆಬ್ಬೆರಳಿನ ಗುರುತು:

ಲಿಖಿತ ಮಾಹಿತಿಯ ಒಪ್ಪಿಗೆ ನಮೂನೆ

ಅಧ್ಯನದ ಶೀರ್ಷಿಕೆ: ''ಆರ್.ಎಲ್.ಜಾಲಪ್ಪ ಆಸ್ಪತ್ರೆ ಮತ್ತು ಸಂಶೋಧನಾ ಕೇಂದ್ರ, ಟಮಕಾ, ಕೋಲಾರದಲ್ಲಿ ವೈದ್ಯಕೀಯ ಸೇವೆಗಳನ್ನು ಬಯಸುವ ವೃದ್ಧಾಪ್ಯ ರೋಗಿಗಳಲ್ಲಿ ಆರೋಗ್ಯ ಪ್ರಚಾರದ ಫಲಿತಾಂಶಗಳ ಕುರಿತು ಬಹು-ಮಾದರಿ ಹಸ್ತಕ್ಷೇಪದ ಪರಿಣಾಮಕಾರಿತ್ವ''

ಕೋಡ್ ಸಂಖ್ಯೆ:

ಈ ಅಧ್ಯಯನದ ಬಗ್ಗೆ ಮತ್ತು ಅದರಲ್ಲಿ ನನ್ನ ಪಾತ್ರದ ಬಗ್ಗೆ ನನಗೆ ನೀಡಿದ ಮಾಹಿತಿಯನ್ನು ನಾನು ಓದಿದ್ದೇನೆ ಮತ್ತು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ ಎಂದು ನಾನು ಖಚಿತಪಡಿಸುತ್ತೇನೆ. ನಾನು ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ಅವಕಾಶಗಳನ್ನು ಹೊಂದಿದ್ದೆ ಮತ್ತು ನನ್ನ ಪ್ರಶ್ನೆಗಳಿಗೆ ನನ್ನ ತೃಪ್ತಿಗೆ ಉತ್ತರಿಸಲಾಗಿದೆ.

ಅಥವಾ

ಈ ಅಧ್ಯಯನ ಮತ್ತು ಅದರಲ್ಲಿ ನನ್ನ ಪಾತ್ರದ ಬಗ್ಗೆ ಎಲ್ಲಾ ಮಾಹಿತಿಯನ್ನು ತನಿಖಾ ತಂಡದ ಸದಸ್ಯರೊಬ್ಬರು ನನಗೆ ಅರ್ಥವಾಗುವ ಭಾಷೆಯಲ್ಲಿ ಓದಿದ್ದಾರೆ / ವಿವರಿಸಿದ್ದಾರೆ ಎಂದು ನಾನು ದೃಢೀಕರಿಸುತ್ತೇನೆ. ನಾನು ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ಅವಕಾಶಗಳನ್ನು ಹೊಂದಿದ್ದೆ ಮತ್ತು ನನ್ನ ಪ್ರಶ್ನೆಗಳಿಗೆ ನನ್ನ ತೃಪ್ತಿಗೆ ಉತ್ತರಿಸಲಾಗಿದೆ.

ಬಿ) ಈ ಅಧ್ಯಯನದಲ್ಲಿ ನನ್ನ ಭಾಗವಹಿಸುವಿಕೆಯು ಸ್ವಯಂಪ್ರೇರಿತವಾಗಿದೆ ಮತ್ತು ಯಾವುದೇ ಕಾರಣವನ್ನು ನೀಡದೆ ಮತ್ತು ಕಾನೂನು ಹಕ್ಕುಗಳ ಮೇಲೆ ಪರಿಣಾಮ ಬೀರದೆ ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಅಧ್ಯಯನದಿಂದ ಹಿಂದೆ ಸರಿಯಲು ನಾನು ಸ್ವತಂತ್ರನಾಗಿದ್ದೇನೆ ಎಂದು ನಾನು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ.

ಸಿ) ನನ್ನ ಗುರುತನ್ನು ಯಾವುದೇ ದಾಖಲೆ ಅಥವಾ ಪ್ರಕಟಣೆಯಲ್ಲಿ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ ಎಂದು ನಾನು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ.

d) ಈ ಅಧ್ಯಯನದಿಂದ ಉಂಟಾಗುವ ಯಾವುದೇ ಡೇಟಾ ಅಥವಾ ಫಲಿತಾಂಶಗಳ ಬಳಕೆ/ಪ್ರಕಟಣೆಯನ್ನು ನಿರ್ಬಂಧಿಸದಿರಲು ನಾನು ಸಮ್ಮತಿಸುತ್ತೇನೆ, ಅಂತಹ ಬಳಕೆಯು ವೈಜ್ಞಾನಿಕ ಉದ್ದೇಶಗಳಿಗಾಗಿ ಮಾತ್ರ.

ಇ) ಈ ತನಿಖೆಯಲ್ಲಿ ನನ್ನ ಭಾಗವಹಿಸುವಿಕೆಯನ್ನು ಒಪ್ಪಿಕೊಳ್ಳುವ ಮೂಲಕ, ತನಿಖಾ ತಂಡದಿಂದ ತರಬೇತಿ ಮತ್ತು ಮೌಲ್ಯಮಾಪನಗಳಿಗೆ ನಾನು ಹೆಚ್ಚಿನ ಸಮಯವನ್ನು ನೀಡಬೇಕಾಗುತ್ತದೆ ಮತ್ತು ಈ ಮೌಲ್ಯಮಾಪನಗಳು ನನಗೆ ಅರ್ಹವಾಗಿರುವ ಪ್ರಯೋಜನಗಳಿಗೆ ಅಥವಾ ನನ್ನ ದಿನಚರಿಯಲ್ಲಿ ಹಸ್ತಕ್ಷೇಪ ಮಾಡುವುದಿಲ್ಲ ಎಂದು ನನಗೆ ತಿಳಿದಿದೆ.

ಎಫ್) ನಾನು ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಸ್ವಯಂಪ್ರೇರಣೆಯಿಂದ ನನ್ನ ಒಪ್ಪಿಗೆಯನ್ನು ನೀಡುತ್ತೇನೆ. ತನಿಖಾಧಿಕಾರಿಗಳು ವೀಕ್ಷಣೆ/ಸಂದರ್ಶನದ ಅವಧಿಗಳು ನಡೆದಾಗಲೆಲ್ಲ ಅವುಗಳನ್ನು ದಾಖಲಿಸಲು ನಾನು ಒಪ್ಪುತ್ತೇನೆ.

ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವವರ ಸಹಿ (ಅಥವಾ ಹೆಬ್ಬೆರಳಿನ ಗುರುತು) / ಕಾನೂನುಬದ್ಧವಾಗಿ ಸ್ವೀಕಾರಾರ್ಹ ಪ್ರತಿನಿಧಿ:

ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವವರ ಸಹಿ/ಹೆಬ್ಬೆರಳಿನ ಗುರುತು: _____

ಸಾಕ್ಷಿಗಳ ಸಹಿ/ಹೆಬ್ಬೆರಳಿನ ಗುರುತು: _____

ಅಧ್ಯಯನ ತನಿಖಾಧಿಕಾರಿಯ ಸಹಿ: _____

ANEXXURE –XIII

SECTION A: PART-1: SOCIO-DEMOGRAPHIC PROFORMA

Instructions: - **Code no:**

Dear Participant,

Below given are statements regarding your baseline data. Please read the items carefully and complete them by encircling the options provided. Do not leave any items. Kindly write the answers wherever necessary. All the information (response) given by you will be kept confidential used only for the study purpose. Kindly answer the questions

1. **Age (in years) _____**

2. **Gender**
a) Male
b) Female

3. Educational status/Qualification
a) Postgraduate
b) Graduate
c) PUC/Diploma
d) High school
e) Primary
f) No formal education

4. **Religion**
a) Hindu
b) Muslim
c) Christian
d) Any other specify

5. **Marital status**
a) Married
b) Unmarried
c) Divorce
d) Widowed
e) Single

6. **Place of residence**
a) Rural
b) Semi-urban
c) Urban

7. **Socioeconomic status**
a.APL
b. BPL

8. Type of Family

a) Nuclear family
b) Joint family
c) Any other Specify _____

9. History of Co-morbid conditions if any specify _____

10. History of Health checkup undergone if yes within duration

a) Yes duration _____
b) NO

SECTION A PART 2: BIOPHYSIOLOGICAL PARAMETER

11. Nutritional status

a. Under weight
b. Normal weight
c. Over weight/Obese

12. Visual Acuity

a. Normal
b. Deficit

13. Hearing Acuity

a. Normal
b. Deficit

14. Activities of Daily living

a. Independent
b. Dependent
c. Partially dependent

15. Sleep pattern

a. Normal/Adequate
b. Disturbed/Inadequate

16. Bowel

a. Regular
b. Irregular

17. Bladder

a. Normal
b. Urinary Incontinence

18. Personal Habits please specify

a. Smoking/Drinking alcohol/Chewing tobacco
b. No

19. Status of Financial dependence

a) Independent
b) Partially dependent
c) Totally dependent

20. Physical activities performed per day

a) Not involved
b) Low (less than 20 min/day)
c) High (more than 30min/day)

SECTION B- PART 3: FIVE POINT LIKERT SCALE TO ASSESS THE PERCEPTION OF GERIATRIC CLIENTS ON HEALTH PROMOTIONAL OUTCOMES.

Instructions: Dear Participant,

You are requested to listen the following statements/items carefully and give your opinion by placing tick mark (✓) in the appropriate column which is required to know your opinion that most closely corresponds. There is no wrong answer; each response will be considered. **5** indicates strong agreement, **4** indicates agreement, **3** indicates uncertainty, **2** indicates disagreement, and **1** indicates serious disagreement. You may select any number between 1 and 5.

Sl.No	I Feel/Believe That	SA(5)	A(4)	U(3)	D(2)	SD(1)
I.	**Perception of aging and Health**					
1.	I lose my enthusiasm for life as I am growing older*.					
2.	I enjoy my life in general and anticipate living a long and healthy life.					
3.	I believe my health will deteriorate in the future *					
4.	To stay healthy, take minimum of 3-5 tablets per day.					
5.	When I'm sick, I attempt to keep going as usual because I don't like going to the doctor*.					
II.	**Physical, Psychological Health**					
6.	To stay healthy, engage in intense exercise for 30 minutes or more three times each week (Walking, Yoga).					
7.	Regularly have a well-balanced diet with low fat, sugar & Salt diet.					
8.	Leading an inactivity lifestyle will prevent fall risks*.					
9.	In old age, adequate sleep is not required*.					
10.	I tend to see the negative aspects of life*.					
11.	I get upset when someone disregards my decision.					
III.	**Social relationships, Financial & Spiritual**					
12.	Necessary to spend time with family to have harmonious relationship					
13.	I feel my life is meaningless*					
14.	I've been reliant on a pension & on my children, as I can't afford to meet needs *					
15.	Life is influenced by religion, belief, and philosophy.					

NOTE:* Indicates negative statements

SECTION C- PART 4: ADOPTED WHOQOL- OLD, QUESTIONNAIRE TO ASSESS THE QUALITY OF LIFE AMONG GERIATRIC CLIENTS

Instructions: This survey solicits your opinions and sentiments regarding several areas of your quality of life, as well as problems that may be significant to you as an older person.

Please answer all the questions. Please respond to all of the questions. If you're not sure what to say in response to a question, go with the one that seems most appropriate. This is frequently your first reaction.

Please keep your expectations, hopes, pleasures, and concerns in mind. We would like you to reflect on the last two weeks of your life.

I. In the next few questions, you will be asked how much you have experienced specific things in the last two weeks.

Sl.no	ITEMS	Not at all	A little	A moderate amount	Very much	An extreme amount
1 (F25.1)	How much do sensory impairments (such as hearing, vision, taste, smell, and touch) affect your day-to-day life?	**1**	**2**	**3**	**4**	**5**
2 (F25.3)	How does a loss of hearing, vision, taste, smell, or touch influence your capacity to engage in activities?	**1**	**2**	**3**	**4**	**5**
3 (F26.1)	How much freedom do you have to make your own decisions?	**1**	**2**	**3**	**4**	**5**
Sl.no	**ITEMS**	**Not at all**	**Slightly**	**Moderately**	**Very much**	**Extremely**
4 (F26.2)	How much do you believe you have control over your destiny?	**1**	**2**	**3**	**4**	**5**
5 (F26.4)	How much do you feel that the people around you are respectful?	**1**	**2**	**3**	**4**	**5**
Sl.no	**ITEMS**	**Not at all**	**A little**	**A moderate amount**	**Very much**	**An extreme amount**
6 (F29.2)	How much are you afraid of not being able to control your death?	**1**	**2**	**3**	**4**	**5**
Sl.no	**ITEMS**	**Not at all**	**Slightly**	**Moderately**	**Very much**	**Extremely**
7 (F29.3)	How much are you afraid of not being able to control your death?	**1**	**2**	**3**	**4**	**5**
8 (F29.4)	How scared are you of dying?	**1**	**2**	**3**	**4**	**5**
Sl.no	**ITEMS**	**Not at all**	**A little**	**A moderate amount**	**Very much**	**An extreme amount**
9 (F29.5)	How concerned are you about dying in pain?	**1**	**2**	**3**	**4**	**5**

II. In the last two weeks, how totally have you experienced or been able to accomplish various things?

Sl.no	ITEMS	Not at all	A little	Moderately	Mostly	Completely
10. (F25.4)	To what extent do sensory issues (such as hearing, vision, taste, smell, and touch) limit your ability to engage with others?	**1**	**2**	**3**	**4**	**5**
11. (F26.3)	To what extent are you able to accomplish your goals?	**1**	**2**	**3**	**4**	**5**
12. (F27.3)	To what extent are you satisfied with your prospects for a successful future?	**1**	**2**	**3**	**4**	**5**
13. (F27.4)	How much do you believe you have been recognized for your achievements in life?	**1**	**2**	**3**	**4**	**5**
14. (F28.4)	To what extent do you feel that you have enough to do each day?	**1**	**2**	**3**	**4**	**5**

III. n the next questions, you will be asked to rate how content, happy, or excellent you felt about various elements of your life in the previous two weeks.

Sl.no	ITEMS	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
15. (F27.5)	How happy are you with your life's accomplishments?	**1**	**2**	**3**	**4**	**5**
16 (F28.1)	How happy are you with how you spend your time?	**1**	**2**	**3**	**4**	**5**
17. (F28.2)	How happy are you with your current level of activity?	**1**	**2**	**3**	**4**	**5**
18 (F28.7)	How happy are you with your ability to participate in community events?	**1**	**2**	**3**	**4**	**5**
Sl.no	**ITEMS**	**Very unhappy**	**Unhappy**	**Neither happy nor unhappy**	**Happy**	**Very happy**
19 (F27.1)	How satisfied are you with the things you may anticipate?	**1**	**2**	**3**	**4**	**5**
Sl.no	**ITEMS**	**Very poor**	**Poor**	**Neither poor nor good**	**Good**	**Very good**
20 (F25.2)	How would you grade your sensory abilities (hearing, vision, taste, smell, and touch, for example)?	**1**	**2**	**3**	**4**	**5**

IV. Any intimate relationships you may have are addressed in the following questions. Please think about these questions in terms of a close spouse or other close person with whom you can share more intimacy than with anybody else in your life.

Sl.no	ITEMS	Not at all	A little	A moderate amount	Very much	An extreme amount
21. (F30.2)	To what extent do you feel a sense of companionship in your life?	**1**	**2**	**3**	**4**	**5**
22. (F30.3)	To what extent do you experience love in your life?	**1**	**2**	**3**	**4**	**5**
Sl.no	**ITEMS**	**Not at all**	**A little**	**Moderately**	**Mostly**	**Completely**
23(F30.4)	How many opportunities do you have to love?	**1**	**2**	**3**	**4**	**5**
24 (F30.7)	To what extent do you have opportunities to be loved?	**1**	**2**	**3**	**4**	**5**

BLUEPRINT

Section B- Part 3: PERCEPTION OF GERIATRIC CLIENTS ON HEALTH PROMOTION OUTCOMES

Sl. No.	Area	Q. No.	Total	
			No.	%
1	Perception of aging and Health	**1-5**	5	**33.3**
2	Physical, Psychological well-being	**6-11**	6	**40**
3	Social relationships/Financial/Spiritual	**12-15**	4	**26.6**
	Total		**15**	**100%**

Sl.No	Statements	Item No	Total	%
1.	**Positive statements**	**2,4,6,7,11,12,15 - (7)**	**35**	**46.6%**
2.	**Negative statements**	**1,3, 5, 8,9,10,13, 14 -(8)**	**40**	**53.3%**
	TOTAL		**75**	**100%**

Section C- Part 4: QUALITY OF LIFE AMONG GERIATRIC CLIENTS

FACET	Abbr	∑ items
Sensory Abilities	**SAB**	**4**
Autonomy	**AUT**	**4**
Past, Present and Future Activities	**PPF**	**4**
Social Participation	**SOP**	**4**
Death and Dying	**DAD**	**4**
Intimacy	**INT**	**4**

SCORE INTERPRETATION

Section B- Part 3: PERCEPTION ON HEALTH PROMOTION OUTCOMES: Five point likert scale used to assess the Perception of geriatric clients on Health promotional outcome measures and it consists of total number of **questions 15** and each are having five options with a **Minimum score-15 & Maximum score-75** which is graded as follows;

For a positive statement, respondents get higher score if there is agreement with statement, however respondent's gets higher score if there is disagreement with the negative statement

Sl. No	Perception on Health Promotion	Score Range
1.	Poor	**1-25**
2.	Moderate	**26-50**
3.	Good	**50 & above**

Section C- Part 4: WHOQOL: The WHOQOL-OLD module has 24 Likert-scaled items organized into six facets: "Sensory Abilities" (SAB), "Autonomy" (AUT), "Past, Present, and Future Activities" (PPF), "Social Participation" (SOP), "Death and Dying" (DAD), and "Intimacy" (INT). Because each of the facets has four items, the total score for all facets can range from 4 to 20, assuming that all of the facets' items have been completed (see Table 5). The WHOQOL-OLD module "total score" is calculated by adding the scores of these six facets or the values of the 24 single items in the WHOQOL-OLD module to obtain a general ("overall") score for quality of life in older persons**.**

FACET	Abbr	∑ items	Items of facets	Possible range of raw score (Min, Max)
Sensory Abilities	SAB	4	1 + 2 + 10 + 20	16 (4, 20)
Autonomy	AUT	4	3 + 4 + 5 + 11	16 (4, 20)
Past, Present and Future Activities	PPF	4	12 + 13 + 15 + 19	16 (4, 20)
Social Participation	SOP	4	14 + 16 + 17 + 18	16 (4, 20)
Death and Dying	DAD	4	6 + 7 + 8 + 9	16 (4, 20)
Intimacy	INT	4	21 + 22 + 23 + 24	16 (4, 20)

- **Basically high scores represent high quality of life, low scores represent low quality of life**

OPINIONNAIRE REGARDING MULTIMODAL INTERVENTION ON HEALTH PROMOTION STRATEGIES

Instructions: I would appreciate your feedback on the multimodal intervention on health promotion strategies delivered to you.

How could you rate the **MMI** intervention in terms of the following?

Sl. No.	Criteria	Excellent	Good	Fair	Poor
1.	The communication & teaching was appropriate to my need				
2.	I got adequate understanding on the health promoting measures				
3.	I found the activities conducted were relevant for my situation				
4.	The MMI intervention is informative and thought provoking				
5.	The intervention were interesting & creative for me				
6.	I could interact freely with the investigator throughout the session				
7.	I felt that intervention was not wastage of time				
8.	The content and activities were easy to understand				
9.	Terminology used is simple and clear				
10.	I had the opportunity to clear all my doubts				
	Any other suggestions				

Scoring:

All questions	Excellent	Good	Fair	Poor
	4	3	2	1

The total score is calculated by finding the sum of the all items. The total score ranges between 10 and 40, with a higher score indicates the **MMI** intervention was useful.

ANNEXXURE XIV

ಅನುಬಂಧ - I

ವಿಭಾಗ ಎ: ಭಾಗ-1: ಸಾಮಾಜಿಕ-ಜನಸಂಖ್ಯಾ ಮಾಹಿತಿ

ಸೂಚನೆಗಳು: - **ಕೋಡ್ ಸಂಖ್ಯೆ:**

ಆತ್ಮೀಯ ಭಾಗವತರೇ,

ನಿಮ್ಮ ಮೂಲ ಮಾಹಿತಿಗೆ ಸಂಬಂಧಿಸಿದ ಹೇಳಿಕೆಗಳನ್ನು ಕೆಳಗೆ ನೀಡಲಾಗಿದೆ. ದಯವಿಟ್ಟು ಪ್ರಶ್ನೆಗಳನ್ನು ಎಚ್ಚರಿಕೆಯಿಂದ ಆಲಿಸಿ ಮತ್ತು ಒದಗಿಸಿದ ಆಯ್ಕೆಗಳನ್ನು ಸುತ್ತುವರಿಯುವ ಮೂಲಕ ಅವುಗಳನ್ನು ಪೂರ್ಣಗೊಳಿಸಿ. ಯಾವುದೇ ಪ್ರಶ್ನೆಗಳನ್ನು ಬಿಡಬೇಡಿ. ಅಗತ್ಯವಿರುವ ಕಡೆ ಉತ್ತರಗಳನ್ನು ಬರೆಯಿರಿ. ನೀವು ನೀಡಿದ ಎಲ್ಲಾ ಮಾಹಿತಿಯನ್ನು (ಪ್ರತಿಕ್ರಿಯೆ) ಅಧ್ಯಯನದ ಉದ್ದೇಶಕ್ಕಾಗಿ ಮಾತ್ರ ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ. ದಯವಿಟ್ಟು ಪ್ರಶ್ನೆಗಳಿಗೆ ಉತ್ತರಿಸಿ

1. ವಯಸ್ಸು (ವರ್ಷಗಳಲ್ಲಿ)

ಎ) 60

ಬಿ) 61-65

ಸಿ) 66-70

) 71-75

2. ಲಿಂಗ

ಎ) ಪುರುಷ

ಬಿ) ಹೆಣ್ಣು

3. ಶೈಕ್ಷಣಿಕ ಸ್ಥಿತಿ/ಅರ್ಹತೆ

ಎ) ಸ್ನಾತಕೋತ್ತರ

ಬಿ) ಪದವೀಧರ

ಸಿ) ಪಿಯುಸಿ/ಡಿಪ್ಲೊಮಾ

d) ಪ್ರೌಢಶಾಲೆ

ಇ) ಪ್ರಾಥಮಿಕ

ಎಫ್) ಔಪಚಾರಿಕ ಶಿಕ್ಷಣವಿಲ್ಲ

4. ಧರ್ಮ

ಎ) ಹಿಂದೂ

ಬಿ) ಮುಸ್ಲಿಂ

ಸಿ) ಕ್ರಿಶ್ಚಿಯನ್

ಡಿ) ಬೇರೆ ಯಾವುದಾದರೂ ನಿರ್ದಿಷ್ಟಪಡಿಸಿದ

5. ವೈವಾಹಿಕ ಸ್ಥಿತಿ

ಎ) ವಿವಾಹಿತ

ಬಿ) ಅವಿವಾಹಿತ

ಸಿ) ವಿಚ್ಛೇದನ

ಡಿ) ವಿಧವೆ

ಇ) ಏಕ

6. ನಿವಾಸದ ಪ್ರಕಾರ

ಎ) ಮನೆ

ಬಿ) ವೃದ್ಧಾಶ್ರಮ

ಸಿ) ಬೇರೆ ಯಾವುದಾದರೂ

7. ಕುಟುಂಬದ ಪ್ರಕಾರ

ಎ) ವಿಭಕ್ತ ಕುಟುಂಬ

ಬಿ) ಅವಿಭಕ್ತ ಕುಟುಂಬ

ಸಿ) ವಿಸ್ತೃತ ಕುಟುಂಬ

ಡಿ) ಬೇರೆ ಯಾವುದಾದರೂ

8.ಯಾವುದಾದರೂ ಸಹ-ಅಸ್ವಸ್ಥ ಸ್ಥಿತಿಗಳ ಇತಿಹಾಸ_____

9. ದೈಹಿಕ ಪರೀಕ್ಷೆ/ಆರೋಗ್ಯ ತಪಾಸಣೆಯನ್ನು _____ ಸಮಯದೊಳಗೆ ಮಾಡಲಾಗಿದೆ

ಎ) 1- 6 ತಿಂಗಳು

ಬಿ) 7 ತಿಂಗಳು - ಒಂದು ವರ್ಷ

ಸಿ) ಇಲ್ಲವೇ ಇಲ್ಲ

ವಿಭಾಗ ಎ ಭಾಗ 2: ಬಯೋ ಫಿಸಿಯೋಲಾಜಿಕಲ್ ಪ್ಯಾರಾಮೀಟರ್‌ಗಳು

1. ಪೋಷಣೆ ಎ. ತೂಕದ ಅಡಿಯಲ್ಲಿ ಬಿ. ಸಾಮಾನ್ಯ ತೂಕ ಸಿ. ಅಧಿಕ ತೂಕ/ಬೊಜ್ಜು	6. ಕರುಳಿನ ನಿರ್ಮೂಲನ ಮಾದರಿ ಎ. ನಿಯಮಿತ ಬಿ. ಅನಿಯಮಿತ
2. ದೃಷ್ಟಿ ತೀಕ್ಷ್ಣತೆ ಎ. ಸಾಮಾನ್ಯ ಬಿ. ಕೊರತೆ	7. ಮೂತ್ರಕೋಶ ಎ. ಸಾಮಾನ್ಯ ಬಿ. ಮೂತ್ರದ ಅಸಂಯಮ
3. ಶ್ರವಣ ತೀಕ್ಷ್ಣತೆ ಎ. ಸಾಮಾನ್ಯ ಬಿ. ಕೊರತೆ	8. ವೈಯಕ್ತಿಕ ಅಭ್ಯಾಸಗಳನ್ನು ದಯವಿಟ್ಟು ನಿರ್ದಿಷ್ಟಪಡಿಸಿ ಎ. ಧೂಮಪಾನ & ಮದ್ಯಪಾನ ಮಾಡುವುದು ಬಿ. ತಂಬಾಕು ಜಗಿಯುವುದು ಸಿ.ಯಾವುದು ಇಲ್ಲ
4. ನಡಿಗೆ ಎ. ಸ್ವತಂತ್ರ ಬಿ. ಅವಲಂಬಿತ	9. ಧೈಹಿಕ ಚಟುವಟಿಕೆಯ ಪ್ರಕಾರವನ್ನು ಸೂಚಿಸಿ? ಎ. ವ್ಯಾಯಾಮ ಯೋಗ ವಾಕಿಂಗ್ ಬಿ. ಕೃಷಿಮನೆಯ ಕೆಲಸಗಳು ಸಿ.ಒಳಗೊಂಡಿಲ್ಲ
5.ನಿದ್ರೆಯ ಮಾದರಿ ಎ. ಸಾಕಷ್ಟು ಬಿ. ಅಸಮರ್ಪಕ	

ವಿಭಾಗ ಬಿ- ಭಾಗ 3: ಆರೋಗ್ಯ ಪ್ರಚಾರದ ಫಲಿತಾಂಶಗಳ ಕುರಿತು ವಯಸ್ಸಾದ ಗ್ರಾಹಕರ ಗ್ರಹಿಕೆಯನ್ನು ನಿರ್ಣಯಿಸಲು ಐದು ಪಾಯಿಂಟ್ ಲೈಕರ್ ಸ್ಕೇಲ್

ಸೂಚನೆಗಳು: ಆತ್ಮೀಯ ಭಾಗವಹಿಸುವವರೇ, ಈ ಕೆಳಗಿನ ಪ್ರಶ್ನೆಗಳನ್ನು ಎಚ್ಚರಿಕೆಯಿಂದ ಆಲಿಸಲು ಮತ್ತು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವನ್ನು ಸೂಕ್ತ ಅಂಕಣದಲ್ಲಿ ಟಿಕ್ ಮಾರ್ಕ್ ( ) ಅನ್ನು ಇರಿಸುವ ಮೂಲಕ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವನ್ನು ನೀಡಲು ವಿನಂತಿಸಲಾಗಿದೆ, ಇದು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವನ್ನು ಹೆಚ್ಚು ನಿಕಟವಾಗಿ ಅನುರೂಪವಾಗಿದೆ ಎಂದು ತಿಳಿಯಲು ಅಗತ್ಯವಿದೆ. ತಪ್ಪು ಉತ್ತರವಿಲ್ಲ; ಪ್ರತಿ ಪ್ರತಿಕ್ರಿಯೆಯನ್ನು ಪರಿಗಣಿಸಲಾಗುತ್ತದೆ. 5 ಬಲವಾದ ಒಪ್ಪಂದವನ್ನು ಸೂಚಿಸುತ್ತದೆ, 4 ಒಪ್ಪಂದವನ್ನು ಸೂಚಿಸುತ್ತದೆ, 3 ಅನಿಶ್ಚಿತತೆಯನ್ನು ಸೂಚಿಸುತ್ತದೆ, 2 ಭಿನ್ನಾಭಿಪ್ರಾಯವನ್ನು ಸೂಚಿಸುತ್ತದೆ ಮತ್ತು 1 ಗಂಭೀರ ಭಿನ್ನಾಭಿಪ್ರಾಯವನ್ನು ಸೂಚಿಸುತ್ತದೆ. ನೀವು 1 ಮತ್ತು 5 ರ ನಡುವೆ ಯಾವುದೇ ಸಂಖ್ಯೆಯನ್ನು ಆಯ್ಕೆ ಮಾಡಬಹುದು.

Sl.no	**ಭಾವಿಸುತ್ತೇನೆ/ನಂಬುತ್ತೇನೆ**	**SA (5)**	**A(4)**	**U(3)**	**D(2)**	**SD(1)**
I.	**ವಯಸ್ಸು ಮತ್ತು ಆರೋಗ್ಯದ ಗ್ರಹಿಕೆ**					
1	ನಾನು ವಯಸ್ಸಾದಂತೆ ನನ್ನ ಜೀವನ ಉತ್ಸಾಹವನ್ನು ಕಳೆದುಕೊಳ್ಳುತ್ತೇನೆ ಎಂದು ಭಾವಿಸುತ್ತೇನೆ*					
2	ನಾನು ಸಂತೋಷದ ಜೀವನವನ್ನು ನಡೆಸುತಿದ್ದೇನೆ ಮತ್ತು ಆರೋಗ್ಯಕರ ಜೀವನವನ್ನು ನಿರೀಕ್ಷಿಸುತ್ತೇನೆ.					
3	ಭವಿಷ್ಯದಲ್ಲಿ ನನ್ನ ಆರೋಗ್ಯವು ಹದಗೆಡುತ್ತದೆ ಎಂದು ನಂಬುತ್ತೇನೆ*					
4	ಆರೋಗ್ಯವಾಗಿರಲು ದಿನಕ್ಕೆ ಕನಿಷ್ಠ 3-5 ಮಾತ್ರೆಗಳನ್ನು ಸೇವಿಸ ಬೇಕು					
5	ನಾನು ಅನಾರೋಗ್ಯದಿಂದ ಬಳಲುತ್ತಿರುವಾಗ, ಎಂದಿನಂತೆ ಮುಂದುವರಿಯತ್ತೇನೆ, ಮತ್ತು ವೈದ್ಯರ ಬಳಿಗೆ ಹೋಗುವುದನ್ನು ಇಷ್ಟಪಡುವುದಿಲ್ಲ*.					
II.	**ದೈಹಿಕ, ಮಾನಸಿಕ ಆರೋಗ್ಯ**					
6	ಆರೋಗ್ಯವಾಗಿರಲು, ಪ್ರತಿ ವಾರ ಮೂರು ಬಾರಿ 30 ನಿಮಿಷ ಅಥವಾ ಅದಕ್ಕಿಂತ ಹೆಚ್ಚು (ವಾಕಿಂಗ್, ಯೋಗ) ತೀವ್ರವಾದ ವ್ಯಾಯಾಮದಲ್ಲಿ ತೊಡಗಿಸಿಕೊಳ್ಳುವುದು ಅವಶ್ಯಕ.					
7	ನಿಯಮಿತವಾಗಿ ಸಕ್ಕರೆ ಮತ್ತು ಉಪ್ಪಿನೊಂದಿಗೆ ಸಮತೋಲಿತ ಆಹಾರವನ್ನು ಸೇವಿಸ ಬೇಕು.					
8	ನಿಷ್ಕ್ರಿಯ ಜೀವನಶೈಲಿಯನ್ನು ಮುನ್ನಡೆಸುವುದು ಪತನದ ಅಪಾಯಗಳನ್ನು ತಡೆಯುತ್ತದೆ*.					
9	ವೃದ್ಧಾಪ್ಯದಲ್ಲಿ, ಸಾಕಷ್ಟು ನಿದ್ರೆ ಅಗತ್ಯವಿಲ್ಲ*.					
10	ನಾನು ಜೀವನದ ನಕಾರಾತ್ಮಕ ಅಂಶಗಳನ್ನು ನೋಡಲು ಒಲವು ತೋರುತ್ತೇನೆ*					
11	ಯಾರಾದರೂ ನನ್ನ ನಿರ್ಧಾರವನ್ನು ನಿರ್ಲಕ್ಷಿಸಿದಾಗ ನಾನು ಅಸಮಾಧಾನಗೊಳ್ಳುತ್ತೇನೆ.					
III.	**ಸಾಮಾಜಿಕ ಸಂಬಂಧಗಳು, ಆರ್ಥಿಕ ಮತ್ತು ಆಧ್ಯಾತ್ಮಿಕ**					
12	ಸಾಮರಸ್ಯದ ನೈಜತೆಯನ್ನು ಹೊಂದಲು ಕುಟುಂಬದೊಂದಿಗೆ ಸಮಯ ಕಳೆಯುವುದು ಅವಶ್ಯಕ					
13	ನನ್ನ ಜೀವನ ಅರ್ಥಹೀನವಾಗಿದೆ ಎಂದು ಭಾವಿಸುತ್ತೇನೆ *					
14	ನನ್ನ ಅಗತ್ಯಗಳನ್ನು ಪೂರೈಸಲು ಪಿಂಚಣಿ ಮತ್ತು ಮಕ್ಕಳ ಮೊತ್ತದ ಮೇಲೆ ಅವಲಂಬಿತನಾಗಿದ್ದೇನೆ.					
15	ಜೀವನವು ಧರ್ಮ, ನಂಬಿಕೆ ಮತ್ತು ತತ್ತ್ವಶಾಸ್ತ್ರದಿಂದ ಪ್ರಭಾವಿತವಾಗಿರುತ್ತದೆ.					

ವಿಭಾಗ C- ಭಾಗ 4: ವೃದ್ಧಾಪ್ಯ ಗ್ರಾಹಕರಲ್ಲಿ ಜೀವನದ ಗುಣಮಟ್ಟವನ್ನು ನಿರ್ಣಯಿಸಲು WHOQOL- ಪ್ರಶ್ನಾವಳಿಯನ್ನು ಅಳವಡಿಸಲಾಗಿದೆ

ಸೂಚನೆಗಳು: ಈ ಸಮೀಕ್ಷೆಯು ನಿಮ್ಮ ಜೀವನದ ಗುಣಮಟ್ಟದ ಹಲವಾರು ಕ್ಷೇತ್ರಗಳ ಬಗ್ಗೆ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯಗಳು ಮತ್ತು ಭಾವನೆಗಳನ್ನು ಕೇಳುತ್ತದೆ, ಹಾಗೆಯೇ ವಯಸ್ಸಾದ ವ್ಯಕ್ತಿಯಾಗಿ ನಿಮಗೆ ಮಹತ್ವದ್ದಾಗಿರಬಹುದಾದ ಸಮಸ್ಯೆಗಳು ಸೂಚಿಸುತ್ತದೆ. ದಯವಿಟ್ಟು ಎಲ್ಲಾ ಪ್ರಶ್ನೆಗಳಿಗೆ ಉತ್ತರಿಸಿ. ದಯವಿಟ್ಟು ಎಲ್ಲಾ ಪ್ರಶ್ನೆಗಳಿಗೆ ಪ್ರತಿಕ್ರಿಯಿಸಿ. ಪ್ರಶ್ನೆಗೆ ಪ್ರತಿಕ್ರಿಯೆಯಾಗಿ ಏನು ಹೇಳಬೇಕೆಂದು ನಿಮಗೆ ಖಚಿತವಿಲ್ಲದಿದ್ದರೆ, ಹೆಚ್ಚು ಸೂಕ್ತವೆಂದು ತೋರುವ ಒಂದು ಆಯ್ಕೆಯೊಂದಿಗೆ ಇರಿಸಿ. ಇದು ಆಗಾಗ್ಗೆ ನಿಮ್ಮ ಮೊದಲ ಪ್ರತಿಕ್ರಿಯೆಯಾಗಿದೆ.

ದಯವಿಟ್ಟು ನಿಮ್ಮ ನಿರೀಕ್ಷೆಗಳು, ಭರವಸೆಗಳು, ಸಂತೋಷಗಳು ಮತ್ತು ಕಾಳಜಿಗಳನ್ನು ಮನಸ್ಸಿನಲ್ಲಿಟ್ಟುಕೊಳ್ಳಿ. ನಿಮ್ಮ ಜೀವನದ ಕೊನೆಯ ಎರಡು ವಾರಗಳನ್ನು ನೀವು ಪ್ರತಿಬಿಂಬಿಸಬೇಕೆಂದು ನಾವು ಬಯಸುತ್ತೇವೆ.

I. ಮುಂದಿನ ಕೆಲವು ಪ್ರಶ್ನೆಗಳಲ್ಲಿ, ಕಳೆದ ಎರಡು ವಾರಗಳಲ್ಲಿ ನೀವು ಎಷ್ಟು ನಿರ್ದಿಷ್ಟ ವಿಷಯಗಳನ್ನು ಅನುಭವಿಸಿದ್ದೀರಿ ಎಂದು ನಿಮ್ಮನ್ನು ಕೇಳಲಾಗುತ್ತದೆ

Sl.no	ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು	ಇಲ್ಲವೇ ಇಲ್ಲ	ಸ್ವಲ್ಪ	ಮಧ್ಯಮ ಮೊತ್ತ	ತುಂಬಾ	ವಿಪರೀತ ಮೊತ್ತ
1 (F25.1)	ಸಂವೇದನಾ ದುರ್ಬಲತೆಗಳು (ಕೇಳುವಿಕೆ, ದೃಷ್ಟಿ, ರುಚಿ, ವಾಸನೆ ಮತ್ತು ಸ್ಪರ್ಶದಂತಹವು) ನಿಮ್ಮ ದೈನಂದಿನ ಜೀವನದ ಮೇಲೆ ಎಷ್ಟು ಪರಿಣಾಮ ಬೀರುತ್ತವೆ?	1	2	3	4	5
2 (F25.3)	ಶ್ರವಣ, ದೃಷ್ಟಿ, ರುಚಿ, ವಾಸನೆ ಅಥವಾ ಸ್ಪರ್ಶದ ನಷ್ಟವು ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ತೊಡಗಿಸಿಕೊಳ್ಳುವ ನಿಮ್ಮ ಸಾಮರ್ಥ್ಯವನ್ನು ಹೇಗೆ ಪ್ರಭಾವಿಸುತ್ತದೆ?	1	2	3	4	5
3 (F26.1)	ನಿಮ್ಮ ಸ್ವಂತ ನಿರ್ಧಾರಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳಲು ನಿಮಗೆ ಎಷ್ಟು ಸ್ವಾತಂತ್ರ್ಯವಿದೆ?	1	2	3	4	5
Sl.no	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ಇಲ್ಲವೇ ಇಲ್ಲ	ಸ್ವಲ್ಪಮಟ್ಟಿಗೆ	ಮಧ್ಯಮವಾಗಿ	ತುಂಬಾ	ಅತ್ಯಂತ
4 (F26.2)	ನಿಮ್ಮ ಹಣೆಬರಹದ ಮೇಲೆ ನಿಮಗೆ ನಿಯಂತ್ರಣವಿದೆ ಎಂದು ನೀವು ಎಷ್ಟು ನಂಬುತ್ತೀರಿ?	1	2	3	4	5
5 (F26.4)	ನಿಮ್ಮ ಸುತ್ತಲಿನ ಜನರು ಗೌರವಾನ್ವಿತರು ಎಂದು ನೀವು ಎಷ್ಟು ಭಾವಿಸುತ್ತೀರಿ?	1	2	3	4	5
Sl.no	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ಇಲ್ಲವೇ ಇಲ್ಲ	ಸ್ವಲ್ಪ ತುಂಬಾ	ಮಧ್ಯಮ ಮೊತ್ತ	ವಿಪರೀತ	ಮೊತ್ತ
6 (F29.2)	ನೀವು ಸಾಯುವ ಮಾರ್ಗದ ಬಗ್ಗೆ ನೀವು ಎಷ್ಟು ಚಿಂತಿತರಾಗಿದ್ದೀರಿ?	1	2	3	4	5
Sl.no	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ಇಲ್ಲವೇ ಇಲ್ಲ	ಸ್ವಲ್ಪಮಟ್ಟಿಗೆ	ಮಧ್ಯಮವಾಗಿ	ತುಂಬಾ	ಅತ್ಯಂತ
7 (F29.3)	ನಿಮ್ಮ ಸಾವನ್ನು ನಿಯಂತ್ರಿಸಲು ಸಾಧ್ಯವಾಗದೆ ನೀವು ಎಷ್ಟು ಭಯಪಡುತ್ತೀರಿ?	1	2	3	4	5
8 (F29.4)	ನೀವು ಸಾಯುವ ಬಗ್ಗೆ ಎಷ್ಟು ಭಯಪಡುತ್ತೀರಿ?	1	2	3	4	5
	ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು	ಇಲ್ಲವೇ ಇಲ್ಲ	ಸ್ವಲ್ಪ	ಮಧ್ಯಮ ಮೊತ್ತ	ತುಂಬಾ	ವಿಪರೀತ ಮೊತ್ತ
9 (F29.5)	ನೋವಿನಿಂದ ಸಾಯುವ ಬಗ್ಗೆ ನೀವು ಎಷ್ಟು ಕಾಳಜಿ ವಹಿಸುತ್ತೀರಿ?	1	2	3	4	5

II. ಕೆಳಗಿನ ಪ್ರಶ್ನೆಗಳು ನೀವು ಎಷ್ಟು ಸಂಪೂರ್ಣವಾಗಿ ಅನುಭವಿಸುತ್ತೀರಿ ಅಥವಾ ಖಚಿತವಾಗಿ ಮಾಡಲು ಸಾಧ್ಯವಾಯಿತು ಎಂಬುದರ ಕುರಿತು ಕೇಳುತ್ತದೆ, ಕಳೆದ ಎರಡು ವಾರಗಳಲ್ಲಿನ ವಿಷಯಗಳು, ಉದಾಹರಣೆಗೆ ನೀವು ಬಯಸಿದಷ್ಟು ಹೊರಬರುವುದು. ನೀನೇನಾದರೂ ಈ ಕೆಲಸಗಳನ್ನು ಸಂಪೂರ್ಣವಾಗಿ ಮಾಡಲು ಸಾಧ್ಯವಾಯಿತು, "ಸಂಪೂರ್ಣವಾಗಿ" ಪಕ್ಕದಲ್ಲಿರುವ ಸಂಖ್ಯೆಯನ್ನು ವೃತ್ತಿಸಿ. ಒಂದು ವೇಳೆ ನೀವು ಈ ಕೆಲಸಗಳನ್ನು ಮಾಡಲು ಸಾಧ್ಯವಾಗಿಲ್ಲ, "ಎಲ್ಲವೂ ಇಲ್ಲ" ಪಕ್ಕದಲ್ಲಿರುವ ಸಂಖ್ಯೆಯನ್ನು ವೃತ್ತಿಸಿ. ನೀವು ನಿಮ್ಮ ಉತ್ತರ ಸುಳ್ಳನ್ನು ಸೂಚಿಸಲು ನೀವು ಬಯಸಿದರೆ ನಡುವೆ ಸಂಖ್ಯೆಗಳಲ್ಲಿ ಒಂದನ್ನು ವೃತ್ತಿಸಬೇಕು ಎಲ್ಲೋ "ಇಲ್ಲ" ಮತ್ತು "ಸಂಪೂರ್ಣವಾಗಿ" ನಡುವೆ. ಪ್ರಶ್ನೆಗಳು ಕಳೆದ ಎರಡು ವಾರಗಳನ್ನು ಉಲ್ಲೇಖಿಸುತ್ತವೆ.

Sl.no	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ಇಲ್ಲವೇ ಇಲ್ಲ	ಸ್ವಲ್ಪ	ಮಧ್ಯಮವಾಗಿ	ಹೆಚ್ಚಾಗಿ	ಸಂಪೂರ್ಣವಾಗಿ
10. (F25.4)	ಸಂವೇದನಾ ಸಮಸ್ಯೆಗಳು (ಕೇಳುವಿಕೆ, ದೃಷ್ಟಿ, ರುಚಿ, ವಾಸನೆ ಮತ್ತು ಸ್ಪರ್ಶದಂತಹ) ಇತರರೊಂದಿಗೆ ತೊಡಗಿಸಿಕೊಳ್ಳುವ ನಿಮ್ಮ ಸಾಮರ್ಥ್ಯವನ್ನು ಎಷ್ಟರ ಮಟ್ಟಿಗೆ ಮಿತಿಗೊಳಿಸುತ್ತವೆ?	1	2	3	4	5
11. (F26.3)	ನಿಮ್ಮ ಗುರಿಗಳನ್ನು ಎಷ್ಟು ಮಟ್ಟಿಗೆ ಸಾಧಿಸಲು ನಿಮಗೆ ಸಾಧ್ಯವಾಗುತ್ತದೆ?	1	2	3	4	5
12. (F27.3)	ಯಶಸ್ವಿ ಭವಿಷ್ಯಕ್ಕಾಗಿ ನಿಮ್ಮ ನಿರೀಕ್ಷೆಗಳೊಂದಿಗೆ ನೀವು ಎಷ್ಟರ ಮಟ್ಟಿಗೆ ತೃಪ್ತರಾಗಿದ್ದೀರಿ?	1	2	3	4	5
13. (F27.4)	ಜೀವನದಲ್ಲಿ ನಿಮ್ಮ ಸಾಧನೆಗಳಿಗಾಗಿ ನೀವು ಗುರುತಿಸಲ್ಪಟ್ಟಿದ್ದೀರಿ ಎಂದು ನೀವು ಎಷ್ಟು ನಂಬುತ್ತೀರಿ?	1	2	3	4	5
14. (F28.4)	ಸಾಧಿಸಲು ನೀವು ಇನ್ನು ಮಾಡಲು ಸಾಕಷ್ಟು ಇದೆ ಎಂದು ನೀವು ಎಷ್ಟು ಮಟ್ಟಿಗೆ ಭಾವಿಸುತ್ತೀರಿ?	1	2	3	4	5

III ಮುಂದಿನ ಪ್ರಶ್ನೆಗಳಲ್ಲಿ, ಹಿಂದಿನ ಎರಡು ವಾರಗಳಲ್ಲಿ ನಿಮ್ಮ ಜೀವನದ ವಿವಿಧ ಅಂಶಗಳ ಬಗ್ಗೆ ನೀವು ಹೇಗೆ ವಿಷಯ, ಸಂತೋಷ ಅಥವಾ ಅತ್ಯುತ್ತಮ ಭಾವನೆಯನ್ನು ಹೊಂದಿದ್ದೀರಿ ಎಂಬುದನ್ನು ರೇಟ್ ಮಾಡಲು ನಿಮ್ಮನ್ನು ಕೇಳಲಾಗುತ್ತದೆ.

Sl.no	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ತುಂಬ ಅಸಮಾಧಾನ	ಅಸಮಾಧಾನ	ತೃಪ್ತಿ ಇಲ್ಲ ಅಥವಾ ಅಸಮಾಧಾನ	ತೃಪ್ತಿಯಾಯಿತು	ತುಂಬ ತೃಪ್ತಿಯಾಯಿತು
15. (F27.5)	ನಿಮ್ಮ ಜೀವನದ ಸಾಧನೆಗಳಿಂದ ನೀವು ಎಷ್ಟು ಸಂತೋಷವಾಗಿದ್ದೀರಿ?	1	2	3	4	5
16 (F28.1)	ನಿಮ್ಮ ಸಮಯವನ್ನು ನೀವು ಹೇಗೆ ಕಳೆಯುತ್ತೀರಿ ಎಂಬುದರ ಬಗ್ಗೆ ನಿಮಗೆ ಎಷ್ಟು ಸಂತೋಷವಾಗಿದೆ?	1	2	3	4	5
17. (F28.2)	ನಿಮ್ಮ ಪ್ರಸ್ತುತ ಮಟ್ಟದ ಚಟುವಟಿಕೆಯಿಂದ ನಿಮಗೆಷ್ಟು ಸಂತೋಷವಾಗಿದೆ?	1	2	3	4	5

18 (F28.7)	ಸಮುದಾಯದ ಈವೆಂಟ್‌ಗಳಲ್ಲಿ ಭಾಗವಹಿಸುವ ನಿಮ್ಮ ಸಾಮರ್ಥ್ಯದ ಬಗ್ಗೆ ನಿಮಗೆ ಎಷ್ಟು ಸಂತೋಷವಾಗಿದೆ?	1	2	3	4	5
Sl.no	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ತುಂಬಾ ಅತೃಪ್ತಿ	ಅಸಂತೋಷ	ಸಂತೋಷವೂ ಅಲ್ಲ ಅಸಂತೋಷವೂ ಇಲ್ಲ	ಸಂತೋಷ	ತುಂಬಾ ಸಂತೋಷ
19 (F27.1)	ನೀವು ನಿರೀಕ್ಷಿಸಬಹುದಾದ ವಿಷಯಗಳಲ್ಲಿ ನೀವು ಎಷ್ಟು ತೃಪ್ತರಾಗಿದ್ದೀರಿ?	1	2	3	4	5
Sl.no	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ತುಂಬಾ ಬಡವ	ಬಡವ	ಬಡವೂ ಅಲ್ಲ ಒಳ್ಳೆಯದೂ ಅಲ್ಲ	ಒಳ್ಳೆಯದು	ತುಂಬಾ ಒಳ್ಳೆಯದು
20 (F25.2)	ನಿಮ್ಮ ಸಂವೇದನಾ ಸಾಮರ್ಥ್ಯಗಳನ್ನು ನೀವು ಹೇಗೆ ಗ್ರೇಡ್ ಮಾಡುತ್ತೀರಿ (ಕೇಳುವಿಕೆ, ದೃಷ್ಟಿ, ರುಚಿ, ವಾಸನೆ ಮತ್ತು ಸ್ಪರ್ಶ, ಉದಾಹರಣೆಗೆ)?	1	2	3	4	5

V. ನೀವು ಹೊಂದಿರುವ ಯಾವುದೇ ನಿಕಟ ಸಂಬಂಧಗಳನ್ನು ಈ ಕೆಳಗಿನ ಪ್ರಶ್ನೆಗಳಲ್ಲಿ ತಿಳಿಸಲಾಗಿದೆ. ನಿಮ್ಮ ಜೀವನದಲ್ಲಿ ಬೇರೆಯವರಿಗಿಂತ ನೀವು ಹೆಚ್ಚು ಅನ್ಯೋನ್ಯತೆಯನ್ನು ಹಂಚಿಕೊಳ್ಳಬಹುದಾದ ನಿಕಟ ಸಂಗಾತಿಯ ಅಥವಾ ಇತರ ನಿಕಟ ವ್ಯಕ್ತಿಯ ವಿಷಯದಲ್ಲಿ ದಯವಿಟ್ಟು ಈ ಪ್ರಶ್ನೆಗಳ ಬಗ್ಗೆ ಯೋಚಿಸಿ.

s.n	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ಇಲ್ಲವೇ ಇಲ್ಲ	ಸ್ವಲ್ಪ	ಮಧ್ಯಮ ಮೊತ್ತ	ತುಂಬಾ	ವಿಪರೀತ ಮೊತ್ತ
21. (F30.2)	ನಿಮ್ಮ ಜೀವನದಲ್ಲಿ ನೀವು ಎಷ್ಟರ ಮಟ್ಟಿಗೆ ಒಡನಾಟದ ಭಾವವನ್ನು ಅನುಭವಿಸುತ್ತೀರಿ?	1	2	3	4	5
22. (F30.3)	ನಿಮ್ಮ ಜೀವನದಲ್ಲಿ ನೀವು ಎಷ್ಟು ಪ್ರೀತಿಯನ್ನು ಹೊಂದಿದ್ದೀರಿ?	1	2	3	4	5
Sl.no	**ಐಟಂಗಳು/ಪ್ರಶ್ನೆಗಳು**	ಇಲ್ಲವೇ ಇಲ್ಲ	ಸ್ವಲ್ಪ	ಮಧ್ಯಮವಾಗಿ	ಹೆಚ್ಚಾಗಿ	ಸಂಪೂರ್ಣವಾಗಿ
23(F30.4)	ಪ್ರೀತಿಸಲು ನಿಮಗೆ ಯಾವ ಮಟ್ಟಿಗೆ ಅವಕಾಶಗಳಿವೆ?	1	2	3	4	5
24 (F30.7)	ನಿಮ್ಮನ್ನು ಪ್ರೀತಿಸುವ ಅವಕಾಶಗಳು ಎಷ್ಟರ ಮಟ್ಟಿಗೆ ಇವೆ?	1	2	3	4	5

ಆರೋಗ್ಯ ಅಭಿವೃದ್ಧಿಯ ಕಾರ್ಯತಂತ್ರಗಳ ಕುರಿತು ಬಹು ಮಾದರಿಯ ಹಸ್ತಕ್ಷೇಪದ ಬಗ್ಗೆ ಅಭಿಪ್ರಾಯ

ಸೂಚನೆಗಳು: ನಿಮಗೆ ತಲುಪಿಸಿದ ಆರೋಗ್ಯ ಪ್ರಚಾರ ತಂತ್ರಗಳ ಬಗ್ಗೆ ಬಹು ಮಾದರಿಯ ಹಸ್ತಕ್ಷೇಪದ ಕುರಿತು ನಿಮ್ಮ ಪ್ರತಿಕ್ರಿಯೆಯನ್ನು ನಾನು ಪ್ರಶಂಸಿಸುತ್ತೇನೆ. ಕೆಳಗಿನವುಗಳ ಪ್ರಕಾರ ನೀವು ಎಂಎಂಐ ಹಸ್ತಕ್ಷೇಪವನ್ನು ಹೇಗೆ ಮೌಲ್ಯ ಮಾಡಬಹುದು

ಕ್ರ.ಸ	ಮಾನದಂಡಗಳು	ಅತ್ಯುತ್ತಮ	ಒಳ್ಳೆಯದು	ನ್ಯಾಯೋಚಿತ	ಕಳಪೆ
1.	ಸಮಾಲೋಚನೆ ಮತ್ತು ಬೋಧನೆ ನನ್ನ ಅಗತ್ಯಕ್ಕೆ ಸೂಕ್ತವಾಗಿತ್ತು				
2.	ಆರೋಗ್ಯ ಉತ್ತೇಜಿಸುವ ಕ್ರಮಗಳ ಬಗ್ಗೆ ನನಗೆ ಸಾಕಷ್ಟು ತಿಳುವಳಿಕೆ ಸಿಕ್ಕಿತು				
3.	ನಡೆಸಿದ ಚಟುವಟಿಕೆಗಳು ನನ್ನ ಪರಿಸ್ಥಿತಿಗೆ ಸಂಬಂಧಿಸಿವೆ ಎಂದು ನಾನು ಕಂಡುಕೊಂಡೆ				
4.	ಅಧಿವೇಶನಗಳು ತಿಳಿವಳಿಕೆ ಮತ್ತು ಚಿಂತನೆಗೆ ಹಚ್ಚುವಂತಿತ್ತು				
5.	ಹಸ್ತಕ್ಷೇಪ ನನಗೆ ಆಸಕ್ತಿದಾಯಕ ಮತ್ತು ಸೃಜನಶೀಲವಾಗಿತ್ತು				
6.	ಅಧಿವೇಶನದುದ್ದಕ್ಕೂ ನಾನು ತನಿಖಾಧಿಕಾರಿಯೊಂದಿಗೆ ಮುಕ್ತವಾಗಿ ಸಂವಹನ ನಡೆಸಿದೆನು				
7.	ಹಸ್ತಕ್ಷೇಪದ ಸಮಯ ವ್ಯರ್ಥವಲ್ಲ ಎಂದು ನಾನು ಭಾವಿಸಿದೆ				
8.	ವಿಷಯ ಮತ್ತು ಚಟುವಟಿಕೆಗಳನ್ನು ಅರ್ಥಮಾಡಿಕೊಳ್ಳುವುದು ಸುಲಭ				
9.	ಬಳಸಿದ ಪರಿಭಾಷೆ ಸರಳ ಮತ್ತು ಸ್ಪಷ್ಟವಾಗಿದೆ				
10.	ನನ್ನ ಎಲ್ಲಾ ಅನುಮಾನಗಳನ್ನು ನಿವಾರಿಸಲು ನನಗೆ ಅವಕಾಶ ಸಿಕ್ಕಿತು				
	ಯಾವುದೇ ಸಲಹೆ				

ಅಂಕಗಳು:

ಎಲ್ಲಾ ಪ್ರಶ್ನೆಗಳು	ಅತ್ಯುತ್ತಮ	ಒಳ್ಳೆಯದು	ನ್ಯಾಯೋಚಿತ	ಕಳಪೆ
	4	**3**	**2**	**1**

ಎಲ್ಲಾ ಪ್ರಶ್ನೆಗಳ ಮೊತ್ತವನ್ನು ಕಂಡುಹಿಡಿಯುವ ಮೂಲಕ ಒಟ್ಟು ಅಂಕವನ್ನು ಲೆಕ್ಕಹಾಕಲಾಗುತ್ತದೆ. ಒಟ್ಟು ಅಂಕ 10 ರಿಂದ 40 ರ ನಡುವೆ ಇರುತ್ತದೆ, ಹೆಚ್ಚಿನ ಅಂಕ ಎಂಎಂಐ ಹಸ್ತಕ್ಷೇಪವು ಉಪಯುಕ್ತವಾಗಿದೆ ಎಂದು ಸೂಚಿಸುತ್ತದೆ.

ANNEXURE XV

CERTIFICATE OF ENGLISH EDITING

TO WHOM SO EVER IT MAY CONCERN

This is to certify that, Mrs.Vani.R, Ph.D. scholar, SDUAHER, Tamaka, Kolar has done a Research study entitled **"Effectiveness of Multimodal Intervention on Health Promotional Outcomes among geriatric clients seeking health services at selected hospitals, Kolar".**

The study was edited for English Language appropriateness by,

Date: 10|06|2022

Signature

Place: Tamaka, Kolar

PRINCIPAL
R. L. Jalappa Central School
Mitakana Halli
Tamaka Kolar 563102

ANNEXURE XVI

CERTIFICATE OF KANNADA EDITING
TO WHOM SO EVER IT MAY CONCERN

This is to certify that, **Mrs.Vani.R**, **PhD scholar**, **SDUAHER**, Tamaka, Kolar has done a Research study entitled as **"Effectiveness of Multimodal Intervention on Health Promotional outcomes among geriatric clients seeking health services at selected hospitals, Kolar".**

The study was edited for Kannada Language appropriateness by,

ANNEXUURE XVII

CERTIFICATE FROM STATISTICIAN

I hereby certify that, I have provided statistical guidance in sample size estimation and Data Analysis to Mrs.Vani.R, PhD scholar, SDUAHER, Tamaka, Kolar for the Research study entitled as **"Effectiveness of Multimodal Intervention on Health Promotional outcomes among geriatric clients seeking health services at selected hospitals, Kolar".**

Signature 10/8/2024

Mr. S. Ravishankar
Asst. Professor, Statistics
Dept. of Community Medicine
SDUMC, Kolar-563103

SAMPLE SIZE ESTIMATION PROCESS

- **60 in each group**

$$n = 2\,\frac{\sigma^2\left(Z_\alpha + Z_{1-\beta}\right)2}{(d)^2}$$

Zα= 95% Confidence Interval
Z (1-*β)* = Power of the study as 80%
σ2 Average variance estimation
d = Effect size.

By employing the Openepi statistical software version 3 calculating the sample size for difference in two means (Power 80%, 95% confidence interval, 05% absolute error (d), the difference of mean Quality of life scores between Group 1 was mean,SD 18±2.6, variance 6.76 and group 2 mean&SD 20±2.65, variance 7.02, the calculated sample size was around 56 in each group. Considering 5% to be an attrition rate, the estimated final sample size was 60 in each group.

Reference:

(Sharif F, Jahanbin I, Amirsadat A, Moghadam MH. Effectiveness of life review therapy on quality of life in the late life at day care centers of Shiraz, Iran: a randomized controlled trial. International journal of community based nursing and midwifery. 2020 Apr;6(2):136.)

Signature

Mr. S. Ravishankar
Asst. Professor, Statistics
Dept. of Community Medicine
SDUMC, Kolar-563103

ANNEXURE XIX : GANTT CHART OF RESEARCH ACTIVITY

C. Modified Gantt Chart of Research activity : Enclosed

PROJECT TITLE: ""Effectiveness of Multimodal Intervention on Health Promotional Outcomes among Geriatric Clients seeking Medical services and at selected Tertiary care Hospital, Kolar".

Sl. No	Activity/Tasks	I (2019-2020)				II(2020-2021)				III(2021-2022)				IV(2022-2023)				V(2023-2024)			
		Sep-Nov	Dec-Feb	March-May	June-Aug	Sep-Nov	Dec-Feb	March-May	June-Aug	Sep-Nov	Dec-Feb	March-May	June-Aug	Sep-Nov	Dec-Feb	March-May	June-Aug	Sep-Nov	Dec-Feb	March-May	June-Aug
1	Commencement &Prepartion of Research work																				
2	Identify the research area																				
3	Formulate Research Question																				
4	Literature review - Synopsis																				
5	Writing Research Proposal																				
6	Research Proposal Submission and Approval from DAC																				
7	Obtaining Permission from CEC																				
8	Progress report for every Six months		1		2		3		4		5		6		7		8		9		10
9	Completion of the course work(Pre-Ph.D Exam)																				
10	Professional Development and its Milestones																				
11	Exploring varied literature sources																				
12	Designing Research Methodology																				
13	Construct the Conceptual Framework & its Application																				
14	Preparing and construction of Tool/Instrument & drafting the module of Interventions																				
15	Training, Tool Validation and Pilot study findings																				
16	Data collection process-Main study																				
17	Data Coding &Processing for Analysis																				
18	Report Writing with Interprettaion through the result findings																				
19	Prepartion for Journal papers & Publications related to study																				
20	Refine of Thesis first draft with Research guide																				
21	Thesis Second Draft submission with Plagiarism Check																				
22	Writing Final version/draft of the thesis																				
23	Final submission to University & its approval																				
24	Ph.D Public Viva-Voce Examination																				
25	Dissemination of findings in Publication/Presentation in Conferences																				
	Remarks																				
	Milestone Activity of the Project									**Key:**	**Completed**			**On Progress**			**Yet to complete**				

Note: Currently the status of project is completed

ANNEXURE XX

LIST OF PAPER PRESENTATIONS

S. NO	Title of the paper presented	Title of Conference/Seminar	Organized by	International	Awards
1.	Multimodal Intervention on Perception and Quality of Life of Geriatric clients regarding Health promotional Outcomes at a selected hospitals, Kolar, Karnataka, India	International Workshop on Mixed Methods Research On 22nd & 23rd July **2024**	Bishop Benziger College of Nursing, **Kollam, Kerala** NAAC accredited B++	**International** Workshop	Best Paper presentation **2nd place**
2.	Impact of Multimodal Intervention on Quality of Life of Geriatric clients regarding Health promotional Outcomes at a selected hospitals, Kolar, Karnataka, India	6th International Conference on Nursing Science and Healthcare 16th & 17th June **2023**	SFNP, Bioleagues **Indonesia**	**Indonesia,** International Conference	Best Paper presentation **2nd place**
3	Multimodal Intervention on Health Promotional Outcomes among Geriatric Clients- Pilot Study	"5th International Conference on Futuristic Nursing Science and Healthcare" 28th 29th & 30th October **2022**.	SFNP, Bioleagues **Nellore India**.	International Conference Nellore	Presenter & participation

- Out of 03 International Scientific paper presentation- Awarded 02 papers as Best Oral Paper Presentation –Second place (International conference Indonesia and Kerala)

SFNP
SOCIETY FOR NURSING PRACTICES

Certificate

OF APPRECIATION

BioLEAGUES®

6th International Conference on Nursing Science and Healthcare

16th & 17th June 2023 | Virtual Conference | Indonesia

DATTA MEGHE INSTITUTE OF HIGHER EDUCATION & RESEARCH

2 Place

This is to certify that Ms/Mr/Mrs/Dr **Vani. R** of

Sri Devaraj Urs Academy of Higher Education and Research Medical College, India has won **Second Prize** for the

Oral Presentation titled *Impact of Multimodal Intervention on Quality of Life of Geriatric clients regarding Health promotional Outcomes at a selected hospitals, Kolar, Karnataka, India* in the

"**6th International Conference on Nursing Science and Healthcare**" organized by Society for Nursing Practices (SFNP)

held on 16th & 17th June 2023.

6th International Conference on Nursing Science & Healthcare

Dr. Seema Singh
Principal & Professor,
Smt. Radhikabai Meghe Memorial College of Nursing (SRMMCON),
Datta Meghe Institute of Higher Education & Research (Deemed to be University), Maharashtra, India

Prof. Sheuli Sen
Principal,
Teerthanker Parshvnath College of Nursing,
Teerthanker Mahaveer University,
Moradabad, Uttar Pradesh, India

Mr. Rudra Bhanu Satpathy
Founder & CEO,
Society For Nursing Practices(SFNP),
India

NARAYANA COLLEGE OF NURSING

CERTIFICATE

OF PRESENTATION

SFNP SOCIETY FOR NURSING PRACTICES

5th International Conference on Futuristic Nursing

28th, 29th & 30th October 2022 | Narayana College of Nursing, Nellore, Andhra Pradesh, India

Theme: Futuristic Nursing - Navigating Beyond the Horizon

This is to certify that Mr/Ms/Mrs/Dr. **Mrs.Vani.R** of Sri Devaraj Urs College of Nursing, Karnataka has Participated and Presented his/her worthy **Oral Presentation** titled *Effectiveness Of Multimodal Intervention on Health Promotional Outcomes Among Geriatric Clients Seeking Medical Services* in the "5th International Conference on Futuristic Nursing" Organized by Narayana College of Nursing, Nellore, Andhra Pradesh, India and Society For Nursing Practices (SFNP) held on 28th, 29th & 30th October 2022.

Andhra Pradesh Nurses and Midwives Council has awarded **13** CNE Credit Hours.

Prof. A. Latha, Ph.D.
Conference Organizing Secretary
IQAC Coordinator
Head, Dept. of Medical Surgical Nursing
Narayana College of Nursing, Nellore, India

Dr. Indira. A, Ph.D.
Conference Chairperson
Nursing Dean
Narayana College of Nursing
Nellore, India

Mr. Rudra Bhanu Satpathy
Founder & CEO
Society For Nursing Practices (SFNP)
Chennai, India

5th International Conference on Futuristic Nursing

BISHOP BENZIGER COLLEGE OF NURSING, KOLLAM

KERALA, INDIA

Accredited by KUHS with A+, Re-accredited by NAAC with B++, Member of United Nations Academic Impact Program, Approved Research Centre of Kerala University of Health Sciences

INTERNATIONAL WORKSHOP

ON

MIXED METHODS RESEARCH

CERTIFICATE OF APPRECIATION

Congratulations Dr./Mr./Ms VANI. R

for being a presenter in the Scientific Paper Presentation and won second place in the International Workshop titled "MIXED METHODS RESEARCH" held on 23rd July 2024 at Bishop Benziger College of Nursing, Kollam.

Manager

Principal

Organizing Secretary

COURSE COMPLETION DETAILS

National Institute of Social Defence
Ministry of Social Justice and Empowerment
Government of India

Reg. No: TAPAS/GC/2022/045

CERTIFICATE

This is to certify that Mr./Ms./Mx. VANI R has successfully completed the Online "Basic Course on Geriatric / Elderly Care" offered under TAPAS (Training for Augmenting Productivity and Services) organized by Senior Citizen Division (SCD), NISD during January to May 2022.

Deputy Director (SCD)

Director NISD

Date of Issue: 15 JUL 2022

LIST OF PUBLICATIONS

Publications related to PhD topic	Journal details
1.“Multi-Modal Intervention on Health Promotional Outcomes Among Geriatric Clients Seeking Medical Services At Selected Hospitals, Kolar, Karnataka, India”- A Pilot study	Journal of Pharmaceutical Negative Results, Volume 13 Special Issue 9 2022
2. “Multimodal Intervention on Quality of Life of Geriatric Clients Regarding Health Promotional Outcomes At Selected Hospitals, Kolar, Karnataka, India.”	**Scopus :** Journal of Korean Academy of psychiatry and mental health nursing Issn:1225-8482 | E-Issn:2288-4653 Vol. 6 No. 1 (2024) Pg. 90-101
3. “Multimodal Intervention on Perception and Quality of Life of Geriatric Clients regarding Health Promotional Outcomes at a selected Hospitals, Kolar, Karnataka, India”	**WOS:** Wolters publishers Journal of family medicine and primary care
4. Effectiveness of multimodal intervention on perception of geriatric clients regarding health promotional outcomes at a selected hospital, Kolar, Karnataka, India.	**Indexed:** IP Journal Annals of Geriatric Education and Medical Sciences, 2023;10(2):34-39.

Original Article

"Multi-Modal Intervention On Health Promotional Outcomes Among Geriatric Clients Seeking Medical Services At Selected Hospitals, Kolar, Karnataka, INDIA"

Mrs.Vani.R[1], Dr. Zeanath cariena Joseph[2], Dr. Priya Reshma Aranha[3]

[1]Assistant Professor/PhD Scholar, Department of Community Health Nursing, SDUCON, SDUAHER. Email.id: vanivanir1988@gmail.com

[2]Professor & HOD, Dept. of Medical-Surgical Nursing, SDUCON CNO, RLJH&RC. Kolar

[3]Professor & HOD, Dept. of Child health Nursing Yenepoya Nursing College, Yenepoya University Mangalore
DOI: 10.47750/pnr.2022.13.S09.650

Abstract

Background: Ageing is a natural phenomenon with opportunities and challenges. Ideal way is to create the awareness to achieve greater health & lead a healthy life to enhance a higher quality of life. This was evidently felt by the Investigator; hence a study was conducted to find out the effectiveness of Multimodal Intervention on Perception & QOL on Health promotion outcomes among geriatric clients.

Methodology: A quantitative quasi experimental non-randomized with Pretest Postest & Control group design was conducted in two hospital settings of ETCM & Hope Health Care Hospital, Kolar. The study has been registered under **CTRI/2021/07/034632** and Sample size was 60, 30 in each group. The pretest data was collected from experimental & control group, using validated Perception questionnaire & WHOQOL standardised tool to assess QOL consisting of 24 items through interview method on one to one basis.

After the pre-test, Multimodal educational Intervention on health promotion outcomes consists of Information pamphlet, Snake & Ladder game and Educational video was given to the Experimental group and routine care to Control group. On **30th day** (Post-test-I) and **60th day** (Post-test-II), data was analysed by descriptive & inferential statistics such as Paired t test, Independent t test, RMANOVA, Post hoc analysis & Chi-square.

Results:

The findings of the study showed that the level of Perception & QOL was higher & positive on Health promotion outcome after Intervention in experimental group when compared with control group with the Mean scores of QOL increased in experimental group during Pretest, Postest I, Postest II from **9.23**± 2.29, **11.8** ±2.8, **12.5** ± 2.71.

Conclusion: Multimodal Intervention was evidently effective in enhancing the level of Perception & Quality of Life and positive Health promotion outcomes among Geriatric clients by ensuring a holistic approach.

Key words: Multimodal Intervention, Geriatric, Health Promotion outcome, Perception level, Quality of Life.

Introduction:

Ageing is a natural phenomenon with opportunities and challenges. Ageing cannot be prevented, but we can learn how to deal with arising conditions to achieve greater health among geriatric to lead a healthy life by understanding their needs and concerns, lending an emotional support & to keep them jovial, which is inevitably the ideal way to enhance a higher quality of life. Elders desires to lead a life with good health, dignity, economic independence and finally a peaceful death.

JKPMHN Journal of Korean Academy of Psychiatric and Mental Health Nursing

ISSN:1225-8482 | E-ISSN:2288-4653 Vol. 6 No. 1 (2024) Pg. 90-101

"MULTIMODAL INTERVENTION ON QUALITY OF LIFE OF GERIATRIC CLIENTS REGARDING HEALTH PROMOTIONAL OUTCOMES AT SELECTED HOSPITALS, KOLAR, KARNATAKA, INDIA."

Mrs. Vani. R[1*],

[1*]Asst.Professor/PhD Scholar Dept. of Community Health Nursing, SDUCON, SDUAHER, Tamaka, Kolar-563103.

Dr. Zeanath Cariena Joseph[2],

[2]Prof & HOD Dept. of Medcal-Surgical Nursing, SDUCON, CNO at RLJH&RC- SDUAHER, Tamaka, Kolar

Dr.Priya Reshma Aranha[3]

[3]Prof & Vice Principal, Dept. of Child Health Nursing, Yenepoya Nursing College, Yenepoya University, Mangaluru.

***Correspondence author**: Mrs. Vani. R

Background of study: Old age is a privilege for second childhood and a new stage of opportunity and strength. Older adults are the most rapidly growing segment of the population. By 2050, 80% of all older people will live in low- and middle-income countries.(1)

Purpose : To understand the Quality of Life of geriatric clients, that influenced through Multimodal Intervention.

Methods: Quantitative approach Quasi-Experimental interventional controlled study with pre-test post-test design and follow-up for two months, adopted by using purposive sampling technique among 120 geriatric clients who gave consent for participation in the study at two different settings of hospitals from July 2022 to January 2023, Kolar. After obtaining CEC, data was obtained using the WHOQOL questionnaire and the Multimodal Intervention package consisting of a Snake & Ladder Health promotion strategies game, Educational Video, and Informational pamphlet been distributed to the experimental group whereas routine care given to the Control group followed by Posttest on the 30th day & 60th day. Reinforcement was carried out by the investigator on fortnightly basis reminders through messages. Data were analyzed by using Descriptive & Inferential statistics such as RMANOVA, Independent't'-test, Paired't-test, and Chi-square.

Results: A significant effect was demonstrated in the experimental group with enhanced mean, SD from pretest to posttest I and Posttest II found to be 54.76±10.39, 74.15±6.75& 77.71±4.99 without any significant changes in the control group.

Original Article

Multimodal intervention on perception and quality of life of geriatric clients regarding health promotional outcomes at a selected hospitals, Kolar, Karnataka, India

Vani R[1], Zeanath C. Joseph[2], Priya R. Aranha[3]

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Abstract

Background of Study: Old age is a privilege for a second childhood and a new stage of opportunity and strength.[1] Older adults are the most rapidly growing segment of the population. By 2050, 80% of all older people will live in low- and middle-income countries.[2] **Purpose:** To evaluate the effectiveness of multimodal intervention on perception and quality of life among geriatric clients. **Methods:** Quantitative approach quasi-experimental interventional controlled study with pre-test, post-test design and follow-up for two months, adopted by using purposive sampling technique among 120 geriatric clients who gave consent for participation in the study at two different settings of hospitals from July 2022 to January 2023, Kolar. After obtaining Central Ethics Committee approval, data was obtained using the structured perception questionnaire and WHO Quality of Life questionnaire, and the Multimodal Intervention package consisting of a snake and ladder health promotion strategies game, educational video, and informational pamphlet distributed to the experimental group, whereas routine care was given to the control group followed by post-test group on the 30th and 60th day. Reinforcement was carried out by the investigator on a fortnightly basis reminders through messages. Data were analyzed by using descriptive and inferential statistics such as repeated measures of ANOVA, independent '*t*'-test, paired '*t*-test, and Chi-square. **Results:** A perception significant effect was demonstrated in the experimental group with enhanced mean, standard deviation from pre-test to post-test I and Post-test II found to be 35.1 ± 7.9, 46.3 ± 6.1, and 48.3 ± 4.7, respectively, without significant changes in the control group. Concerning quality of life, important variations were demonstrated in the experimental group with enhanced mean, SD from pre-test to post-test I and Post-test II found to be 54.76 ± 10.39, 74.15 ± 6.75 and 77.71 ± 4.99, respectively, without any significant changes in the control group. **Conclusion:** Geriatric population was the biggest beneficiary, multimodal intervention was proven to be effective and can be implemented in hospitals and community settings in improving the perception and quality of life of senior clients to foster healthy aging.[3]
CTRI Trial Reg no: CTRI/2021/07/034632.

Keywords: Geriatric, health promotion, multimodal intervention

Introduction

Aging is a natural phenomenon with opportunities and challenges. Aging cannot be prevented, but we can learn how to deal with rising conditions to achieve greater health among geriatric to lead a healthy life by understanding their needs and concerns, which is inevitably the ideal way to focus on comprehensive holistic health

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Annals of Geriatric Education and Medical Sciences

Journal homepage: https://www.agems.in/

Original Research Article

Effectiveness of multimodal intervention on perception of geriatric clients regarding health promotional outcomes at a selected hospital, Kolar, Karnataka, India

Vani R[1]*, Zeanath C. J[2], Priya Reshma Aranha[3]

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Kolar

ABSTRACT

Purpose: To understand the Perception of geriatric clients, that influence through Multimodal Intervention.
Materials and Methods: Quantitative approach Quasi-Experimental interventional controlled study with pre-test post-test design and follow-up for two months, adopted by using purposive sampling technique among 120 geriatric clients who gave consent for participation in the study at two different settings of hospitals from July 2022 to January 2023, Kolar. After obtaining CEC, data was obtained using the validated perception questionnaire and the Multimodal Intervention package consisting of a Snake & Ladder Health promotion strategies game, Educational Video, and Informational pamphlet been distributed to the experimental group whereas routine care given to the Control group followed by Posttest on the 30^{th} day & 60^{th} day. Reinforcement was carried out by the investigator on fortnightly basis reminders through messages. Data were analyzed by using Descriptive & Inferential statistics such as RMANOVA, Independent 't'-test, Paired 't'-test, and Chi-square.
Results: A significant effect was demonstrated in the experimental group with enhanced mean, SD from pretest to posttest I and Posteest II found to be 35. ±7.9, 46.3 ±6.1 and 48.3 ±4.7 without any significant changes in the control group.
Conclusion: Geriatric population was the biggest beneficiary, Multimodal Intervention was proven to be effective and can be implemented in hospitals, and community settings in improving the perception of geriatric clients to foster healthy aging.
Sduaher Project Reg NO : SDUAHER/KLR/Dept.R&I/89/2020-2021 (13/03/2021)
CTRI Trial Reg no: CTRI/2021/07/034632 (16/07/2021)

1. Introduction

Aging is a natural phenomenon with *opportunities and challenges*. Aging cannot be prevented, but we can learn how to deal with arising conditions to achieve greater health among geriatric to lead a healthy life by understanding their needs and concerns, which is inevitably the ideal way to enhance a higher *perception towards quality of life.*[1]

As per the key facts of aging per WHO 2022, between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12% to 22%[2] Health promotion is avital component among the elderly.[2] In such a situation, health issues can be effectively addressed by adopting a holistic approach to Health promotion by empowering individuals and communities to implement actions to enhance healthy aging, promoting strategies, and

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CHAPTER –VII

SUMMARY CONCLUSION IMPLICATIONS & RECOMMENDATIONS

CHAPTER VI

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

This chapter presents the summary, conclusion, and Nursing Implications of the study.

SUMMARY

A Quasi-experimental non-randomized control group pretest-posttest design was adopted to assess the **"**Effectiveness of Multi-Modal Intervention regarding Health Promotion on Perception and Quality of Life among Geriatric Clients seeking Medical services at selected Hospitals, Kolar**"**.

A review of related literature enabled the investigator to develop the conceptual framework, evolve the methodology for the study, and plan analysis of the data, in the most meaningful and effective way the conceptual framework adopted for the study was based on modified Pederson's Health Promotion Model (2002 revised), which mainly focuses on attaining positive health outcome by adopting health-promoting behaviors.

The study was conducted at R. L Jalappa Hospital and Research Centre Kolar and Dist SNR hospital. The sample of the study consisted of 120 geriatric clients (60 for each experimental and control group). Non-probability purposive sampling technique was adopted. The data was collected from geriatric clients aged between 60-75 years. The data was collected by using a structured perception questionnaire and standardized WHOQOL tool using a point Likert scale.

Content validity of the tools and multimodal Intervention was obtained from fourteen experts. Based on the subject expert's suggestions and consultation with the guide the tool was modified, and pretesting of the tool was done on 12 subjects. All the items were clearly

understood with appropriate responses by the subjects. The overall time taken for the data collection and intervention is 40-45 minutes.

The reliability of the tool was inferred by administering the tool to twelve subjects. The reliability for internal consistency was 0.79 and for stability, it was 0.81 which is highly reliable. Hence the prepared tools were found to be reliable and feasible. Multimodal Intervention was given to all the subjects in the experimental group on the same day of data collection.

The structured perception questionnaire and standardized WHOQOL tool using a five-point Likert scale were used for geriatric clients to collect data during the pretest, posttest, and posttest 2.

The collected data was planned and analyzed by using both descriptive and inferential statistics based on study objectives and hypotheses of the study Socio-demographic and information specific to surgical history-related data was analyzed by using frequency and percentage.

The level of perception and quality of life and effectiveness of multimodal intervention were determined by using frequency mean, median, range, standard deviation, percentage, paired t-test, unpaired, chi-square, RM ANOVA, and Bonferroni posthoc test.

The study results showed that the mean perception scores were significantly improved in the experimental group from pretest to posttest 1 & and posttest 2 compared to the control group ($p<0.05$). Concerning, Quality of life the mean scores showed a significant difference ($p<0.05$) with enhanced QOL scores among geriatric clients, compared to a control group from pretest to posttest 1 and posttest 2. Between the groups, the comparison showed a significant difference ($p<0.05$)

Thus it is concluded that MMI(Multimodal Intervention) is an effective way to enhance the perception and Quality of Life regarding health promotion among geriatric clients. A positive correlation was found between perception and quality of life variables and found to be significant in the experimental group and a negative correlation in the control group among geriatric clients.

Study findings revealed that there was a significant association of socio-demographic variables and the pretest level of perception indicated that the obtained $\chi 2$ value was greater than the table value only in the sample of the experimental group about age ($\chi 2$ 6.61, p=.010), Residence ($\chi 2$ 4.89, p= .026), and History of health checkup ($\chi 2$ 4.87, p= .027). Hence the Research **Hypotheses H_4** is accepted. Whereas the obtained value was not significant for other variables like gender, educational status, religion, marital status, socioeconomic status, type of family, and history of comorbidity. In the control group, it was found that the $\chi 2$ value was greater than the table value about marital status ($\chi 2$=15.4p=0.001), indicating a significant association and non-significant for the remaining variables.

About the association of socio-demographic variables and Quality of life, findings depict that the obtained $\chi 2$ value was greater than the table value only in the sample of the experimental group about educational status ($\chi 2$ 12.5p=0.001), Residence ($\chi 2$ 4.83,p=.027), and type of family ($\chi 2$= 7.70,p=.005) and History of Comorbidity ($\chi 2$ =4.14,p=.034). Whereas in the control group, it is found that, the $\chi 2$ value was greater than the table value about religion (χ^2 = 6.09,p=.013) indicating a significant association and non-significant for the remaining variables. Hence the Research Hypotheses **H_5** is accepted. And stated hypotheses are rejected for the remaining variables.

CONCLUSION

The present study focused on assessing the **"**Effectiveness of Multi-Modal Intervention regarding Health Promotion on Perception and Quality of Life among Geriatric Clients at selected Hospitals, Kolar**"**.. Based on the findings the conclusions are presented under the following points.

1. As per the first objective of the study findings regarding the overall level of perception. The findings in the pretest represent, that the majority of the geriatrics in the experiment group (70%) had a moderate level of perception, 30% had poor perception, and none of the study participants belonged to a good level of perception regarding health promotion outcomes. At the time of posttest assessment 1 on the 30th day after the Multimodal intervention, the majority (76.7%) had a moderate level of perception, 23.3% had a good level of perception, and none had a poor level of perception. On the 60th day of posttest 2, the majority 56.7% had moderate perception and 43.3% had a good perception regarding health promotion outcomes and none of the study participants had a poor level of perception.

Whereas in the control group in the pretest majority of the geriatrics (61.6%) had a moderate level of perception, 33.4 % had poor perception, and 5% had a good level of perception regarding health promotion. At the time of posttest assessment, 1 on the 30th day, the majority (70%) had a moderate level of perception, 30% had poor perception and none of the samples had a good level of perception. On the 60th day of posttest 2, the majority 65% had moderate perception 35% had poor perception regarding health promotion outcomes and none of the study participants belonged to a good level of perception. Thus the stated **Research Hypotheses H_1 is accepted**.

2. Represents the overall level of Quality of Life scores in experimental & control groups. The findings in the pretest depict, that the majority of the geriatrics in the experiment group (65%) had moderate levels of QOL, 35 % had poor QOL, and none of the study participants belonged to a good level of QOL regarding health promotion outcomes. At the time of posttest assessment 1 on the 30th day after the Multimodal intervention, the majority (63.3%) had a moderate level of QOL, 36.7% had a good level of QOL, and none of the study participants had a poor level of QOL. On the 60th day of posttest 2, the majority 58.3% had moderate QOL and 41.7% had good QOL regarding health promotion and none of the samples had poor QOL.

Whereas in the control group in the pretest majority of the geriatrics (73.4%) had a moderate level of QOL, 26.6% had poor QOL, while none of the study participants belonged to a good level of QOL regarding health promotion. At the time of posttest assessment 1 on the 30th day, the majority (80%) had a moderate level of QOL, 20 % had poor QOL and none of the samples had a good level of QOL. On the 60th day of posttest 2, the majority 70% had moderate QOL and 30% had poor QOL regarding health promotion outcomes and none of the study participants had good QOL.

3. The second objective of the study was to evaluate the effectiveness of multimodal intervention regarding health promotion in the experimental and control groups. The comparison mean posttest perception scores were significantly higher than the pretest perception scores(mean ± SD post-test 1=46.35 ±6.1, post-test 2=48.33 ±4.7) after the multimodal intervention, which proved that multimodal intervention is very effective in increasing the perception regarding health promotion among the geriatric clients in the experimental group, However in the control group there was no significant differences observed from pretest and posttest mean perception scores. Thus the stated **Research Hypotheses H_2** is accepted.

4. The effectiveness of multimodal intervention observed in the mean quality of life scores represents that in the experimental group, the mean quality of life scores were significantly higher during both posttests (mean ± SD post-test 1=74.11 ± 6.7, post-test 2=77.7± 4.99) after the multimodal intervention, which proved that multimodal intervention is very effective in increasing the quality of life regarding health promotion among the geriatric clients in the experimental group, However in the control group there was no significant differences observed from pretest and posttest mean quality of life scores. Thus the stated **Research Hypotheses H_2** are accepted.
5. It is observed that there was a strong positive correlation between perception and QOL variables which was significant at $p < 0.05$ in the experimental group after the multimodal intervention, so it states that, as the perception increases the Quality of Life also increases towards health promotion outcomes. There was a statistically significant relationship between perception and Quality of Life variables. Thus the stated research hypotheses H_3 is accepted.
6. Study findings revealed that there was a significant association of socio-demographic variables and pretest perception scores indicated that in the experimental group age ($\chi 2$ 6.61, p=.010), Residence ($\chi 2$ 4.89, p= .026), and History of health checkup ($\chi 2$ 4.87, p= .027) found to be significant. The stated hypotheses were rejected for the other variables like gender, educational status, religion, marital status, socioeconomic status, type of family, and history of comorbidity. In the control group, it was found that the $\chi 2$ value was greater than the table value about marital status ($\chi 2$=15.4p=0.001), indicating a significant association and non-significant for the remaining variables. Hence the Research Hypotheses H4 is accepted.
7. Further about significant association of socio-demographic variables and pretest Quality of life findings depicts significance in experimental group educational status ($\chi 2$

12.5p=0.001), Residence ($\chi 2$ 4.83, p=.027), and type of family ($\chi 2$= 7.70, p=.005) and History of Comorbidity ($\chi 2$ =4.14, p=.034). Whereas in the control group, it is found that, religion (χ^2 = 6.09, p=.013) indicates the significant association and non-significant for the remaining variables. Hence the Research Hypotheses H_5 is accepted.

Finally, the researcher concluded that the findings of the study clearly showed that multimodal intervention was significantly effective in improving the perception and quality of life and promoting positive health outcomes and as a whole is an indicator for the evidenced based quality care. And, the concept of health promotion and healthy aging needs to be deeply rooted among the geriatric population to enhance their health, and to foster a super-aged society.

NURSING IMPLICATIONS:

The core of health promotion for older adults is to increase or maintain functional capacity, maintain or improve self-care, and stimulate one's social network. It's crucial to promote health. The findings of the study have implications for nursing practice education, administration, and research. As a whole, it emphasizes acquiring knowledge, developing skills enhancing the level of perception, and ensuring quality of life through positive health promotion outcomes to foster healthy aging.

Nursing Practice:

- The role of nurses in the healthcare industry is a vital aspect of society. Nurses should shoulder the responsibility of promoting health preventing illness and rehabilitation clients.
- The findings of the study will help the nursing team to carry out the activities in a planned way to achieve positive health promotion outcomes that meet the needs of geriatric clients and family members.
- Multimodal intervention also helps geriatric clients to understand the concepts of promoting health and helps to take an active part in preventing or minimizing complications and ensuring quality outcomes.
- The prepared multimodal intervention can be made available to all geriatric clients.
- To achieve evidence based quality nursing care nurses should practice health-promoting strategies as their standing instruction in enhancing perception and quality of life and promoting positive health outcomes.
- Nurses working in the geriatric units need to develop the practice of routine assessment of health promotion measures and use multimodal intervention strategies.

- The present study along with the literature supports creating awareness through multimodal educational intervention which improves the healthy lifestyle and sense of well-being to improve geriatric quality of life.

Nursing Education

- Education is a base of knowledge that decides the quality of future nurses. Nursing educators have the responsibility of equipping the students with adequate knowledge and skills to equip them to provide quality care in the future.
- The study emphasizes the significance of short-term in-service education programs for nurses, to provide specific care to geriatric clients in achieving positive outcomes.
- The study findings will help the nurse educator to plan construct, and reconsider the importance of multimodal intervention on perception and quality of life to enhance health promotion outcomes while developing a curriculum.
- It also helps to specify the expanded and extended role of nurses in the care of geriatric clients.
- The study findings will also help the staff nurses and geriatric clients to improve their level of knowledge and change their behavior specifically for a better quality of life.
- This study also helps to encourage and provide need-based care to geriatric clients and to choose additional specialized courses on geriatric care.

Nursing Administration:

- Administration plays a major role in regulating and coordinating the laws and policies in patient care. The quality of an administrator is determined by the quality of her subordinates.
- A nursing administrator has a significant role in encouraging and motivating the nursing officers to improve their knowledge to keep in pace with the changing needs of society as a whole and geriatric health promotion in particular it is important for the administrators to facilitate programmes to improve the knowledge for nurses regarding health promotion among geriatric clients. [65]
- The study findings will help the Nurse Administrator to plan and deliver health care services in an organized manner throughout all the phases of nursing care by developing policy on the care of geriatrics.
- It further provides the basis for developing and adopting policies and protocols in nursing care aspects to ensure uniform practice by health care team members which emphasizes health promotion ensuring higher quality of life and improved perception among geriatric clients.
- The nursing administrator can mobilize the available resources and expert personnel towards educating nurses regarding Geriatric health promotion care aspects.
- The nursing administrator should plan and organize continuing nursing education programs for nurses in geriatric care, and health promotion to promote a higher quality of life.
- Nurse administrators should propose an idea of making exclusive geriatric wards both in the public and private sectors with specialized healthcare teams in the area of geriatric.

Nursing Research

- Research in nursing is the need of the hour to improve the health status of the clients. It helps the nurses not only in improving their knowledge but also in incorporating the findings of new research findings for quality care.
- The findings of the present study serve as a basis for professional and student nurses to conduct future quantitative and qualitative research on geriatric clients in teaching health promotion measures.
- The study will motivate and initiate researchers to conduct the same study in different settings on a large sample for better generalization of study findings.
- The Study findings may reveal the effectiveness of multimodal intervention regarding health promotion on perception and quality of life and also the statistical inferences drawn from the study findings will help the researcher to recommend further Investigation.
- Emphasis should be given to the utilization of research findings. Appropriate utilization of research helps nurses to make evidence-based decisions regarding the care of the geriatric.
- Further research can be motivated to bring innovative ideas by inculcating various strategies to promote health outcomes in geriatric care.

RECOMMENDATIONS

Based on the experience gained during the period of the study and the interpretations made and conclusions drawn thereafter the following recommendations are made:

1. A similar study may be undertaken by adopting the true experimental research designs.
2. A similar study can be replicated in other settings using the same tools and intervention on a large scale for a longer period for generalization.
3. A study can be conducted to identify the geriatric client's needs and expectations to provide quality care.
4. A study empower the knowledge and perception of healthcare team members can be evaluated for a better understanding of multimodal Intervention regarding Geriatric care

Strength of the Study:

1. In this study, the multimodal intervention developed by the researcher includes comprehensive holistic health promotion strategies which are essential for geriatric preventive care.
2. This is the first study to highlight on perception and Quality of Life of geriatric clients at Kolar.
3. Study Registered under the Clinical Trials Registry of India
4. The researcher has undergone a Basic Training course on Geriatric organized by the Ministry of Social Defense, GOI.

Limitations of the study:

Geriatric care is a broader concept. It involves both preventive and promote aspects, however, promotive measures were discussed. The generalizability of the results was limited to one geographical area, Kolar. The study sample size is limited to 120 only also future studies should check for the relationship between perception and quality of life.

New Knowledge Generated:

During the study, the following are the areas where new knowledge generated

1. Finding the Research statement with Novelty
2. Gathering Reviews relevant to the topic of the study to identify the gaps
3. Organizing and structuring the tool or questionnaire.
4. Implementation of Educational Intervention strategies such as "Multimodal Intervention" to promote the health of the elderly.

5. Acquired knowledge for writing a manuscript for publication and dissemination of findings for poster and paper presentation.
6. Gained awareness about the importance of plagiarism and the specifications of the journals according to the UGC Care List I & II.

Achievement /Merit of the Study:

1. **Vulnerable:** Geriatric group was the biggest Beneficiary
2. **Uniqueness:** Developing & employing Multimodal Intervention is found to be useful for a super-aged society.
3. **Holistic Intervention:** Comprehensive and cost-effective strategy to improve Perception and Quality of life of the geriatric population.
4. **CTRI** Registration of the Study: **CTRI/2021/07/034632**
5. **Geriatric course**: Undergone Basic Training course on Geriatric organized by the Ministry of Social Defense, GOI.
6. **Educational Intervention** is the best method to modify behavioral changes among geriatric.
7. **Best paper presentation award:** Two best paper awards at international conferences held in Indonesia and Kerala.
8. **Publications** related to the study are: **04**
9. **Professional Development activities:** been a Trainer, Delegate, and Organizer for various International and national conferences.
10. **Author:** for various Journals

This chapter dealt with the summary, conclusions, brief report of findings, Nursing implications recommendations, the strength of the study, new knowledge generated, and achievements.

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