ENHANCING THE QUALITY OF LIFE OF THE ELDERLY IN RESIDENTIAL CARE – FEASIBILITY OF A RISK MANAGEMENT AND STRENGTHS-BASED INTERVENTION

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ABSTRACT

The increasing population of the elderly all over the world, coupled with a shifting social dynamic that no longer places the family as the primary caregiver, calls for improved aged-care systems in the community. This has led to a surge in alternative agencies of caregiving, like Elderly Care Homes. This study explores the prevalent risks in residential Elderly care Homes in Thrissur District of Kerala, and the feasibility of a risk management and strengths-based intervention to enhance the quality of life of the elderly in residential care. In the first phase of the study, a comprehensive risk assessment was carried out in 62 care homes. A scoping review was carried out to explore how the quality of life of the elderly is affected by risk factors. In the second phase, using a pre-test post- test comparison model, an interventional study was carried out with the residents in one elderly care home as the experimental group and the residents in another home as the comparison group. The intervention module was prepared using a risk management and strengths-based approach, and the quality of life of the residents was measured by the WHOQOL100 tool.

The first phase of the study identified 19 most common risk factors in the residential care homes. It was observed that while care homes largely adhered to basic safety protocols, risks associated with quality of life were not managed on a priority basis. In the second phase, the total Quality of Life index in the experimental home increased from 3.28 before the intervention to 4.19 after the intervention, with significant increases in all the 6 domains of the WHOQOL. The QoL values for the comparison group in the same time period, showed a slight decline. The study concludes that a risk management and strengths-based intervention is feasible in residential care homes for the elderly and proves that it is effective in enhancing the quality of life of the elderly in residential care.

Keywords: Quality of Life, Risk Management, Strengths-based Approach, Elderly Care Homes, Intervention, Oldage

സംഗ്രഹം

ലോകമെമ്പാടും വയോജനങ്ങളുടെ ജനസംഖ്യ വർധിച്ചുവരുന്നതായി കണക്കുകൾ സൂചിപ്പിക്കുന്നു. അതേ സമയം, മാറി വരുന്ന സാമൂഹിക സാഹചര്യത്തിൽ, വയോജനങ്ങൾക്ക് തങ്ങളുടെ സംരക്ഷണത്തിനായി കുടുംബത്തെ മാത്രം ആശ്രയിക്കാനും സാധിക്കുന്നില്ല. അതുകൊണ്ടുതന്നെ ഇന്നത്തെ സമൂഹത്തിൽ മെച്ചപ്പെട്ട വയോജന പരിചരണ സംവിധാനങ്ങൾ ആവശ്യമായി വരുന്നു. ഈ തിരിച്ചറിവിന്റെ അടിസ്ഥാനത്തിൽ വൃദ്ധസദനങ്ങൾ പോലുള്ള ഇതര സംവിധാനങ്ങൾ സമൂഹത്തിൽ വർധിച്ചു വരുന്നു.

ഈ പഠനം കേരളത്തിലെ തൃശ്ശൂർ ജില്ലയിലെ വൃദ്ധസദനങ്ങളിൽ നിലനിൽക്കുന്ന അപായസാധ്യതതകളെ ക്കുറിച്ച് അറിയാനുള്ള ശ്രമവും, തുടർന്ന് പരിഹാരാധിഷ്ഠിതവും ശക്ത്യാധിഷ്ഠിതവുമായ ഇടപെടലിലൂടെ വൃദ്ധസദനങ്ങളിൽ താമസിക്കുന്ന വയോജനങ്ങളുടെ ജീവിത നിലവാരം ഉയർത്താനുള്ള സാധ്യതകളെക്കുറിച്ചുള്ള അന്വേഷണവും ആണ്.

ഗവേഷണത്തിന്റെ ആദ്യ ഘട്ടത്തിൽ, 62 വൃദ്ധസദനങ്ങളിൽ സമഗ്രമായ അപായ സാധ്യതാ പഠനം നടത്തി. വിവിധ തരത്തിലുള്ള അപായ ഘടകങ്ങൾ വയോജനങ്ങളുടെ ജീവിത നിലവാരത്തെ എങ്ങനെ ബാധിക്കുന്നു എന്ന് കണ്ടെത്തുന്നതിനായി പഠനങ്ങളെ കേന്ദ്രീകരിച്ച ഒരു സ്കോപിംഗ് റിവ്യൂ നടത്തി.

രണ്ടാം ഘട്ടത്തിൽ ഗവേഷക നടത്തിയത് ഒരു ഇന്റെർവെൻഷൻ സ്റ്റഡി ആണ്. പ്രീ-ടെസ്റ്റ് പോസ്റ്റ്-ടെസ്റ്റ് കംപാരിസൺ മോഡൽ ഉപയോഗിച്ച് നടത്തിയ പഠനത്തിൽ, ഒരു വൃദ്ധസദനത്തിൽ താമസിക്കുന്ന വയോജനങ്ങളെ പരീക്ഷണ ഗ്രൂപ്പായും, മറ്റൊരു വൃദ്ധസദനത്തിലുള്ളവരെ താരതമ്യ ഗ്രൂപ്പായും തിരഞ്ഞെടുത്തു.

പരീക്ഷണ ഗ്രൂപ്പിലുള്ളവർക്കു വേണ്ടി അപായപരിഹാരാധിഷ്ഠിതവും ശക്ത്യാധിഷ്ഠിതവുമായ ഒരു ഇടപെടൽ പ്രക്രിയ വികസിപ്പിച്ചെടുക്കുകയും, അത് ആ വൃദ്ധസദനത്തിൽ നടപ്പിലാക്കുകയും ചെയ്തു. രണ്ടു സദാനങ്ങളിലെയും വയോജനങ്ങളുടെ ജീവിതനിലവാരം അളക്കുന്നതിനു വേണ്ടി WHOQOL100 ചോദ്യാവലിയാണ് ഉപയോഗിച്ചത്.

പഠനത്തിന്റെ ആദ്യ ഘട്ടത്തിലൂടെ, വൃദ്ധസദനകളിൽ ഏറ്റവും കൂടുതലായി കാണപ്പെടുന്ന 19 അപായ ഘടകങ്ങൾ തിരിച്ചറിയാൻ സാധിച്ചു. വൃദ്ധസദനങ്ങൾ അടിസ്ഥാന സുരക്ഷാ പ്രോട്ടോക്കോളുകൾ ഏറെക്കുറെ പാലിക്കുന്നുണ്ടെങ്കിലും, ജീവിത നിലവാരവുമായി ബന്ധപ്പെട്ട അപായ സാധ്യതകൾ മുൻഗണനാടിസ്ഥാനത്തിൽ കൈകാര്യം ചെയ്തിട്ടില്ലെന്ന് നിരീക്ഷിക്കപ്പെട്ടു.

രണ്ടാം ഘട്ടത്തിൽ, WHOQOL-ന്റെ 6 ഡൊമെയ്നുകളിലും ഗണ്യമായ വർദ്ധനവോടെ, പരീക്ഷണ ഗ്രൂപ്പിലെ മൊത്തം ജീവിത നിലവാര സൂചിക, ഇന്റർവെൻഷനു മുൻപുണ്ടായിരുന്ന 3.28 എന്ന മൂല്യത്തിൽ നിന്ന് ഇന്റർവെൻഷനു ശേഷം 4.19 ആയി ഉയർന്നു. ഇതേ കാലയളവിൽ കംപാരിസൺ ഗ്രൂപ്പിന്റെ ജീവിത നിലവാര സൂചിക ചെറുതായി താഴ്ന്നതായും കണ്ടു.

വൃദ്ധാസദനകളിൽ അപായപരിഹാരാധിഷ്ഠിതവും ശക്ത്യാധിഷ്ഠിതവുമായ ഇടപെടലുകൾ സാധ്യമാണെന്നും, ഇവിടെ താമസിക്കുന്ന വയോജനങ്ങളുടെ ജീവിതനിലവാരം ഉയർത്തുന്നതിൽ ഇത് ഫലപ്രദമാണെന്നും ഈ പഠനം തെളിയിക്കുന്നു

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CHAPTER 1

INTRODUCTION

Old age is widely acknowledged as 'the second childhood'. This stereotype has persisted across diverse literary works throughout history, spanning ancient to contemporary periods. It is often associated with theories such as the humoral theory of ageing, the dependence of older individuals on care, issues related to dementia, and the perceived parallels between childhood and old age (Covey, 1992).

Studies show that, with ageing, the quality of life, as defined by parameters like health, financial status, autonomy, social participation, etc generally decreases. (Noto, 2023; Figueira et al, 2008)

On the other hand, the improvement in medicine, technology, lifestyle etc is pushing the longevity of human life, and most nations across the world are showing a predicted shift towards population ageing in the coming few decades. Connecting the dots, this would mean that eventually, a large part of the human population would be struggling with poor Quality of Life, if urgent measures are not taken to address this issue.

This study derives its motivation from this core issue. Since the last decade of the 20th century, there has been a dramatic increase in studies related to quality of life, and this has now become a central theme in the literature on older adults (Rejeski and Mihalko, 2001)

In countries like India, recent decades have also seen overwhelming changes in the family structure. With adult children migrating away from home in search of better opportunities, aged parents have to face the situation of being left alone in old age. In this context, institutionalisation may become an apt support system - both for the financially sound as well as the economically backward elderly. Hence, this study takes up the institutional care setting and explores factors like risks, risk management and quality of life in this setting.

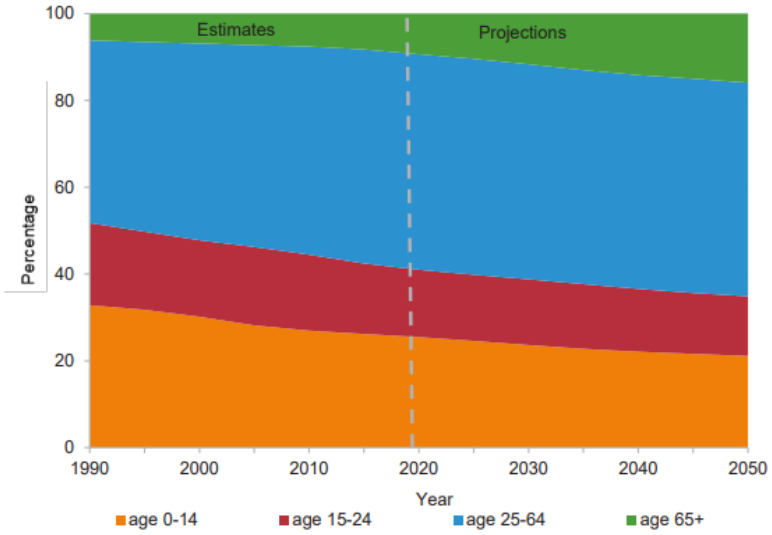
This chapter details the demographic factors relevant to this study, and outlines its context and content.

1.1 Demographics

Population ageing is a worldwide trend, with virtually every country experiencing a growth in the number and proportion of older individuals within their populations. In 2019, there were approximately 703 million people aged 65 or older globally, and this number is expected to double to 1.5 billion by 2050. The percentage of the population aged 65 and over has increased from 6% in 1990 to 9% in 2019 and10% in 2022, and it is projected to further rise to 16% by 2050, meaning that one in six people worldwide will be aged 65 or over.

Figure 1.1

Global Population by broad age groups, 1990-2050 (percentage)



Source: United Nations, Department of Economics and social affairs World Population Ageing, 2019

While population ageing was previously more prominent in developed regions, by the beginning of the 21st century, it has become a significant concern in both developed and developing countries. One major worry is whether the shrinking workforce will be able to support the growing number of dependents, including children and older adults.

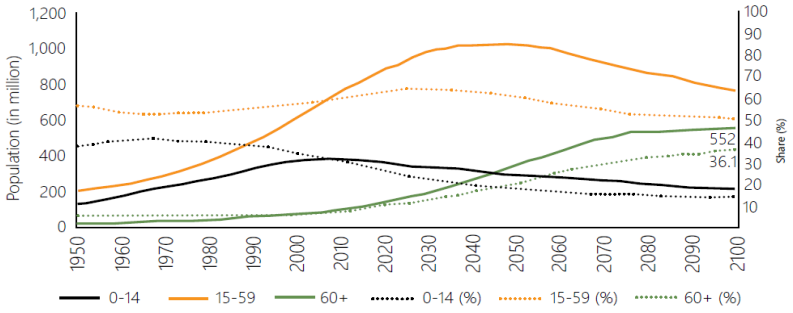
The oldage dependency ratio, which measures the number of people aged 65 and over relative to those aged 20 to 64, is forecasted to more than double in Eastern and South-Eastern Asia, Latin America and the Caribbean, Northern Africa and Western Asia, and Central and Southern Asia. This demographic shift will exert greater financial strain on oldage support systems.

By 2050, the number of persons aged 65 years or over worldwide is projected to be more than twice the number of children under age 5 and about the same as the number of children under age 12. (United Nations, World Population Prospects 2019 & 2022)

India is no exception to this trend. In 2022, there were 149 million individuals aged 60 and above, constituting about 10.5% of the total population. By 2050, this demographic is projected to double to 20.8%, with a total of 347 million older persons. By the end of the century, the elderly will constitute over 36 percent of the total population of the country.

Figure 1.2

Size and share of Population by age group, 1950-2100



Note:
Solid lines plotted along the primary y-axis (left) represent the absolute population.
Dotted lines plotted along the secondary y-axis (right) represent the share of the age group in the total population.

Source: Department of Economic and Social Affairs, Population Division, *World Economic Prospects (2022 Revision)*, (United Nations, 2022), available at https://population.un.org/wpp/Publications/.

Source: India Ageing Report, 2023

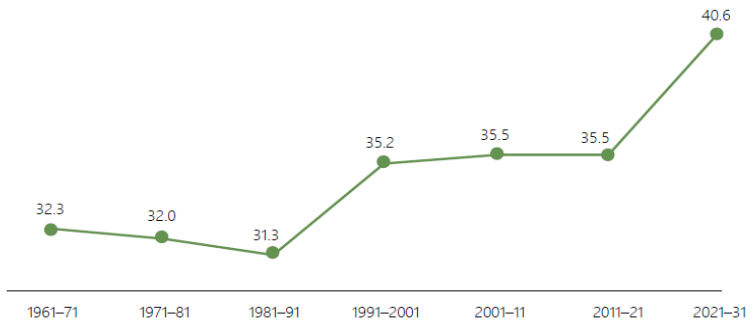
This notable growth in the elderly population will profoundly impact India's healthcare, economy, and society. Therefore, preparing for this expected surge and implementing appropriate policies and programs to ensure the wellbeing of current

and upcoming older generations is a pressing priority for the government and other relevant stakeholders. (India Ageing Report, 2023)

The decadal growth of the elderly population in India decreased marginally from 32 percent between 1961 and 1971 to 31 percent in the period from 1981 to 1991. However, there was an acceleration in growth during 1991 to 2001, reaching 35 percent. Projections indicate that this growth rate is expected to increase significantly to 41 percent between 2021 and 2031. (India Ageing Report, 2023)

Figure 1.3

Decadal Growth of the elderly population



Note: Projections beyond 2011 are based on data drawn from *Census of India 2011.*

Source: ORGI. *Census of India 2011* (Office of Registrar General & Census Commissioner, Ministry of Home Affairs, Government of India, 2011).

Source: India Ageing Report, 2023

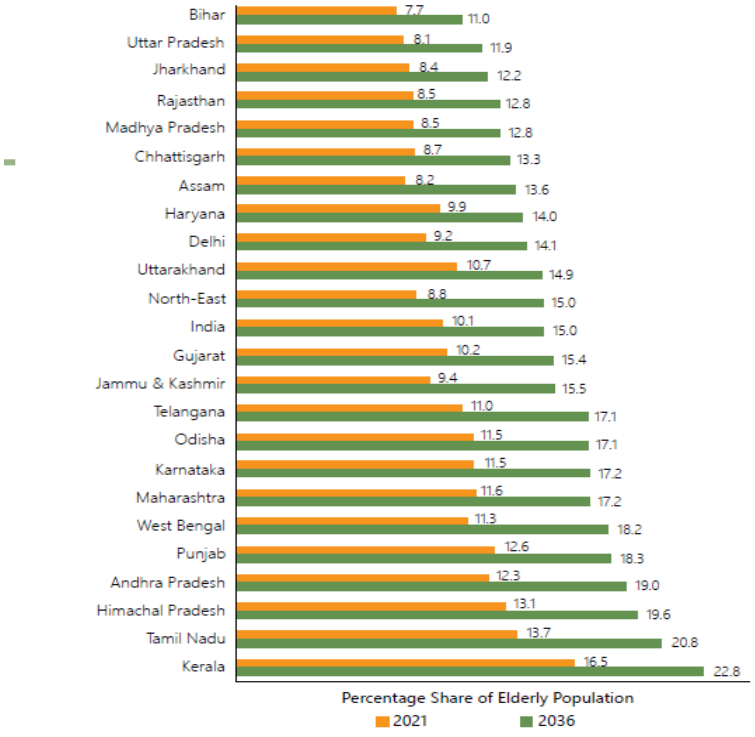
The ageing index is a metric that quantifies the ratio of elderly individuals (aged 60 years and above) to children (below 15 years). This index score rises as the population ages. As of 2021, India's ageing index stands at 39 older persons per 100 children.

One notable aspect of ageing in India is the substantial variation between states in terms of the absolute numbers, growth rates, and proportions of the elderly population. This variation is due to the differing stages and speeds of demographic transition across different states. As a result, there are significant differences in the age distribution of the population and the ageing experience across regions. In 2021, many states in the southern region and specific northern states like Himachal

Pradesh and Punjab had a higher percentage of elderly individuals compared to the national average. This gap is projected to widen further by 2036.

Figure 1.4

Projected share of elderly population



Source: Ministry of Health and Family Welfare, *Population Projections for India and States 2011-36: Report on the Technical Group of Population Projections* (National Commission on Population, Ministry of Health and Family Welfare, Government of India, 2020), available at https://main.mohfw.gov.in/sites/default/files/Population%20Projection%20Report%202011-2036%20-%20upload_compressed_0.pdf.

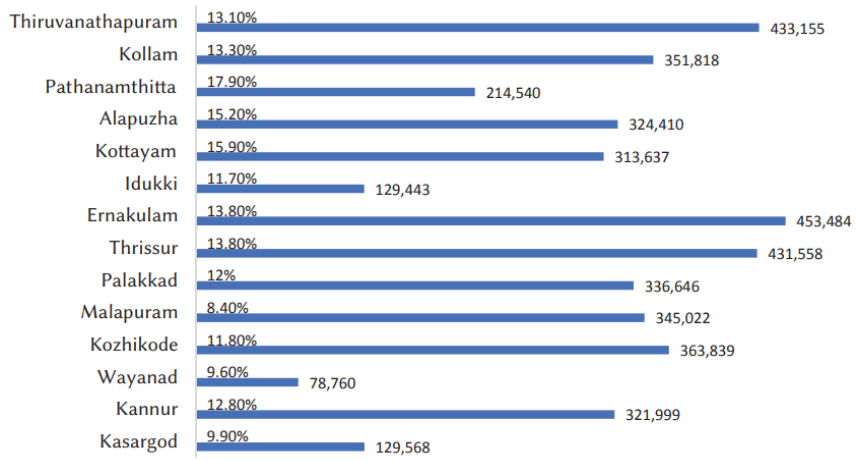
Source: India Ageing Report 2023

Among all the states, Kerala is projected to have the highest increase in the percentage of elderly population. By 2036, approximately 22.8% of Kerala's population is expected to be senior citizens, surpassing the projected national average of 15%. In 2021, Kerala already had a share of elderly individuals accounting for 16.5% of its population. The state is not only grappling with the challenges posed by an ageing population but also faces a phenomenon termed 'feminization of ageing.' This refers to the fact that women tend to live longer than men, with an average life expectancy of 22 years for women at 60, which is four years more than men.

This emphasises the need for prioritising programs and policies that promote a healthier life, especially in states where life expectancy at 75 years exceeds ten years. In Kerala, the population share in this age group is 9.9%, slightly higher than the national average of 9.1%. The care of elderly women is a significant concern, as many find themselves alone, widowed, with limited income and assets, thus relying heavily on family support.

Figure 1.5

Number of elderly people in Kerala



Source: Kerala Development Report 2021

The challenges posed by a rapidly ageing population must be addressed both at the national and household levels. Historically and predominantly, families have been responsible for caring for the elderly, but this dynamic is shifting due to factors such as migration, increased mobility, economic progress, and changing family structures. Consequently, the task of elderly care is becoming more complex.

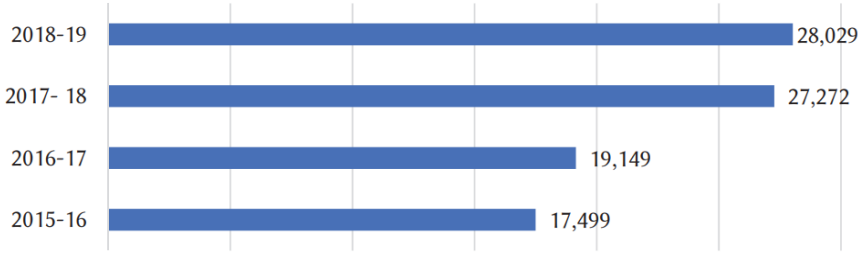
The increasing demand in the elderly care sector has led to a surge in various types of care facilities across Kerala, including paid homes, retirement retreats, assisted living homes, convalescent centres, senior living homes, and hospice homes. This sector has become a lucrative business opportunity, attracting private entities to offer modern amenities in elderly care homes.

The stigma associated with elderly care homes is gradually diminishing. Previously viewed as places where children abandoned their elderly parents, elderly care homes are now being sought after by aged individuals, including those who are well-off, as they actively inquire about the services and facilities provided in paid old age homes. ("Deccan Herald," 2022). A report in The Hindu states that the number of old age homes in Kerala had increased by 69% in the previous 4 years (The Hindu, Sept 20, 2015). The New Indian Express in 2016 had reported a doubling in this number within a 3-year period (The New Indian Express, January 9, 2016).

While wealthier elderly individuals can afford to pay for services in the market, those who are economically disadvantaged face greater vulnerability and often rely on government assistance. Both the government and non-governmental organisations (NGOs) in Kerala offer old age homes for the elderly. In 2021, there were 16 government-run old age homes operated by the Social Justice Department, with 11 of these homes having been transferred to local governments. Additionally, there were 620 old age homes registered under the Orphanages and Other Charitable Homes Act of 1960 in Kerala. The population residing in old age homes, both under the Social Justice Department and Registered Welfare Institutions, has seen a notable increase from 2015 to 2019. (Sebastian, Rajan, Shajan, & Sunitha, 2020)

Figure 1.6

Residents in old age homes in Kerala



Source: Kerala Development Report 2021

Though Kerala has the highest number of old age homes in India, their quality of care varies significantly. Many of these homes primarily focus on providing basic necessities like food and shelter and operate in a custodial manner. The Kerala

Development Report of 2021 has recognised the need to modernise these facilities and make them more resident-friendly. (Kerala Development Report, 2021)

This study focuses on identifying and assessing the risks in unpaid elderly care homes, in an effort to come up with ways and means of risk management, and measures to improve the Quality of Life of the institutionalised elderly.

1.2 Healthy Ageing, Quality of Life and Strengths- Based Approach

While ageing is inevitable, how we age is something on which we do have a measure of control. In recent times, medical science has identified a distinct group among older adults, known as "super-agers," referring to individuals in their 70s and 80s who exhibit mental or physical capabilities similar to those much younger.

Researchers have undertaken long-term studies on super-agers worldwide, focusing on their behaviours, habits, and health indicators, particularly those aged under 90 and free from dementia or cognitive decline. Apart from examining factors such as overall health, family medical history, and psychosocial aspects, there's a growing emphasis on developing improved and targeted integrated-care approaches. These approaches are community-based, tailored to the needs of older individuals, and involve effective coordination and long-term care systems. Such efforts are crucial for all societies, particularly those with ageing and super-aging populations.

The United Nations Decade of Healthy Ageing (2021–2030) is a worldwide initiative that aligns with the final 10 years of the Sustainable Development Goals (SDGs). This initiative fosters collaboration among governments, civil society, international agencies, professionals, academia, media, and the private sector to enhance the wellbeing of older individuals, their families, and the communities they reside in.

The UN Resolution (75/131) reflects concerns about the global lack of readiness to address the rights and needs of older people, despite the predictable and accelerating pace of population ageing. It acknowledges that ageing populations not only affect health systems but also various societal aspects, such as labour and financial markets, and the demand for goods and services like education, housing, long-term

care, social protection, and information. Hence, a comprehensive whole-of-society approach is necessary to address these challenges effectively.

The Decade of Healthy Ageing will adopt a human rights approach, emphasising the universality, inalienability, and indivisibility of human rights for all individuals, without discrimination. These rights include access to the highest possible standards of physical and mental health, a decent standard of living, education, protection from exploitation, violence, and abuse, the ability to live in the community, and participation in public, political, and cultural activities. (WHO)

The rights mentioned above are invariably linked to the Quality of Life of elderly individuals. While there is no single universal definition for the term 'Quality of Life', researchers agree that it is multi-dimensional and includes different aspects of physical, mental and social wellbeing as well as environmental conduciveness. (Grabowska et al., 2021)

Quality of Life (QoL), as defined by the World Health Organization (WHO), refers to how an individual perceives their standing in life within the framework of their cultural and value systems. This perception is influenced by their aspirations, expectations, standards, and worries.

A good QoL can mean that the older population is ageing healthily and positively. It could mean that the older persons perceive a low risk of disease and disability, have high mental and physical function and are actively engaged with life.

Studies show that QoL steadily increases or at least sustains through midlife to early old age, but after 70's it shows a pronounced decrease. However, this is not purely an age-related phenomenon, but rather a combination of different factors pertaining to physical, psychological and social wellbeing. (Zaninotto, Falaschetti, & Sacker, 2009; Hansen & Blekesaune, 2022; Ward, McGarrigle, & Kenny, 2019)

This indicates that timely interventions to address these contributing factors can enhance the Quality of Life of the elderly. This is where a strengths-based approach becomes useful.

The strengths-based approach is a positive way of looking at things, focusing on identifying and amplifying the inherent strengths, abilities, and resources of individuals, groups, or communities. Rather than viewing challenges and weaknesses, the Strengths-Based Approach seeks to recognise and build upon existing assets and positive attributes. This paradigm shift not only fosters resilience and self-confidence but also promotes holistic wellbeing and meaningful growth. (Stoerkel & Nash, 2019)

The Strengths-Based approach, thereby, views the elderly persons as resourceful, capable and invested in their own wellbeing. This approach emphasises leveraging the unique experiences, skills, knowledge, and resilience that elderly individuals possess. Instead of placing the full burden of care on the caregiver, this approach encourages collaborative partnerships between older adults, caregivers, healthcare professionals, and community organisations to co-create supportive environments that promote health, happiness, and a high quality of life throughout the ageing process. (Nelson-Becker et al., 2020)

1.3 Motivation for the Study

The researcher strongly feels that our elders deserve a graceful life in their twilight years. It is nothing less than the society's debt to its elderly. To this extent, this research goes beyond a rights-based or even humanitarian approach - it is prompted by a strong value system and a deep urge to do what is right. It originates from the researcher's personal commitment to work towards a system where older adults enter Elders' Homes happily and by choice - and are able to live joyfully and purposefully, with self-respect and dignity.

1.4 Scope of the Study

The researcher bases the current study on the above-mentioned contexts and has chosen the following framework. The study focuses on the unpaid elderly care institutions in Thrissur District of Kerala, India, and adopts a strengths-based approach to risk management and improving the quality of life of the institutionalised elderly.

The first phase of the study consists of a comprehensive risk assessment in these institutions. Of the 95 institutions listed in the district, after applying the inclusion-exclusion criteria, the researcher was able to conduct the assessment in the 62 selected unpaid elderly care homes in Thrissur. The results of this phase shed light on the ground realities of elderly care institutions and identify the scope and areas for risk reduction and management.

A scoping review was done to study the existing literature evidencing the effect of risks on the Quality of Life of the elderly.

The second phase is an interventional study on improving the Quality of Life of the elderly in residential care. A quasi-experimental research design is used here, more specifically, a Pre-test Post- test non-equivalent comparison group design. (Lal Das, 2022)

Two women's homes with an intermediate and similar score in the risk assessment survey were chosen - with one as the experimental group and the other as the comparison group.

The WHOQOL-100 questionnaire was used as the assessment tool, and was administered to both groups.

After analysing the scores in the questionnaire, further exploration was done into the experimental group, to identify their strengths through personal interactions and focus group discussions. Considering these strengths, and the risks identified in the first phase of the study, an intervention module was constructed based on extensive literature reviews and discussions with professionals. The module was based on the strengths-based approach, focussing on identifying and building upon the resources of the elderly in an institutional setting.

The module was implemented over a period of 6 months. A post-test was conducted at the end of this stage, using the same WHOQOL100 tool, in both the homes.

The results were analysed, using relevant statistical tools and software.

From the results, it was seen that the intervention was successful in improving the quality of life of the elderly in residential care.

Recommendations and suggestions were formulated based on the results, further review of literature, consultations with experts, and the researcher's own observations and insights.

The following chapters explain in detail the literature reviews, the methodology, the detailed analysis of results, key findings and recommendations of this study.

CHAPTER 2

REVIEW OF LITERATURE

2.1 Introduction

The field of social work research has progressed tremendously in the past few years. While undertaking new research, it is important to explore the existing body of literature on various themes relevant to the present study. The key learnings from the review of literature are presented in this chapter.

The chapter begins with the various theories of ageing, and moves on to describe the characteristics, bio-psycho-social perspectives as well as risks and challenges of ageing. The policies and schemes related to the elderly are mentioned, followed by the different support systems for the elderly. Then the key concepts of this study are explored - namely, Institutional care, Quality of Life, Strengths-Based approach and Risk Management.

2.2 Theories of Aging

Ageing is one of the most discussed and debated human processes ever. It is understood as a universal, intrinsic, progressive and deleterious process. Since ancient times, people have tried to understand, explain and even stop ageing. Still, there is no one theory that can completely explain the ageing process. Instead there are multiple theories, viewing the process from different angles, which aim to explain ageing from different perspectives (Vina et al, 2007)

Theories of ageing can be broadly classified into three - Biological Theories, Psychological Theories and Sociological Theories. These are briefly reviewed in this section.

2.2.1 Biological Theories of Ageing

Biological theories look at the physiological processes that accompany ageing - the cellular and molecular level changes, impact of age on biological systems, etc.

Biological theories broadly fall into two categories - Stochastic Theories and Non Stochastic Theories (Lange & Grossman, 2006)

2.2.1.1 Stochastic Theories

These theories take a statistical perspective, and consider ageing as the result of episodic and random changes, whose effects accumulate over time (Lange & Grossman, 2006). Some stochastic theories are mentioned below:

a) **Free Radical Theory**: This was proposed by Dr Denham Harman in 1956. Free radicals are highly reactive species produced in the body during aerobic respiration. They react with other neighbouring cells, causing cumulative damage. These cumulative damages, according to Harman, are the cause of ageing (Brintz, 2013)

b) Error Theory: Proposed by Orgel in 1963, this theory suggests that errors can happen in protein translation, which accumulate over time, creating a catastrophic feedback loop, leading to increasingly inaccurate protein synthesis, eventually leading to death of the organism (Milholland et al, 2017)

c) Wear & Tear Theory: Introduced by Dr. August Weismann in 1882, this theory suggests that cells and tissues have parts which wear out in time (Jin, 2010)

d) Connective Tissue Theory: This was proposed by Johan Bjorksten in 1942. According to this theory, crosslinked proteins accumulate in the body over time, damaging cells and tissues. This slows down the bodily processes, and causes ageing (Jin, 2010)

2.2.1.2 Non Stochastic Theories

These theories consider ageing as a result of pre-determined systematic events that happen to all organisms over a period of time (Lange & Grossman, 2006).

Some examples are given below.

a) **Programmed Theory:** Dr Hayflick in 1961, proposed that the average human cell can divide only 50 times or so, after which it stops dividing. So life expectancy is pre-programmed, and is species -specific. For human beings, this biological clock was found to be about 110-120 years (Meiner, 2014).

b) **Immunity Theory:** The immune system in human beings protects the individual from invading pathogens. The immune system is programmed to become weaker over time, leaving the person more vulnerable to disease (Jin, 2010)

c) **Endocrine Theory:** This theory suggests that ageing is hormonally regulated. For example, the decline in growth hormone, sex hormones etc is genetically predetermined and causes the ageing process.

2.2.2 Psychological Theories of Ageing

Psychological theories of ageing consider that development does not stop with adulthood, but is a life-long process. These are influenced by biological and sociological factors, and how a person responds to the tasks of his/her age (Meiner, 2014). These theories refer to the psychological changes of ageing, as well as the psychological mechanism developed to cope with the losses that accompany ageing (Wernher & Lipsky, 2015).

Some of the psychological theories of ageing are briefly described here.

2.2.2.1 Erikson's Psychosocial Theory

Erik Erikson's theory of psychosocial development outlines eight stages that individuals pass through from infancy to old age. Each stage presents a unique challenge or crisis that individuals must navigate in order to achieve a sense of psychological wellbeing and personal growth. These stages provide chances to overcome challenges, and achieving mastery fosters continuous personal growth. Notably, individuals can revisit and enhance earlier stages to achieve better outcomes.

Of these eight stages, the last two are relevant for old age.

Stage 7 - Generativity vs. Stagnation (Middle Adulthood): Adults focus on contributing to society and future generations through work, family, and community involvement, or they may feel a sense of stagnation and lack of purpose.

Stage 8 - Integrity vs. Despair (Late Adulthood): Older adults reflect on their lives and achievements, finding a sense of integrity and acceptance or experiencing feelings of despair and regret over unmet goals and unrealized dreams. (Wernher & Lipsky, 2015).

Peck's Expansion of Erikson's Theory: In 1968, Peck expanded Erikson's theory to address the realities of extended lifespans beyond age 65. He recognized the need to break down the concept of "old age" into more nuanced stages. Peck proposed three new stages within the eighth stage of ego integrity versus despair:

(1) Ego differentiation versus work role preoccupation: In this stage, older adults transition away from work roles, seeking alternative sources of identity and self-worth. Retirement can challenge feelings of value, but those with diverse identities can find fulfilment in other roles.

(2) Body transcendence versus body preoccupation: This second stage involves accepting physical changes due to aging, aiming to adapt or rise above declines to maintain wellbeing. Success comes from finding joy in social connections and activities.

(3) Ego transcendence versus ego preoccupation: This final stage entails embracing mortality without fixating on it, focusing instead on remaining engaged with life beyond one's lifespan. Achieving ego transcendence means looking forward to a future beyond personal mortality. (Ignatavicius & Workman, 2013 in Meiner, 2014)

2.2.2.2 Selective Optimisation with Compensation

Baltes (1987) has explored the psychological dynamics of development and aging across the lifespan and developed a model of successful aging. This theory

emphasizes that individuals adopt strategies to manage the functional losses that come with age. The adaptation process consists of three key elements:

- Selection: People focus on fewer things as they get older due to changes in their abilities.
- Optimization: They actively engage in activities that make their lives better.
- Compensation: They find new ways to handle challenges caused by aging.

This process of selective optimisation and compensation helps the individual cope with declining functions, and enables successful aging. (Baltes & Baltes, 1990) in Lange & Grossman, 2006)

2.2.2.3 Jung's Theory of Individualism

The Swiss psychologist Carl Jung (1960) proposed a theory about how personalities develop over a lifetime, spanning childhood through old age. He described personality as composed of the ego, personal unconscious, and collective unconscious. According to Jung, personalities tend to be oriented either towards external experiences (extroversion) or internal reflections (introversion), with a balance between these aspects crucial for mental wellbeing. As people grow older, they start to contemplate their beliefs and achievements in life. Jung suggests that successful aging involves embracing the past, adjusting to physical changes, and dealing with the loss of significant individuals (Meiner, 2014; Lange & Grossman, 2006)

2.2.3 Sociological Theories of Aging

Sociological theories examine shifts in roles and relationships within society. In many ways, these theories explore how older adults adapt to social changes in their lives.

Some of the prominent sociological theories are discussed below.

2.2.3.1 Activity Theory

This theory posits that activity is crucial for maintaining life satisfaction and a positive self-concept. Remaining active helps older individuals feel youthful and engaged, preventing social withdrawal solely based on age. Essentially, individuals actively strive to sustain a middle-aged mindset. The theory operates on three principles: (1) Activity is preferable to inactivity, (2) Happiness is preferable to unhappiness, and (3) Older individuals are best suited to assess their success in fulfilling the first two principles (Havighurst, 1972). In this framework, activity encompasses both physical and intellectual engagement. Thus, even in the face of illness or advancing age, older individuals can maintain "active" lifestyles and attain a sense of life satisfaction (Havighurst et al, 1963 in Meiner 2014).

Most researchers support the basic tenet of the Activity Theory, that is, the importance of staying active in old age. A clear link has been discovered between activity and life satisfaction among older individuals. Moreover, older adults value the quality of their activities more than the quantity (Lemon, Bengston, & Peterson, 1972). Social connections in activities are also significant. Social activities in groups or with friends are more likely to enhance life satisfaction compared to solitary or formal activities (Longino and Kart, 1982). Social engagement has been highlighted as a predictor of life satisfaction, particularly among retirees (Harlow & Cantor, 1996). Successful aging, therefore, involves maintaining activity despite limitations. These studies imply that the nature of activities may be more critical than just their frequency of occurrence (Lange & Grossman, 2006).

2.2.3.2 Disengagement Theory

Cumming and Henry (1961) proposed that ageing involves a gradual disengagement from society and relationships, and individuals transition from being society-centered to self-centered. They argued that this disengagement is desired -there is a mutual agreement between older adults and society on a reciprocal withdrawal.

Older adults are freed from social responsibilities, allowing them time for introspection, while the transfer of responsibility to the younger generation ensures the continuity of society. This process results in a new equilibrium which is

satisfactory for both parties. Social structural change, according to Cumming and Henry (1961), involves a reduction in the number of social connections and a redefinition of goals, ultimately leading to a balanced state. (Marshall & Clarke 2007; Lange & Grossman, 2006; Meiner, 2014)

2.2.3.3 Continuity Theory

The continuity theory, initially proposed by Havinghurst, Neugarten & Tobin in 1963, suggests that individuals respond to aging in a manner similar to how they've responded to previous life events. Old age is not seen as a separate phase but as a continuation of earlier life stages. The theory posits that people strive to maintain their habits, preferences, commitments, values, and beliefs as they age, contributing to the continuity of their personalities. Personality influences the roles individuals choose and how they enact them, affecting satisfaction with life. According to this theory, personality tends to remain consistent throughout life, with four identified personality types in older adults: integrated, armored-defended, passive-dependent, and unintegrated. Integrated individuals adjust well to aging, while armored-defended individuals maintain middle-aged roles, and passive-dependent individuals may become highly dependent or disinterested in the world. Unintegrated types struggle with aging adjustment. Atchley (1989) expanded on the theory, suggesting that older adults seek to preserve existing structures and prefer strategies tied to past experiences for adaptation. Change is linked to perceived past experiences, promoting continuity in psychological characteristics, social behavior, and circumstances. Continuity is viewed as a significant adaptive strategy driven by individual preference and social approval.

2.2.3.4 Age Stratification Theory

Starting from the 1970s, scholars focusing on aging began to broaden their scope to include societal and structural influences shaping perceptions of the elderly population. The age stratification theory stands as a notable example, addressing societal values. At its core, this theory highlights the concept of interdependence between older individuals and society, as emphasized by Riley, Johnson, & Foner (1972). It views aging persons as both individual elements within society and as

members interacting with peers in social processes. The theory aims to elucidate the dynamic interplay between older adults and society, illustrating how they mutually influence each other in various ways.

Riley (1985) outlines the five major concepts of this theory: Firstly, individuals progress through society in cohorts, collectively aging socially, biologically, and psychologically. Secondly, new cohorts continuously emerge, each with its unique historical experiences. Thirdly, society itself is stratified based on age and roles. Fourthly, not only do individuals and roles within each stratum change continuously, but society as a whole evolves. Lastly, the interaction between aging individuals and society is dynamic, not static. (Meiner, 2014)

2.2.3.5 Person-Environment-Fit Theory

Lawton's theory of person-environment fit, as described by Lawton (1983, 1985), posits that physical and social environments interact dynamically with a person's behavior, shaping and being shaped by each other in an ongoing process. For older individuals, the relationship between "environmental press," signifying the discord between the individual and their surroundings, and the adaptation to that environment, is influenced by one's coping abilities (Crist et al., 2019).

Individuals, regardless of age, possess certain personal competencies that evolve and define them throughout their lives. Lawton (1982) categorized these competencies as ego strength, motor skills, biological health, and cognitive and sensory-perceptual capacities, all of which assist individuals in navigating their environment. As individuals age, some of these personal competencies may change or decline, impacting their ability to interact effectively with their surroundings.

Lawton's theory further suggests that with aging, the environment may increasingly pose challenges, leading individuals to feel inadequate in coping with it. In a society marked by rapid technological progress, this theory elucidates why older individuals may perceive themselves as ill-equipped and may withdraw from societal engagement (Meiner, 2014).

2.2.3.6 Gerotranscendence Theory

Tornstam (1994) introduced the theory of gerotranscendence as a novel sociological aging perspective. This theory suggests that as individuals age, they undergo a cognitive transformation from a materialistic and rational standpoint to a sense of unity with the universe. Successful transformation is characterised by an increased focus on external matters, acceptance of death without fear, prioritisation of meaningful relationships, a feeling of connection with both past and future generations, and spiritual harmony with the universe. (Lange & Grossman, 2006)

According to this theory, ageing encompasses the potential for individuals to develop a new perspective and deeper understanding of life. Gerotranscendence signifies a transition in viewpoint from materialism and rationality toward a more cosmic and transcendent outlook, often resulting in greater life satisfaction.

Gerotranscendence can manifest in different ways. The transcendence of time can lead to a blurring of lines between the past and the present. There could be a feeling of being connected to earlier and future generations, as part of a cosmic flow. Older adults may start losing the fear of death. At the same time, they learn to accept that all things in life cannot be scientifically explained, and human intellect may have certain limitations.They can look back on their earlier life and discover hidden aspects of self. They become more selective regarding the company they keep or the activities they involve in. They are able to distinguish between the self and the role, and try to transcend roles and get closer to the real self.

Summing up, the gerotranscendence theory credits human beings with the capacity to grow and mature in all stages of life. This is especially true of old age, where the person seems to develop an innate cosmic connection, finding peace and happiness by transcending the daily chaos of life. According to Tornstam, the maladies related to old age, for example depression or anxiety, are caused when gerotranscendence is blocked in some way, either by external events or by internal constraints. Accepting the signs of gerotranscendence will help caregivers to understand and support the elderly in a more positive way. (Tornstam, 2003)

2.2.3.7 Indian concepts of Aging

In the Indian lifestyle, Karma (action) and dharma (the righteous path of action) hold significant importance. Traditional Indian life was structured around the stages (Ashrams) of life: Brahmacharya (student life), Grihastha (householder life), Vanaprastha (forest dweller), and Sanyasa (ascetic life), each preparing individuals for the next stage.

Brahmacharya aimed at holistic development, encompassing formal and informal education to enable self-sufficiency in later life stages. Grihastha focused on fulfilling duties and obligations in accordance with dharma. It involved acquiring wealth through wisdom and skills, and fulfilling desires in a righteous manner while upholding family and societal responsibilities.

Vanaprastha, typically entered around the age of fifty, involved a transition towards self-discovery and relinquishing primary family responsibilities. Sanyasa, the final stage, marked complete detachment from social obligations, with the pursuit of "moksha" (liberation) as the ultimate goal. In Sanyasa, individuals withdraw from societal engagements to seek self-realisation and enlightenment.

The stages of Vanaprastha & Sanyasa are typically related to Old Age. While vanaprastha signifies a gradual transition from family roles into a larger societal role, sanyasa signifies complete withdrawal, with sole focus on contemplation. As the physical body ages, it is seen that the activities of the individual tend to become more intellectual and spiritual in nature. (Kumar, 2021)

2.2.4 Contextualising the theories

A review of literature suggests that there is no one particular theory of ageing that is complete in itself. While each theory looks at the phenomenon of ageing from a unique perspective, there are also common features among these theories themselves. For example, the ancient Indian concept of the stages of life has striking resemblances to Erikson's theory. The developmental tasks described in Erikson's 7th stage, adulthood, are similar to the characteristics of Vanaprastha, while his 8th stage of old age has similarities with *sanyasa*. Peck's expansion of Erikson's theory

has some characteristics common to Tornstam's theory of Gerotranscendence, both of which strikingly resemble the *sanyasa* stage of the Indian theory. (Kakar, 1968)

An overview of the psychological and sociological theories brings out one strong point of view. Most theories consider old age as a unique and essential phase of life, with its own characteristic features, processes and developmental tasks. That is, old age is not a phase of waning strength, but involves developing new and different strengths, which may be subtler and even of a higher order. This perception of old age is especially pronounced in the Indian concept, as well as the theory of gerotranscendence. Erikson's psychosocial theory and its offshoots assign special roles to the different age groups within later middle age to old age. Theories like activity theory and SOC also take note of the special needs and preferences of the elderly.

From a social work perspective, there is a need to integrate the theoretical framework with everyday practice. The principle of individualisation is very relevant in this context. People are unique and different, and this applies to the ageing process also. A general understanding of the theories will help the social worker to apply these concepts according to the person and the situation. A strong theoretical background helps in better understanding of the elderly clients and in designing more effective and theoretically sound interventions.

2.3.1 Old Age - characteristics

The process of ageing is a biological reality that unfolds independently of human influence. However, societies also construct their own interpretations of old age. In developed countries, chronological age, typically around 60 or 65, aligns with retirement ages and is considered the onset of old age. Conversely, in many developing nations, chronological age holds less significance, with societal roles and the ability to contribute actively serving as defining factors of old age. (Kowal,2001)

Terms like 'elderly,' 'older persons,' and 'senior citizens' often suggest a uniform group, yet there exists substantial diversity among older individuals and across different societies, making a precise definition challenging. Ageing has been viewed

through various lenses, including biological, demographic, sociological, and psychological perspectives.

The World Health Organization (WHO) defines individuals aged 60 to 74 as elderly, while the United Nations (UN) recommended 60 as the threshold for the elderly population in 1980. The UN categorises the elderly as follows: 'Young Old' (60-75 years), 'Old-Old' (75-85 years), and 'Very Old' (85 years and above). In 2002, the World Population Data Sheet identified those aged 65 and above as part of the elderly population.

In the Indian context, the National Policy on Older Persons designates individuals above 60 as senior citizens, coinciding with the retirement age in the government sector. Terms such as 'Young-Old' (60-69), 'Old-Old' (70-79), and 'Oldest Old' (80-89) have been used to delineate different age groups within the elderly population. (Shettar, 2013)

Old age can be characterised by a number of factors including both physical and mental. These characters are not any stereotypes. Some marks of old age can vary from person to person depending on life situations. There are also some universally accepted general characteristics too.

The characteristics of old age encompass a range of physical, psychological, social, and spiritual aspects that define this stage of life. Some common characteristics include:

- Biological Changes: Old age is associated with physiological changes such as decreased muscle mass, diminished sensory perception, reduced metabolism, and increased susceptibility to illness and disease.

- Health Challenges: Older adults may experience chronic health conditions, disabilities, and functional limitations that impact their quality of life and independence. Managing health issues becomes a significant aspect of daily life in old age.

- Psychological Changes: Aging often involves changes in cognitive function, including memory decline, decreased processing speed, and changes in executive function. There may also be shifts in emotional regulation and psychological resilience.

- Social Changes: Old age can bring changes in social roles and relationships. This may include retirement from work, becoming a grandparent, and experiencing changes in social networks and support systems. Social isolation and loneliness are common challenges faced by older adults.

- Spiritual and Existential Reflection: Many older adults engage in introspection and reflection on the meaning of life, mortality, and spirituality. This can lead to a deeper sense of purpose and existential fulfilment.

- Adaptation and Coping: Older adults often demonstrate resilience and adaptability in the face of life changes and challenges. They may develop coping strategies to maintain autonomy and wellbeing.

- Diversity and Heterogeneity: It's important to recognize the diversity among older adults in terms of health status, socioeconomic status, cultural background, and life experiences. Ageing experiences vary widely among individuals.

- Continued Growth and Development: Despite the challenges of ageing, many older adults continue to pursue personal growth, learning, and meaningful activities. Maintaining a sense of purpose and engagement in life is crucial for wellbeing in old age. (Charles & Carstensen, 2010) & (Dziechciaż & Filip, 2014)

2.3.2 Old Age: Bio-psycho-social perspectives

The study of ageing and related phenomena has gained greater significance in recent years, with the realisation that the world is facing a shift towards an ageing population. Ageing is also a personal issue, as every individual has to go through

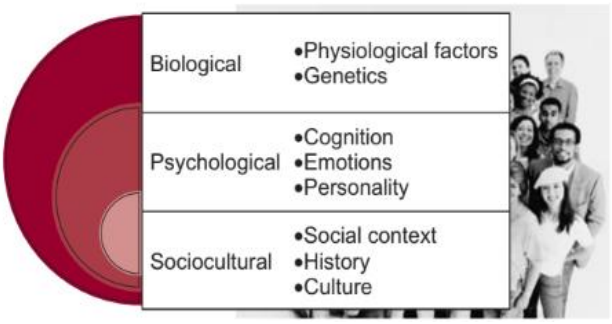
this human phase eventually. In order to understand the complexities and unique characteristics of ageing, a holistic approach is required - one that considers the interaction of biological, psychological, sociological and spiritual aspects of ageing. This bio-psycho-social approach is being adopted more frequently in studies related to ageing.

Figure 2.1 gives an outline of what the biological, psychological and sociological aspects involve.

The biopsychosocial model also implies that knowledge and insights from various fields like biology, medicine, nursing, sociology, history, and even the arts and literature help in gaining a holistic understanding of how individuals change and develop over time (Whitbourne & Whitbourne, 2011).

Figure 2.1

Biopsychosocial Model



Source: Adult Development and Ageing (Whitbourne & Whitbourne, 2011)

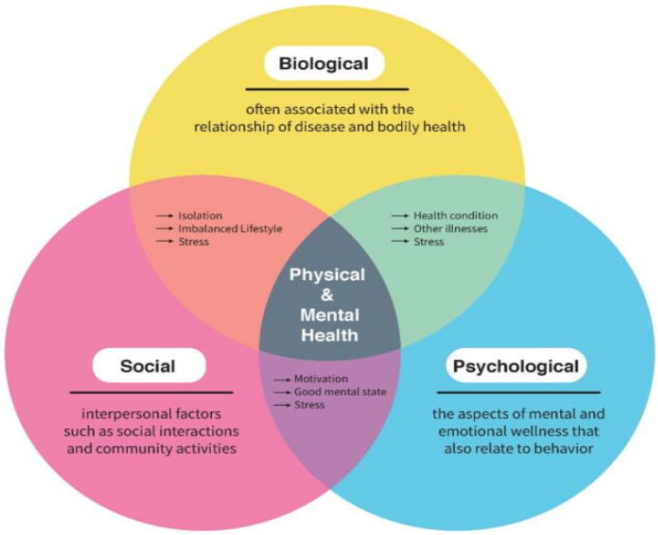
Biological ageing involves gradual changes in cell metabolism and physicochemical properties, leading to reduced self-regulation, tissue regeneration, and alterations in bodily structures and functions. This process is natural and irreversible, manifesting as successful, typical, or pathological ageing. Age-related biological changes impact mood, environmental perception, physical health, social engagement, and the status of the older adults within families and society. Psychosocial ageing encompasses individual awareness and adaptation to ageing. Various adaptation attitudes emerge, including constructive, dependent, and hostile behaviours toward oneself and others. As individuals age, challenges in adjusting to new circumstances increase, cognitive

and intellectual abilities may decline, sensory perception diminishes, and thought processes alter. Social ageing pertains to culturally influenced perceptions of ageing and societal attitudes towards it, which can evolve alongside changing customs and norms. (Dziechciaż & Filip, 2014)

The Bio-Psycho-Social (BPS) model is being widely applied in the medical field, as doctors and scientists have started to realise the inseparable relationships between these aspects. It demonstrates the importance of maintaining wellness in all these areas. (Megan, 2021)

Figure 2.2

Physical & Mental Health



Source: https://surgery.wustl.edu/three-aspects-of-health-and-healing-the-biopsychosocial-model/

The bio-psycho-social model is also a suitable framework in the field of mental health. Prior studies have identified a range of biopsychosocial elements that shift as individuals age, which can forecast mental health outcomes among older adults. Biological factors include age, gender, physical capabilities, health issues, and chronic illnesses. Psychological factors encompass mood, personality traits, and subjective feelings of wellbeing. Social factors contributing to mental health risks in older adults include smoking habits, levels of physical activity, sleep quality, daily

routines, social connections, marital status, feelings of loneliness, engagement with religion and spirituality, as well as early life circumstances. (Murniati et al, 2022)

A major drawback of the traditional biomedical model of ageing is that it cannot explain why older people, in spite of physical decline, still report high levels of life satisfaction. This is often referred to as the age-invariance paradox. Hence, it is not sufficient to study age simply in terms of physiological changes.

One of the criteria that can be used to define successful ageing is 'Subjective Well Being' (SWB). An older adult can regulate his/ her SWB, by choosing and pursuing a personally and culturally significant goal, which also satisfies psychological needs. Physical activity (PA) is key in this regard. PA has various physiological and cognitive consequences, which increase the vitality of the older adult, which enable him/ her to pursue the set goals. Being physically active also directly leads to satisfaction of certain psychological goals like self-respect. Moreover, the goals that a person chooses to pursue, and his/ her ability to pursue it, are heavily influenced by psychological and social-structural factors (Kanning & Schlicht, 2008).

Physical changes are very important indicators of old age, and are seemingly inevitable. However, advances in modern medicine, aided by factors like regular exercise and a balanced diet, can prolong health and delay the biological challenges of ageing. Psychological challenges like depression can be overcome and cognitive decline delayed through positive perceptions, self-esteem, and mental stimulation. Systems and sources for social support can positively impact the emotional health of older adults. These help to combat the usual decline in social interactions that accompanies ageing. By examining the bio-psycho-social factors that lead to healthy ageing, communities can create routines and systems to ensure that older adults remain an active and engaged part of it. (Dua, 2017)

2.3.3 Old Age: Risks & Challenges

The elderly population in India faces several pressing challenges, which include failing health, economic insecurity, isolation, neglect, abuse, fear, boredom, and lowered self-esteem.

- Failing Health: Aging is often synonymous with declining health. Elderly individuals account for a significant portion of doctor visits, hospitalizations, and bedridden days due to health issues. Access to quality, age-sensitive healthcare is limited, exacerbating the problem. To address failing health, there's a need for accessible healthcare services, preventive measures, and comprehensive care for elderly patients, including rehabilitation and end-of-life support.

- Economic Insecurity: Many elderly individuals struggle to sustain themselves financially, facing challenges like reduced productivity, competition from younger generations, and limited access to resources. Economic security is crucial for the elderly, necessitating support for income generation and social welfare grants for those unable to support themselves.

- Isolation: Feelings of loneliness and isolation are common among the elderly, often exacerbated by family and community dynamics. Inclusion in family and societal activities, along with community initiatives and counselling, can help alleviate isolation.

- Neglect: Elderly individuals, especially those dependent on others, require physical, mental, and emotional care. Neglect, stemming from changing lifestyles and family structures, can lead to serious consequences. Counselling, community sensitization, and legal interventions are necessary to address neglect.

- Abuse: The elderly are vulnerable to various forms of abuse, including physical, emotional, and financial abuse. Prevention efforts should focus on raising awareness, educating younger generations, and empowering the elderly about their rights.

- Fear: Many older individuals live in fear, rational or irrational, which needs to be addressed through reassurance, counselling, and preventive measures.

- Boredom (Idleness): Boredom arises from a lack of meaningful occupation and can lead to physical and mental decline. Encouraging productive

activities, utilising existing skills, and promoting recreational pursuits can combat boredom among the elderly.

- Lowered self-esteem: Lowered self-esteem among the elderly is influenced by factors such as isolation, neglect, and reduced responsibilities. Engaging elderly individuals in family and community activities, encouraging skill development, and fostering a sense of worth can help restore self-confidence.

Addressing these challenges requires a multifaceted approach involving healthcare, social support, community engagement, and policy interventions to ensure the wellbeing and dignity of the elderly population in India. (Swathy, 2016 & Sivaraju, 2011)

2.3.4 Policies and Schemes for the Elderly

The United Nations Principles for Older Persons, as outlined in General Assembly resolution 46/91 of December 16, 1991, can be summarised as follows:

- Independence: Older individuals should have access to basic necessities such as food, water, shelter, clothing, and healthcare. They should also have opportunities for income generation, control over their retirement decisions, access to education and training, and the ability to live in environments that suit their preferences and needs.

- Participation: Older persons should remain active members of society, contributing to policy-making processes, sharing their knowledge with younger generations, and engaging in community service and volunteering.

- Care: They should receive care and protection from their families and communities based on cultural values. Access to healthcare, social services, and institutional care should be available to maintain their wellbeing and dignity.

- Self-fulfilment: Older individuals should have opportunities for personal development, access to educational and cultural resources, and the ability to pursue their interests and goals.

- Dignity: They should be able to live with dignity, free from exploitation and abuse, and treated fairly and respectfully regardless of age, gender, race, disability, or other factors.

In essence, these principles emphasise the importance of supporting and respecting older persons' independence, participation, care, self-fulfilment, and dignity in society. (United Nations, 1991)

The National Policy for Senior Citizens 2011 in India is a comprehensive government framework aimed at addressing the needs and rights of the elderly population in the country. The key features of the policy are summarised below.

- Healthcare: The policy emphasises the promotion of accessible, affordable, and quality healthcare services for senior citizens, including preventive care, treatment, rehabilitation, and palliative care.

- Social Security: It aims to ensure financial security for senior citizens by enhancing access to pension schemes, social security benefits, and insurance programs tailored to their needs.

- Income Security: The policy recognizes the importance of providing income support to elderly individuals, including through pensions, savings schemes, and welfare programs.

- Housing and Livelihood: It underscores the need for senior-friendly housing and living environments that accommodate their specific requirements and promote independent living. Additionally, it encourages opportunities for continued employment or income-generating activities for those capable and willing to work.

- Care and Support: The policy advocates for the provision of adequate care and support services for senior citizens, including long-term care facilities,

day care centres, and home-based care services, to meet their physical, emotional, and social needs.

- Legal Protection: It emphasises the protection of the rights and interests of senior citizens through legal measures, including laws against elder abuse, exploitation, discrimination, and neglect.

- Social Integration and Participation: The policy promotes the active participation of senior citizens in community life, social activities, and decision-making processes, aiming to enhance their sense of belonging and social connectedness.

- Awareness and Education: It calls for awareness campaigns and educational initiatives to sensitise society about the rights, needs, and contributions of senior citizens and to dispel age-related stereotypes and prejudices.

- Research and Development: The policy encourages research and development efforts to address the evolving needs and challenges of senior citizens, including in healthcare, technology, and social services.

Overall, the National Policy for Senior Citizens 2011 reflects the Indian government's commitment to promoting the wellbeing, dignity, and rights of elderly individuals and fostering a society that respects and values its senior citizens. (National Policy for Senior Citizens, 2011)

2.3.5 Old Age: Support Systems

Traditionally, the family and the community have been the major support systems for the elderly. Family & social support is a complex construct which involves various aspects like daily living support, financial support, emotional support, decisional support, etc. These can be broadly delineated as instrumental support and affective support. (Wang et al, 2020)

Community-based supports and services (CBSS) are tailored to assist older adults living in communities, enabling them to stay in their homes safely and potentially avoid or delay institutionalisation. These services act as a bridge to specific

resources for older adults and their caregivers, offering wellness programs, nutritional assistance, educational sessions on health and ageing, caregiver counselling, as well as aid with housing, finances, and home safety. CBSS also fosters community involvement through volunteer opportunities, empowering individuals to take control of local aspects of their communities (Siegler et al, 2015).

For elderly individuals, community-based services are invaluable. They encompass various forms of support, with a focus on social support as a crucial component. Elderly individuals can access social support through senior centres, assisted living facilities, meal delivery services, religious groups, and adult day care centres, among others. These services offer meaningful social interactions to combat loneliness and isolation. However, effective social support goes beyond mere companionship or conversation; it should incorporate engaging activities, as highlighted by studies (National Care Planning Council, USA, 2011).

Senior citizens clubs or centres can meet the needs of older individuals by training them in essential life skills and offering guidance on available emergency support systems. Self Help Groups (SHGs) or Neighbourhood Groups (NHGs) for elderly women can help them engage in income-generating activities. This will enhance their confidence and self-esteem, and foster a sense of contribution to society. These groups also serve as platforms for elderly women to connect, share experiences, and relieve stress. NGOs can also actively initiate empowerment programmes for the elderly. (Thekkedath & Joseph, 2009)

Table 2.1 outlines some useful community-based services that will support the elderly and their caregivers.

Table 2.1: Community based services

Client services	**Description**
Home delivered meals	Meals delivered to the home of those who cannot prepare or obtain adequate nutrition

Congregate meals	Meals served in a community setting to those who cannot prepare or obtain adequate nutrition
Transportation	Includes subsidized mass transit, curb-to-curb paratransit and other assisted transportation, and driver education
Personal care	Hands-on or cueing to assist individuals with ADLs or IADLs
Homemaker services	Services designed to maintain a healthy home environment such as housekeeping, meal preparation, laundry, and shopping
Information and assistance	Used to help individuals or their representatives identify, access, and use support services (exclusive of case management)
Nutrition education and counseling	Assessment of and assistance in meeting of an individual's nutritional needs by a licensed nutritionist or dietician
Adult day care	Community-based program offering social, recreational, and health-related services in congregate setting
Case management	Professional management of an individual's health care; identification and assessment of biopsychosocial needs; monitoring use of services to ensure positive outcomes
Outreach	To inform and educate the public of the availability of services, benefits, and programs
Chore	Household tasks such as heavy cleaning and yard work
Legal assistance	Consultation and representation for consumer issues, housing, benefits, etc.

Caregiver services	Description
Respite	Can involve adult day care, in-home or brief periods out of home in a nursing home or assisted living facility
Access assistance	Assistance to caregivers to gain access to AOA programs
Counseling, support group, training	Miscellaneous: individual counseling; caregiver support groups; training in caregiving skills
Supplemental services	Extra services provided on a short-term basis

Source: (Siegler et al, 2015)

Support systems can be classified into formal and informal systems. The informal systems include kin, friends and neighbours, while the formal system consists of institutions. It is important to understand which group the elders will turn to, how frequently, for what and why.

There are two major theories in this regard. The 'Task - Specific Model' by Litwak postulates that the dependence on the support system is directed by the nature of the task and the characteristics of the support group. For example, for tasks that are of unpredictable nature and require less technical expertise, they tend to depend on informal support groups like friends and family. Within this, they may turn to neighbours for responding to emergencies, that require proximity and immediate action, while friends are called upon to meet social needs. Kin may be depended upon for financial or daily living needs. However, when the tasks are predictable and need professional expertise, the elderly may turn to formal support systems like nursing homes, care homes, day care centres, home nursing services, etc.

The 'Hierarchical Compensatory Model' by Cantor suggests that the dependency is directed by the primacy of the relationship. The elderly first turn towards the most preferred group, usually the kin, and, in the absence of this group, the next preferred group takes over, and so on. This is independent of the nature of the tasks. From this

perspective, institutional care usually comes as the last resort for those who have no other support groups. (Vogel & Palmer, 1985)

From these two theories, it can be inferred that institutional care is preferred in two cases - one, when there is a felt need for professional support, and two, when there are no other support systems available.

Research indicates that the living arrangement significantly contributes to the wellbeing of elderly individuals. In India, the prevalent living arrangement for the elderly involves co-residing with adult children in extended or multi-generational families, where family members offer financial support, personal care, and emotional assistance. (Sharma, 2021)

Studies have shown that the majority of elderly individuals express a preference for ageing in their own homes, known as "ageing in place," as it offers familiarity and comfort. However, the expenses associated with necessary home modifications can often pose significant barriers. To address this challenge, numerous organisations are leveraging housing as a means to offer supportive services tailored to the needs of the elderly. These services are designed to enable older adults to stay in their homes while still receiving necessary assistance, fostering continued engagement with their communities. (Ageing in Place, 2013)

Despite the increasing trend of nuclear families, especially in urban areas, the family system remains the primary source of support for the elderly. However, this arrangement often places a significant burden on the primary caregiver, typically a female family member. A balanced approach would involve continuing care within the family structure while integrating community support, such as home nursing services, respite care, and senior centres, to alleviate caregiver stress.

Furthermore, institutional care should not be viewed as a last resort but rather as a suitable option for individuals requiring intensive support, particularly when the elderly person's behavioural issues stem from organic causes. Admission to institutional care should not be perceived as neglecting the elderly; instead, it should be seen as a decision made in the best interest of their wellbeing. (Gupta, 2009)

2.3.5 Institutional Care of the Elderly

The history of English workhouses dates back to the 1830s, where records show they typically accommodated around 300 individuals, including the elderly, sick, orphaned children, unemployed, and people with disabilities. By 1851, there was a noticeable increase in the population aged above 65, leading to the transformation of workhouses into geriatric homes post-World War II, with a similar rise in older people within lunatic asylums.

Residents in these institutions were often segregated from the community and managed by institutional authorities, which raised concerns about loss of independence, privacy, dignity, and choice. Financial constraints further complicated admissions to care homes, with legislation later dividing care responsibilities between health authorities and local/social services.

The Registered Homes Act of 1984 and subsequent regulations aimed to establish quality standards for care homes, leading to periodic inspections by local authorities. Eventually, care homes evolved into small businesses, with entry criteria based on needs and financial assessments conducted by social workers. (Harbishettar et al, 2021)

Intellectual debates from the 1950s onwards, highlighted by researchers like Barton, Goffman, Foucault, and Szasz, examined the institutional role in society and its impact on residents. While Foucault and Szasz viewed institutions as sites of repression and social control, Barton and Goffman focused on the depersonalization experienced by residents within these settings. (Menezes, 2020)

Literature in the UK in the 1980s and 1990s discusses the merits of a ‘service’ model to residential care homes, rather than a ‘social care’ model.

In the social care approach, the home management is held fully responsible for the wellbeing of the elderly resident, implying that the latter is incapable of doing so on his own. This pressurises the caregivers to restrict the privacy, independence and dignity of the elderly in their care. Even though responsible risk taking was

recommended in these homes by policy, the staff tended to completely avoid risks, due to fear of being held responsible for any untoward incident.

Researchers have suggested the ‘service’ model, where the relationship between the home management and the elderly resident is similar to that of a hotel manager with his client. Residential care homes could be privately owned, with affordable pricing, which would fit the pension budget of the elderly. The staff will be available to ‘serve’ the residents, but only at the latter’s behest. Some case studies are also seen, which bring out the success of this model, which ensures privacy, dignity and independence to the elderly residents. (Bland, 1999)

In modern India, the documented history of residential care for older adults traces back to 1814 with the establishment of the first facility in Madras (now Chennai) by a society formed by British merchants and bankers. This facility aimed to assist Anglo-Indians and domiciled Europeans facing difficulties. Subsequently, in 1882, another home for the aged was founded in Kolkata by Asphar, a Maltese individual, under the banner of the "Little Sisters of the Poor." These early facilities provided essential support such as shelter, clothing, and medical care to those who could not live independently but were capable of managing personal or nursing needs.

Initially, the focus of these institutions was primarily on fulfilling basic requirements. Religious organisations also contributed by establishing ashrams for the elderly, offering basic care within a spiritual environment. Over time, the scope of care expanded to include nursing, nutrition, and physical and mental health services.

Residential care homes for the elderly in India currently operate within a non-formal sector, making it challenging to ascertain exact numbers officially. However, HelpAge India estimated approximately 1,176 senior living facilities in 2009, with Kerala, West Bengal, and Tamil Nadu having notable numbers. A 2018 survey conducted by Tata Trusts, the United Nations Population Fund, and the NGO Samarth revealed that the existing facilities were inadequate to meet the growing demand for senior living options. (Harbishettar et al, 2021)

Traditionally, Indian society upheld the value of "filial piety," with elderly individuals residing with their offspring. However, societal changes such as the nuclearization of family structures have altered this dynamic. As a result, older adults are increasingly finding themselves living alone or relocating to old age homes, a trend once considered taboo (Dommaraju, 2015). Old age homes are now emerging as a viable accommodation option for seniors in Indian society, reflecting evolving psychosocial values and family dynamics. (Akbar et al., 2014).

There is a basic question here regarding who the elderly can depend upon to be responsible for their security in old age. With the traditional familial roles breaking up, the natural choice would be to turn to the State. The Government of India has brought in legislation and schemes for the elderly, as mentioned in the previous section. Still, these policies may not be enough to ensure continued day to day support and security. This is where the Market emerges as a potential option. Private elder care services range from telephone help lines, home delivery of medical services, meal or grocery delivery, escort to doctor appointments, help in completing tax forms, etc. In the USA, elderly persons, in case they need such services, prefer to pay for it, as it gives them a sense of independence, due to the reciprocity of the transaction. In India, NRI children usually do not hesitate to pay for such services for their parents, as they want their parents to have a good life, but cannot give them their own proximity.

Paid old age homes also belong to this category of services. Old age homes, whether managed by non-profit organisations or private entrepreneurs, typically charge monthly rates and often require a significant joining fee or security deposit. The monthly fees for a moderately-priced old age home are comparable to the salary of a full-time domestic servant in the area. They are affordable for individuals with pensions, substantial savings, or children who are employed and can afford to cover the expenses. (Lamb, 2013)

The old age home industry consists of both not-for-profit and private facilities. Private homes primarily serve older individuals from the 'middle class' who can afford their services, while charitable organisations in the not-for-profit sector cater to older people lacking financial resources. The Integrated Programme for Senior

Citizens offers essential amenities such as food, shelter, and medical care to older adults lacking support, and it operates through state-level grants distributed directly to registered old age homes and day centres. In the fiscal year 2018–2019, only 310 facilities received funding through this program nationwide. Accurate records regarding the total number of old age homes in India and the number of residents within them are unavailable because homes without funding are not required to obtain licences, register, or undergo inspection. (Burholt et al, 2022)

Considering both the for profit and non-profit models, the Elderly Care Homes in India can be broadly classified into three types (Mittal, 2021)

1. Destitute Homes (or Ashrams): In India, a significant portion of the elderly population belongs to economically disadvantaged backgrounds and relies on family support. However, many elderly individuals from such backgrounds are left without adequate financial or social assistance. Destitute homes offer free care for the elderly who lack family support. These homes, supported by the government or charitable organisations, provide shelter, food, clothing, and medical treatment at no cost.

2. Old Age Homes (Paid): These are primarily private, for-profit entities that cater to middle-income elderly individuals. Paid old age homes offer various services, including shelter, food, clothing, and medical care, at affordable prices. They serve as viable options for elderly individuals who are ill and have no one to care for them. While residents may experience loneliness due to separation from their families, they also value the independence provided by these homes.

3. Retirement Homes: Designed for financially secure individuals aged 55 and above, retirement homes cater to an affluent segment of the population. These senior living communities offer a range of services, including healthcare, accommodation, and hospitality. They are available for lease or outright purchase and often feature amenities such as clubhouses, swimming pools, and gyms. As the senior housing sector in India is still emerging, the services and facilities offered by developers vary across cities and projects.

> Approximately 75% of developers provide basic amenities such as shelter, food, and medical care, along with additional features like Wi-Fi internet and library access. About 25% of developers offer premium amenities such as clubhouses and spas. Additionally, most retirement homes have partnerships with reputable hospitals and medical care providers, with staff trained in geriatric care (Senior Housing: A Sunrise Sector in India, 2017).

The concept of senior living communities has existed in the West since the early 80s. In India, developers are just beginning to grasp the huge business potential in this sector. (Jain, 2019)

The senior living sector encompasses a blend of real estate, hospitality, and care services, offering high-quality housing and nursing facilities to address the needs of an expanding elderly population. It provides a range of options, from independent living arrangements in early retirement to more needs-based solutions such as assisted living, memory care, and skilled nursing as individuals' care requirements evolve.

In response to today's dynamic and ever-changing market landscapes, the senior housing sector offers specialised solutions. Multi-modality Continuing Care Retirement Communities (CCRCs) integrate various levels of care within a single setting, enabling residents to age in place comfortably. Investments in the senior housing sector have proven to yield significant returns within the real estate market while also serving as an effective platform for delivering home care, healthcare services, and social and environmental support efficiently and comprehensively.

In the cultural context of South Asia, residing at home is the preferred living arrangement for the elderly. The decision to consider alternative residential options typically arises when family members, especially male offspring, are absent, or when the caregivers are unable to cope with the demanding physical and mental health needs of the elderly, necessitating respite or long-term care. Moreover, instances of neglect or abuse by familial caregivers also prompt the exploration of residential care options. Consequently, comparing the conditions and outcomes of

elderly individuals receiving in-home care versus residing in residential care homes is not straightforward in the Indian context. (Senior Housing, 2017)

In India, a country with a population of 140 million older individuals, only 0.07% reside in old age homes or retirement facilities. The idea of such homes is relatively new in India, and many people still resist the notion due to traditional beliefs. However, as societal dynamics change rapidly with economic shifts and children moving away in search of better prospects, attitudes toward old age homes have evolved. While Indians hold strong emotional ties to their homes in old age, they increasingly view these facilities as a viable option, though often as a last resort.

Rather than permanent residency, there's a growing preference for short-stay options among the elderly and their families. Traditional Indian communities also seek community-based day-care centres for the elderly, offering various services like skill-building, financial, medical, legal advice, and entertainment. Active participation of the elderly in such centres is deemed important.

Given these trends, there's a pressing need to establish more senior citizens' homes, day-care centres, and shelters equipped with comprehensive care services, especially for destitute elderly individuals lacking family support from marginalized sections of society. (Agewell, 2021)

A literature review conducted in India revealed a diverse range of experiences and perspectives among older adults residing in residential facilities. While some older adults express positive views regarding such facilities, citing reasons like enhanced security, access to medical attention, and a sense of independence, the majority still express a preference for their own homes and families despite having encountered neglect or abuse in those settings. Common stressors associated with residing in residential facilities include difficulties in adapting to a new environment, adherence to strict schedules, declining functional abilities, separation from family and community, feelings of social isolation, a sense of powerlessness, and exposure to frequent instances of illness and death within the facility (Harbishettar et al, 2021).

Feelings of loneliness can be particularly distressing for elderly individuals, especially when they have lost their spouse and their children have moved out of the home for reasons such as education or employment. While many elderly individuals seek solace within their social networks to alleviate loneliness, some find themselves isolated and lonely despite having such connections. This situation often prompts them to consider moving to old age homes, where they can engage with others and share their experiences, thereby finding companionship and support. (Kapur, 2018)

Old age homes offer specialised medical services, balanced meals, and amenities like communication facilities and entertainment, ensuring residents' physical and emotional wellbeing. Residents of old age homes often feel a sense of belonging and support, sharing their joys and sorrows with fellow residents, fostering a familial atmosphere. Old age homes provide seniors with ample leisure time to pursue creative activities in a peaceful environment without the burden of work or excessive responsibilities. Residents have the freedom to observe and participate in religious activities, fostering a harmonious and leisurely lifestyle. Safety is a significant concern for seniors, and old age homes provide consistent security, offering a stable and comfortable living environment. (Bhat, 2021).

The Government of India, as well as different state governments have provided non-profit organisations that run old age homes with a minimum set of standards to be followed. These focus on physical elements of the facilities (e.g. the size of room, presence of CCTV), access to basic services (e.g. productive activities for residents, housekeeping and assistance with daily activities) and medical services. However, these standards have no clear definitions of concepts related to other human rights and needs, like dignity, quality of life, etc. (Burholt et al, 2022)

Kerala, with a population of approximately 35 million, is one of the most densely populated states in India. The elderly population, aged 60 and above, accounts for 13% of Kerala's population, which is higher than the national average of 8% in India.

Along with the breakup of the joint family system, another major reason for the change in Kerala's social structure is the migration of young people, both within India and abroad. (In Kerala, a significant portion of the working population migrates to countries like the Middle East and the West). This has resulted in an increase in elderly individuals living alone, especially after the death of their spouses, which they found challenging, particularly men. In response to this growing need, homes for the elderly began to emerge in Kerala, experiencing an increase in demand and acceptance. Some elderly individuals choose to move into these residential facilities willingly, while others do so out of necessity.

Institutional care for the elderly in Kerala dates back to 1957, and by 1999, there were approximately 144 old age homes in the state, managed by various entities including government agencies, religious bodies, and social service organisations. These homes range from free government-run facilities catering to the economically disadvantaged to paid luxury retirement facilities serving higher socioeconomic groups.

In recent years, Kerala has witnessed a surge in elder care facilities offering top-notch healthcare services and social activities while promoting independence. Many individuals, particularly those with financial stability and high-paying jobs, have chosen to move into these facilities for a more comfortable lifestyle.

This trend reflects an emerging group in society with distinct needs and reasons for opting for elderly care facilities, different from the traditional population of such homes. This option is increasingly viewed as an attractive one for older individuals in Kerala. (Augustine, 2020).

According to studies by the Confederation of Indian Industries, the top 5 concerns of senior citizens that prompt them to choose living in an institution are given in Figure 2.3

Figure 2.3

Five Concerns of Seniors

Source: CII - Senior Care Industry Report India 2018: Igniting potential in senior care services' May 2018.

Furthermore, like most advanced economies, India is experiencing the phenomena of feminization of ageing, as seen by a sex ratio that favours women among elderly, with 1033 elder females per 1000 elder males (Gupta, 2016).

Essentially, in traditional Indian society, women often define themselves in relation to their husbands. They have significant dependency on their fathers, husbands, and later on their sons, both economically and socially. Factors such as limited education and access to healthcare further increase the vulnerability of elderly women compared to men. The question is that if men, who were once active in the workforce and are now considered burdensome, then how will women, who have historically been unseen contributors, be treated when they are no longer deemed useful. (Singh et al, 2014)

Studies show that, though the feminization of ageing has begun in India, it is not uniform across the country. Childlessness and widowhood are important considerations which prompt the decision to move to an old age home. Middle class women, who can afford it, prefer paid homes. (Kalavar & Jamuna, 2011)

Another reason that compels elderly women to move to old age homes is the abusive behaviour of their children or other family members. Emotional abuse, abandonment, financial exploitation, physical mistreatment, and neglect are commonly experienced by elderly women. The primary perpetrators of abuse tend to be sons and daughters-in-law. Many widows feel that they are a burden to their families. Financially independent elderly individuals may face abuse for not relinquishing their assets to their children. A study in Assam shows that spousal violence is prevalent among married elderly women, even in their later years. Those aged 80 and above, or those dealing with health problems, often attribute their abuse to health-related concerns. (Patir, 2023)

Given the greater life expectancy of elderly women compared to men, their social circumstances represent a significant focus of current research. Following years of active family engagement, transitioning to institutional settings often leads to psychological and social challenges that impact their quality of life. These challenges manifest as increased dependency, social isolation, and limited mobility or confinement to beds, arising not only from chronic health issues but also from psychosocial factors such as reduced social and family support and changing life circumstances. (Minimol, 2016)

Due to a lack of psychological and emotional support, women in old age homes may experience depression. They may show their emotions through irritability and short tempers. Some attempt to cope by engaging more in religious practices like prayer and meditation. (Vincent & D'Mello, 2019)

Adapting to a new environment poses significant challenges. Adjustment entails aligning oneself with the requirements of the environment, involving the dynamic interaction between an individual and their surroundings. This process is ongoing and involves the modification of both the individual and the environment, whether they are physical, social, or psychological in nature. (Babu & Reddy, 2012 in Sandhyarani & Rao, 2014)

For older people, especially women, the transition from ‘home’ to ‘old age home’ is not an easy process. Even though they try their best to compromise, adapt, adjust and be happy this still creates a lot of stress.

Research underscores the importance of diverse social interactions for stress reduction, improved health, and longevity. The elderly possess a strong capacity for social involvement, which is vital for maintaining mental wellbeing. Encouraging participation in family meetings, group activities, and community service can enhance social engagement and recreation. Involving elderly women in activities like sharing life experiences in educational settings can combat isolation and provide a sense of purpose.

Government policies should establish quality standards for old age homes, ensuring they are elderly-friendly and safe. Regular assessments and multidisciplinary teams comprising medical professionals, therapists, nutritionists, and social workers should support these institutions. Training in geriatric care, including risk management, will facilitate individualised care tailored to the needs of the elderly, promoting overall wellbeing beyond mere institutional care. (Minimol, 2016)

2.3.6 Quality of Life of Institutionalised Elderly

The concept of Quality of Life (QoL) is recognized as highly intricate, abstract, and multifaceted, making it challenging to define and apply consistently in research and practical settings. QoL is significant across various fields including environmental, social, medical, and psychological sciences, as well as in public policy and general public perception. Despite its importance, there remains a lack of consensus regarding its precise definition. (Panday, 2017)

The terms 'quality-of-life', 'wellbeing', and 'happiness' have distinct meanings, yet their usage is vague and inconsistent. Sometimes, they are used to denote everything that is good and valuable, and sometimes they refer to specific merits. To understand the term ‘Quality of Life’ better, there is a classification proposed, based on two divisions: between life 'chances’ and life 'results', and between 'outer' and 'inner' qualities. These divisions yield four aspects of life quality: 1) the livability of

the environment, 2) the life-ability of the individual, 3) the external utility of life, and 4) the inner appreciation of life. (Veenhoven, 2000)

Figure 2.4 gives a visual representation of this classification.

Figure 2.4

Four Qualities of Life

	Outer qualities	*Inner qualities*
Life chances	Livability of environment	Life-ability of the person
Life results	Utility of life	Appreciation of life

Source: (Veenhoven, 2000)

While studying quality of life, a significant factor that needs to be considered is what is termed as 'Response Shift'. This refers to a change in the meaning of one's self-evaluation of a target construct (here, the Quality of Life) as a result of: (a) a change in the respondent's internal standards of measurement (scale recalibration, in psychometric terms); (b) a change in the respondent's values (i.e. the importance of component domains constituting the target construct); or (c) a redefinition of the target construct i.e. reconceptualization. (Sprangers & Schwartz, 1999)

There is considerable evidence in literature regarding paradoxical and counterintuitive findings, which may be explained through the concept of response shift. For instance, individuals facing life-threatening diseases or disabilities have been observed to consistently report a stable quality of life (Andrykowski et al., 1993; Bach and Tilton, 1994). Many studies employing self-report questionnaires have come out with findings which indicate that cancer patients often do not exhibit a lower quality of life compared to the general healthy population. This contrasts with findings from more in-depth interviews and the observations of healthcare professionals. This tendency of underreporting appears to extend to other patient

groups as well. This phenomenon elucidates how perceptions of quality of life are shaped. Here, there is a shift in the internalised standard against which patients gauge their perception. Consequently, a genuine effect, such as a decline in quality of life due to cancer, may be entirely masked. Hence the researcher needs to exercise caution when interpreting responses in questionnaires related to quality of life, psychological distress, and similar aspects. Breetvelt and Van Dam, 1991).

Theoretical debates regarding what makes up a good quality of life and how to measure it are closely linked to discussions about successful ageing. Key aspects like independence, social engagement, personal growth, control over one's life, fulfilling social roles, cognitive abilities, adaptability, and overall wellbeing are seen as important for both quality of life and successful ageing (Larson 1978; Andrews 1986; Baltes and Baltes 1990; Day 1991; Lawton 1996; Fry 2000 in Brown et al, 2004).

Does institutionalisation affect the Quality of Life of the Elderly? Literature cites many studies where the QoL of institutionalised elderly have been compared with those of their community dwelling peers. These studies are much varied with regard to the specific aspects of QoL addressed, the geographical area, the socio-demographic profile of participants, the questionnaire used, etc. Hence, conclusive and generalised results are not expressly stated, and further evidence-based studies are required. (de Medeiros et al, 2020)

Earlier research on institutional care has focused on evaluating the quality of care provided rather than examining what contributes to the quality of life for residents themselves. Additionally, the emphasis has often been on the perspectives of staff rather than those of the residents (Birren et al., 1991). Staff perspectives have highlighted the importance of empowerment in promoting activities and independence, thus enhancing quality of life (Wells et al., 1986; Brown and Thompson, 1994; Saul, 1993). Staff generally perceive social engagement among residents and fulfilling social roles as crucial for quality of life (Abbott et al., 2000). Concerns have been raised about the negative impact of changes, particularly the transition to residential care, on residents' quality of life (Oldman and Quilgars, 1999).

There have been observations regarding potential conflicts between maximising residents' perceived quality of life and meeting institutional or financial regulations. For instance, Glendinning (1977) acknowledged the tension between maximising living space options within care homes and adhering to fire and safety regulations.

However, what about the perspectives of older residents themselves? Denham (1991) and Davies (1981) detailed aspects such as physical wellbeing, emotional health, and overall health as significant for older people's quality of life, yet there's a lack of empirical research on whether residents themselves in institutions consider these aspects important. Even when residents' perspectives have been sought, predefined aspects of quality of life have often been presented to them, with residents simply indicating their relative importance (Birren et al., 1991).

Regarding the views of older individuals in the community regarding residential care, Sinclair and Williams (1990) found that loss of independence and privacy, as well as the potential for unpleasant social interactions, were seen as detrimental to quality of life, while improved physical surroundings and efforts to combat loneliness were viewed positively. There are both similarities and differences in the dimensions of quality of life identified by residents of institutional care and older individuals in the community. When relationships were mentioned, the emphasis was on the quality of these relationships and the importance of fostering connections with like-minded individuals (Abbott et al., 2000; Watkins, 1996; Biggs et al., 2000; Peace et al., 1979). Independence and autonomy were valued, often linked to desires for social or practical roles (Abbott et al., 2000; Oldman and Quilgars, 1999). Concerns also included safety, cleanliness, and food variety (Biggs et al., 2000), as well as positive staff attitudes, respect for individuality, and privacy (Fenton, 1985; Spalding and Frank, 1986; Uting, 1977). Additionally, there is a desire for more privacy and less impersonal treatment of residents (Fenton et al., 1985).

Assisted living facilities often lack in providing satisfactory social and environmental aspects of life quality. Residents in such facilities experience limitations compared to their previous independent lifestyles. To compensate for their restricted freedom, it's essential to diversify social activities and extend visiting

hours with relatives whenever feasible. As women residing in assisted living facilities generally report lower quality of life scores compared to men, empowering them with self-care responsibilities and allowing them to personalise their living spaces akin to their previous homes could be beneficial. Professional support, both physical and psychological, must be readily available. Moreover, initiatives aimed at helping elderly individuals remain in their own homes and social settings should be developed and promoted. (Bodur & Dayanir, 2009)

Some studies have found that elderly individuals residing in sheltered housing exhibit higher scores on the "social functioning" scale, compared to those living independently in the community. Sheltered housing provides a range of social activities conveniently accessible to residents within their living environment. This accessibility reduces the need for significant effort to engage in social interactions, even for those facing emotional or mental challenges. Additionally, the presence of peers of similar age fosters social comparisons that may encourage participation in these activities, supported further by staff encouragement. Conversely, logistical barriers often hinder participation in social activities for elderly individuals residing in the community. (Bodner et al, 2011)

A Study comparing the health-related quality of life (HRQoL) indicators between institutionalised and community-dwelling elderly men and women shows that Elderly men residing in institutional settings reported higher scores in both physical and psychological aspects of Health-Related Quality of Life (HRQoL) when compared to their counterparts living in the community. However, both institutionalised and community-dwelling elderly women displayed comparable levels of HRQoL. Even though institutionalised elderly individuals, both men and women, were older than their counterparts living in the community, they demonstrated similar performance in physical assessments. These findings suggest the effectiveness of the rehabilitation program provided at the institution, which involves a multidisciplinary team comprising physicians, physiotherapists, psychologists, nurses, nutritionists, and kinesiologists. Comprehensive health services are given, including exercise programs, nutritional guidance, and social support, thereby promoting improvements in the physical capabilities of elderly individuals.

Despite their positive physical profiles, institutionalised elderly participants exhibited lower proficiency in performing basic and instrumental activities of daily living compared to community-dwelling elderly individuals. This difference is likely attributed to the lower cognitive capacity observed in institutionalised elderly individuals, as cognitive functions play a significant role in the ability to perform daily activities.

Despite their high levels of dependence, institutionalised elderly participants reported similar or even better HRQoL indicators compared to their community-dwelling counterparts. This could be attributed to factors such as the physical fitness of the elderly individuals and the amenities provided within the institution, including easily accessible spaces, short hallways, handrails, and walking paths that enhance the sense of safety. Additionally, the presence of a full-time healthcare staff likely contributes to the improved perception of HRQoL among institutionalised elderly individuals. (Cucato et al, 2016)

A program called the ‘supportive community’ was developed in Israel for older people who live at home. The program provides its members with a service package that includes medical and social services, emergency call-button, cultural activities, and a ‘community parent’ who is responsible for the members. Studies found that the quality of life among the older people living at their homes who are members of a supportive community was higher than among the older people living in a nursing home. (Even-Zohar, 2014)

Another study finds institutionalised individuals generally scoring lower in quality of life, wellbeing, and functionality due to factors like dependence, functional limitations, and reduced autonomy associated with institutionalisation.

Regarding the risk of falls, older adults in geriatric clubs and those residing at home had lower risk scores compared to those in geriatric homes. However, falls remain a significant concern among older adults, with studies reporting high incidence rates, particularly among institutionalised populations.

Physical activity levels were generally lower among institutionalised older adults, possibly due to sedentary lifestyles associated with ageing and institutionalisation. Despite this, some studies emphasise the positive impact of physical activity programs in institutional settings.

In terms of physical condition, non-institutionalized individuals generally exhibited better muscle strength, aerobic capacity, and flexibility compared to those in long-term care institutions. Functional deterioration, particularly in lower limb strength and flexibility, was observed among institutionalised older adults. (Beltran et al, 2017)

Elderly individuals in institutionalised settings have been seen to demonstrate a lower perception of primary control, indicating less confidence in their ability to influence outcomes in their environment compared to those living in the community. Since control perception correlates with autonomy, a key factor in assessing the quality of life among the elderly, these results suggest that institutionalisation negatively impacts quality of life, especially when institutions lack resources to offer diverse activities aimed at enhancing control perception and overall wellbeing.

The inherent nature of institutionalisation limits the ability to control one's life with constraints in managing one’s belongings, restricted freedom over one’s time, space, social interactions, and decision-making. Within the institutional context, loss of reference points, belongingness, and individual autonomy are overshadowed by administrative decisions, leading to feelings of apathy, passivity, and identity loss, consequently diminishing control perception. Moreover, many institutionalised elders are already advanced in age, with declining health, precarious finances, and a history of abandonment or neglect by family members, all factors contributing to lower control perception.

In contrast, older adults living in the community have more opportunities to exert control over their lives, make decisions, and exercise autonomy, thereby having greater freedom to shape their living environment.

The availability of personal space influences control perception within institutions. The high social density in institutional living compromises privacy, a crucial aspect for control perception, especially considering that seniors' rooms are their only truly personal spaces. (Khoury & Sá-Neves, 2014)

Another study shows that institutionalised elders show better QoL in Physical domain, but a lower QoL in the social domain, compared to their community- living counterparts. The improved physical health of institutionalised elderly may possibly be attributed to consistent mealtimes and reduced physical strain. Conversely, their social wellbeing appears to be lacking, potentially stemming from diminished social interactions compared to those in the community who benefit from closer proximity to family members and neighbours.

Counselling, fostering intergenerational connections, and providing social and family support are crucial, particularly for elderly individuals in institutional settings. To facilitate these efforts, it is important to empower the elderly through training for income-generating activities, with the involvement of non-governmental organisations. Additionally, fostering inter-sectoral coordination between local government bodies like Panchayat Raj and Health departments is essential. Regular health assessments, encompassing both physical and mental wellbeing, should be conducted periodically for individuals residing in old age homes and within the community alike. (Kumar et al, 2020)

While designing interventions to improve the Quality of Life of the elderly, it has to be taken into account that the elderly are also resourceful themselves. Identifying and harvesting these resources to make them partners in their own care, is possible by adopting a strengths-based approach.

2.3.7 Strengths-Based Approach

Traditionally, professionals have addressed elderly care by focusing on dependency and the associated burden. However, older people are a valuable resource for families and society, demonstrating significant strength and potential. The older workforce has seen a notable increase, doubling from 62 million in 1950 to 141

million in 2000, and is projected to reach nearly 195 million by 2050. Older people often care for orphans and grandchildren, taking on significant caregiving roles within families, especially in communities where they traditionally supported child-rearing. They also contribute substantially to volunteering, especially in community and welfare organisations, with older volunteers dedicating more time than younger ones.

Socially, older people maintain strong relationships with family and friends, providing emotional support and stability. They often live with others, including spouses, and continue to play crucial roles within extended families. Many older adults are primary carers for other older individuals, particularly their spouses. They also support their adult children financially and practically, establishing reciprocal family support patterns. Grandparenting has become increasingly significant, with modern grandparents being more active and involved in their grandchildren's lives than previous generations.

Thus, older individuals significantly impact the workforce, family dynamics, and community support systems, showcasing their enduring value and multifaceted contributions to society. (Ponnuswami et al, 2012)

Given the vast knowledge, practical wisdom, and diverse skill sets of older individuals, it is only logical that social work interventions for the elderly adopt a strengths-based perspective. This shift emphasises viewing the elderly as valuable resources. International organisations, including the United Nations, advocate for this paradigm shift, encouraging all stakeholders, including the elderly themselves, to adopt this perspective. (Ponnuswami et al, 2012)

Strengths-based practice involves a collaborative process between individuals receiving support and their supporters, working together to achieve outcomes by leveraging the individual's strengths and assets. This approach emphasises the quality of the relationship between the support provider and recipient, as well as the unique contributions of the person seeking support. By fostering collaboration, it enables individuals to be co-producers of services and support rather than mere consumers (SCIE, 2014).

A strengths-based approach in social work focuses on placing individuals, families, and communities at the centre of care and wellbeing, enhancing relationships within the community, and building social capital. It responds to needs while emphasising the positive attributes and potential of individuals and neighbourhoods. This approach is grounded in the belief that social work relationships are collaborative and that people are inherently resourceful and capable of solving their own problems with appropriate support.

The strengths perspective highlights the resilience inherent in human nature, which is fundamental to social work practice. This perspective is particularly relevant for working with older adults, who can draw on their extensive life experiences to address current challenges. (Roundtable Report, SCIE, 2017)

Almost anything can be considered as a strength, under a given set of circumstances. It includes, but is not limited to, the insights gained from overcoming challenges like abuse, trauma, illness, and oppression; personal qualities, traits, and virtues; knowledge acquired both intellectually and through life experiences; individual talents; cultural and personal stories; pride in personal achievements; community support; and spirituality. (Saleeby, 2009)

Empowerment, resilience, and membership are key concepts in the strengths-based approach. Empowerment involves helping individuals, families, and communities identify and utilise their internal and external resources and tools (Kaplan & Girard, 1994, in Saleeby, 1996). Resilience is the capacity to recover from adversity (Garmezy, 1994, in Saleeby, 1996). Membership emphasises the importance of individuals being responsible and valued members of a supportive group or community (Walzer, 1983, in Saleeby, 1996).

Strengths-based approaches seek to transform the assessment and support of individuals with care needs by social work and social care services. These approaches shift the focus from identifying needs and deficits to recognizing resources and strengths, with the primary goal of enhancing the lives and wellbeing of users and caregivers. Strengths-based care models leverage personal resources,

social networks, and community assets to empower individuals to achieve their goals. (Department for Health and Social Care, UK, 2019 in Caiels et al 2021)

A key aspect of strengths- or asset-based approaches is their focus on positive health and wellbeing. This is rooted in two main principles. First, they emphasise identifying and unlocking the nurturing factors within the user's environment that promote wellbeing. Second, they serve as an alternative to the deficit approach, which focuses on the causes of illness, problems, needs, and deficiencies (Foot, 2012 in Caiels et al 2021). Strengths-based approaches represent a positive shift from a pathogenic response to illness to a salutogenic one. The salutogenic theory emphasises the factors that create and sustain human health and wellbeing, rather than those causing disease (Antonovsky, 1979 in Caiels et al 2021), and is a well-established concept in public health and health promotion (Lindström & Eriksson, 2005 in Caiels et al 2021).

Table 2.2 gives a comparison of the traditional pathogenic approach and the strengths-based approach (Saleeby, 2009)

Table 2.2: Comparison of Pathology and Strengths

Pathology	Strengths
Person is defined as a "case"; symptoms add up to a diagnosis.	Person is defined as unique; traits, talents, resources add up to strengths.
Therapy is problem focused.	Therapy is possibility focused.
Personal accounts aid in the evocation of a diagnosis through reinterpretation by an expert.	Personal accounts are the essential route to knowing and appreciating the person.
Practitioner is skeptical of personal stories, rationalizations.	Practitioner knows the person from the inside out.
Childhood trauma is the precursor or predictor of adult pathology.	Childhood trauma is not predictive; it may weaken or strengthen the individual.
Centerpiece of therapeutic work is the treatment plan devised by practitioner.	Centerpiece of work is the aspirations of family, individual, or community.
Practitioner is the expert on clients' lives.	Individuals, family, or community are the experts.
Possibilities for choice, control, commitment, and personal development are limited by pathology.	Possibilities for choice, control, commitment, and personal development are open.
Resources for work are the knowledge and skills of the professional.	Resources for work are the strengths, capacities, and adaptive skills of the individual, family, or community.
Help is centered on reducing the effects of symptoms and the negative personal and social consequences of actions, emotions, thoughts, or relationships.	Help is centered on getting on with one's life, affirming and developing values and commitments, and making and finding membership in or as a community.

Source: Saleebey (2009)

The strengths-based approach acknowledges that people indeed face challenges and problems that require a holistic perspective for effective resolution. While traditional problem-solving methods typically involve identifying issues, analysing causes, setting goals, making plans, implementing them, and evaluating outcomes, this approach has its limitations. It often leads to labelling and restricting options, overlooks individuals' unique capabilities, and tends to focus on limitations rather than possibilities.

In contrast, the strengths-based approach doesn't disregard problems but rather seeks to uncover the positive aspects of a person's resources and strengths, which form the foundation for addressing challenges. It emphasises building trusting relationships, empowering individuals to take an active role in their care, collaborating on mutually agreed goals, tapping into personal motivation and hope, and fostering sustainable change through experiential growth.

The strengths-based approach is centred around understanding the key factors that contribute to individual resilience and the wellbeing of families and communities. It promotes a proactive mindset, viewing resilience as a goal that guides both prevention and evaluation efforts. Intervention strategies prioritise the client's input and emphasise building strong relationships. Distressed individuals are engaged with empathy and dignity, while capacity-building is seen as an ongoing, lifelong process. This approach also highlights the potential for growth and repair in individuals and focuses on enhancing strengths rather than focusing solely on weaknesses or deficits.

This approach avoids a one-size-fits-all design in favour of personalised approaches, refrains from solely attributing difficulties to external factors like broken homes or poverty, and maintains credibility in distinguishing between cause and effect. (Hammond, 2010)

The terms strengths-based and asset-based are often used interchangeably. Asset can be defined as any resource, skill, or knowledge that enhances the ability of individuals, families, and neighbourhoods to maintain their health and wellbeing. (Foot, 2012) It can include supportive family and friendship networks,

intergenerational solidarity, community cohesion, environmental resources for promoting physical, social, and mental health, employment security, opportunities for voluntary service, affinity groups, religious tolerance, lifelong learning, safe and pleasant housing, political democracy and participation, and social justice and equity (Hills et al 2010, in Foot 2012).

An asset-based approach values the skills and knowledge of individuals, networks, personal resources, community resources, and community cohesion. These aspects are very similar to those of a strengths-based approach. Both approaches aim to address "needs"—as defined by the deficit model—by nurturing the strengths and resources of individuals, their families, and communities. While both models share similar goals and areas of focus, there is some indication that the term "asset-based" may refer more specifically to community-related development. (Caiels et al 2021)

Even as it has revolutionised the concepts and nature of social work practice, the strengths-based approach is not free from criticisms either.

The strengths-based approach has been primarily criticised for placing excessive responsibility on individuals and civil society, thereby diverting attention from the necessity of government interventions and provisions. It assumes that all individuals possess the capacity for rational self-determination, which may not always be the case. It is seen to be challenging the importance of the role of social work professionals. This approach is often seen as inadequate in addressing issues related to poverty and economic survival. (Gray, 2011)

Furthermore, it is claimed that very few evaluations of strengths-based treatment have been published. In studies that report positive outcomes, it is unclear whether these results are due to the strengths perspective itself or the addition of other services. Findings also suggest that the principles of the strengths perspective are not sufficiently operationalized or measured. Therefore, it is felt that while the strengths perspective represents a value stance, there is limited evidence supporting it as a distinct and uniquely effective practice model. (Staudt & Drake, 2001)

It has also been said that the strengths perspective is just ‘positive thinking in disguise, and that it simply reframes deficit and misery, so that clients are excused

from taking any transformative action. In other words, this approach ignores reality and downplays real problems that clients may have. Moreover, this approach exposes the social work professional to dangerous manipulations by clients who may have a destructive frame of mind. (Saleeby, 2009)

These criticisms could be emanating from a superficial understanding of the core principles of the strengths-based approach. Research and literature on this topic is growing by the day, with systematic frameworks, evidence-based methodologies and scientific evaluations, encouraging the development and application of a strengths-based approach in social work practice.

The strengths perspective being a philosophical viewpoint that emphasises the inherent resilience present in human nature, it is particularly relevant in working with older adults, as they possess a wealth of life experiences that can be leveraged to tackle current challenges. (Chapin et al, 2006)

Adopting a Strengths-based approach to the care of older persons involves identifying their strengths in different domains, and finding ways and means to enhance and utilise them.

Strengths in the Personal realm encompass resilience, the ability to adapt positively to challenges, a healthy self-image, and satisfaction with life. To cultivate these strengths, it is beneficial to facilitate platforms where older individuals can exchange experiences with peers or younger generations, and to recognize and celebrate their achievements and effective coping skills.

Within the Family sphere, strengths can include maintaining strong family bonds, supporting children, and caring for grandchildren. To enhance these strengths, it is important to acknowledge and value the contributions of the older adults to both family and community, and to encourage grandchildren to express appreciation.

Strengths in the social domain are: active engagement in social activities, volunteering for community welfare, nurturing friendships, good relationships with neighbours, and showing empathy and support. To strengthen these aspects, older adults should be motivated to participate in social events. Designing programs that

facilitate their involvement and tap into their wisdom, and arranging structured interactions with younger individuals are also useful.

Considering the health aspect, the strength of an older adult lies in embracing vulnerability, seeking assistance when needed, openly addressing challenges, and adopting a survivor mindset. These strengths can be enhanced by promoting physical activities, and appreciating positive health behaviours.

Similarly, there are multiple strengths with regard to different aspects of day-to-day living, like housing, finance, etc. Adapting to new living situations, maintaining independent living arrangements, financial autonomy, stable income, and prudent spending habits are some examples. Enhancing these strengths entails providing necessary resources and services that support independent living and integrating older adults into welfare initiatives and programs that promote financial stability (Minimol, 2016).

The strengths-based approach suggests that older individuals can effectively navigate changes, especially when they have supportive relationships with friends, family, professionals, and other care networks. There are five primary factors that contribute to supporting strengths. (Nelson-Becker, Chapin, & Fast, 2013 in Nelson-Becker et al 2020):

- Recognizing that every older person possesses strengths, some developed earlier in life and others that may emerge later, is crucial. Identifying and nurturing these strengths fosters a sense of hope.

- Relying solely on the traditional medical model for assessment and intervention may restrict rather than enhance capacity. Older individuals retain the ability to learn, grow, and adapt.

- Adopting a collaborative approach can be therapeutic and empower older individuals to pursue their aspirations.

- It's important for older individuals to remain involved in decision-making and to guide the direction of the assistance process, unless they are unable to do so due to mental capacity limitations.

- Recognizing and enhancing environmental assets and resources, either by identifying them or collaborating to create them, is a significant task for older adults, caregivers, and professional helpers. It's also essential for society at large to promote successful ageing together.

In the backdrop of the strengths-based approach, we must shift our perspective on older individuals from viewing them as burdens to recognizing them as valuable repositories of resources, knowledge, experience, and wisdom. While they deserve social and financial security in their later years, they also require opportunities to contribute actively to society. To address the diverse challenges they face, it is crucial to adopt well-designed approaches and implement elder-friendly policies at the grassroots level.

Issues such as establishing a robust social security system, ensuring access to quality healthcare for the elderly, and empowering them through skill development and training programs are pressing concerns that demand immediate attention. Creating frameworks that foster an environment conducive to the wellbeing of older individuals, where they can lead active, healthier, and more empowered lives, is imperative.

It is essential to raise awareness about the evolving needs and rights of older people and to educate and sensitise younger generations about issues related to ageing. This will contribute to building a society that respects and supports individuals as they age. (Agewell, 2021)

Social support systems for the elderly have been outlined in an earlier section of this chapter. One among these, residential care institutions for the elderly, being the topic of this study, needs to be specially mentioned here in the context of discussion of the strengths-based approach.

Older adults in long term care have traditionally been subject to the ‘caretaker approach’ by their carers and the institution management. The strengths-based approach overturns many existing attitudes and practices in such institutions. It calls for a comprehensive review of the bio-psycho-social and spiritual environments in

the institutions, and a re-orientation of the carer mindset to co-create conducive situations for harnessing the strengths of the elderly inmates to improve their quality of life.

This begins with a thorough and systematic assessment of not only the strengths, but also the risks present in these environments. This enables a two-pronged approach to improving care - essential risk management alongside effective strengths-based programmes for improving quality of life.

2.3.7 Risk Management in Institutional Care

Safety is a critical concern in care homes for older adults. It involves preventing harm and minimising unnecessary risks to residents. Harms can arise from residents' comorbidities and frailty, requiring responsive care, or from poor quality or neglectful care, such as omission of activities or overtreatment. (Cooper et al, 2018; Natan et al, 2010) Psychological harm may also occur due to unsafe practices that lack respect for personal dignity. Similarly, some residents might feel insecure, particularly when adjusting to the care home environment or due to the actions of other residents. These are risks that need to be managed through appropriate care practices. (Rand et al, 2021)

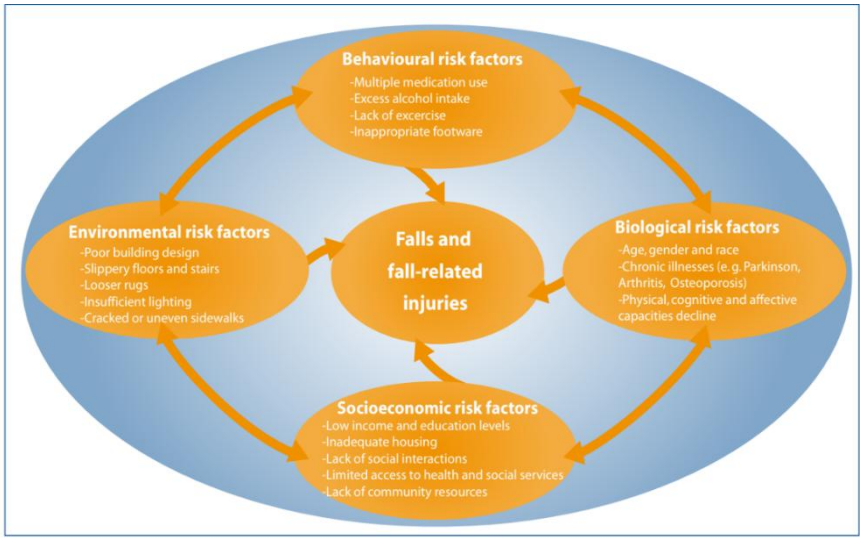
Care homes are unique as they serve as living spaces, not fully institutional yet not offering complete privacy. There needs to be a balance between maintaining a homely environment and ensuring safety from risks like trip hazards or infection. The purpose of care is to enable residents to live well, supporting everyday activities, maintaining dignity, and respecting personal preferences. Tensions may arise between individual preferences and safety, or among the safety needs of different residents. Safeguarding, which ensures residents' rights to live safely and free from harm, abuse, or neglect, is a crucial aspect of care delivery in these settings. (Rand et al, 2021)

Although safety concepts are more discussed in healthcare settings, adopting healthcare safety assessment approaches can be beneficial to care homes too. (Gartshore et al, 2017)

In a care home setting, a variety of bio-psycho-social and environmental factors can contribute towards a single risk. For example, the WHO Global Report on Falls Prevention in Older Adults cites more than 16 risk factors in different domains, contributing to just one risk - that is of falls and fall-related injuries.

Figure 2.5

Risk factor model for falls in older age



Source: WHO Global Report on falls prevention in older age (2007)

Improving safety is complex and requires support from organisational leadership, culture, and processes, along with alignment of regional or national governance and regulation. (Fulop & Ramsay, 2019)

The values, beliefs, and behaviours that employees embrace in an organisation to prioritise and enhance safety are referred to as the safety culture. Key elements of safety culture include fostering openness (informed culture), fairness (just culture), continuous learning (learning culture), and thorough reporting (reporting culture). This culture serves as a platform for discussing adverse events and developing strategies to prevent future occurrences. It promotes an environment where mistakes can be openly discussed, and processes and systems can be improved without fear of punishment. (Indarwati et al, 2023)

The organisational leadership should proactively facilitate an ‘error-free culture’ in terms of care and support systems. This includes ensuring an old age-friendly physical environment, closely monitoring the older adults, improving staff competence and developing effective management techniques. (Shi et al, 2021)

The environment in a care home is largely under the control of the home management, and hence, this is an area where the leadership can show its mettle with regard to safety practices.

Environmental hazards can be within the building as well as outside. Some environmental risks identified in an elderly care home are summarised in table 2.3

Table 2.3: Environmental risks identified

Room or area	Hazards assessed
General household	Poor lighting (too dim) Lighting too bright Light switches hard to reach/find No night light(s) Carpets/floor coverings torn or in poor condition Rugs that slip Slippery floors Furniture or clutter obstructing walkways Cupboards/shelves too high Cupboards/shelves too low Taps hard to reach or to turn on/off Unstable chairs or tables Chairs without armrests or with low backs Extension cords across walkways Unsafe electrical appliances
Kitchen	Dials on stove difficult to see
Bathroom/toilet/laundry	Bathtub/shower recess slippery Bathtub/shower recess without grab rails Soap, shampoo, etc, not accessible Hob on shower recess Glass doors not safety glass Medicine cabinet poorly lit Toilet without grab rails Toilet seat too low Toilet with inward opening door Location of toilet in house Toilet located outside
Stairs	Too steep Too long In need of repair Step edges hard to see Proper handrails not present Handrails unstable or not secured Handrails not long enough Inadequate lighting
Outside	Sloping, slippery, obstructed or uneven pathways Steps, landings, verandas, patios or entrances slippery when wet

Source: (Carter et al, 1997)

Other factors to be considered for safety include the maintenance, cleanliness, and security of the home and its yard, fire hazards as well as accessibility of neighbourhood amenities like bus stops, grocery stores, and banks. Inside the home, factors like clutter, garbage, spoiled food, infestations, etc are potential risk factors.

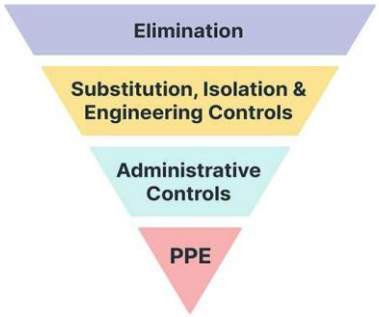
The physical appearance and wellbeing of the older adult, including their dress, hygiene, and grooming are also important factors to be considered while looking for potential risks. (Culo, 2011)

Risk management involves identifying, evaluating, and controlling risks. This process should be proactive, organised, systematic, and ongoing. (Safe Work Australia, 2018). The risk management process comprises four steps: identifying hazards, assessing risks, controlling risks, and reviewing control measures.

The hierarchy of control measures is given in figure 2.6

Figure 2.6

Hierarchy of control Measures



Source: https://www.ausmed.com/learn/articles/risk-assessment-home

Risk avoidance is also another key strategy for risk management. It involves eliminating risk by addressing and mitigating existing threats. In risk management, this strategy seeks to not only reduce risk but also to eliminate its source or replace it with a smaller, more manageable one. Initially, the concept was primarily associated with fall prevention. However, in recent years, scholars have expanded the idea to encompass the psychosocial aspects of ageing. (Wan & Chiu, 2019)

Risk avoidance is especially relevant for care homes, where the bio-psycho-social environment can be controlled largely by the home management.

For example, most environmental risks can be avoided by adopting an age-friendly design while constructing the building and developing the premises.

In elderly care facilities, the design of living spaces should adhere to the following principles:

1. Safety: Ensuring that living spaces are safe for the elderly, preventing accidents like falls and collisions.

2. Convenience: Making sure that the elderly can easily access, move around, and use facilities and equipment, thus reducing the difficulty of their activities.

3. Familiarity: Creating a comfortable and familiar living environment to help the elderly feel at home and at ease.

4. Ease of Maintenance: Selecting facilities and equipment that are cost-effective and easy to maintain, thereby reducing maintenance costs (Bu & Wang, 2023)

Psycho-social risks can also be avoided to a large extent by understanding them and putting in place preventive and/or protective measures.

Physical activities and meditation practices have been shown to help protect against negative emotions like depression, anxiety, and loneliness (Yang et al., 2005; Chan et al., 2017) while enhancing subjective wellbeing. Additionally, these activities have been shown to improve sleep quality in older adults. (Chan et al, 2016)

Good nutrition has been shown to prevent cognitive decline in older adults (Lee et al., 2001; Solfrizzi et al., 2003; Valls-Pedret et al., 2012; Llewellyn et al., 2010 in Wan & Chiu, 2019)

Engagement in leisure activities is found to slow cognitive decline and reduce the risk of dementia in older adults (Wan & Chiu, 2019). Volunteering, for example, acts as a protective factor against the psychological challenges linked to a diminished sense of purpose in life, which often occurs when there are fewer major role identities. According to interactional role theory, social roles shape one's self-identity. Formal volunteering offers a role identity that older adults can use to gain psychological benefits, and thereby has a significant protective effect on mortality

for socially isolated older adults compared to those who are socially integrated. (Greenfield & Marks, 2004)

Spiritual interventions, including meditation, mindfulness practice, yoga, and prayer, can help prevent the development of psychopathology in older adults. Spiritual practices are found to be useful in effectively managing depressive symptoms and anxiety, improving sleep, and in bringing about better health outcomes like reduced blood pressure, a lower risk of falls, and improved cognitive function in terminally ill patients. (Lavretsky, 2010)

Ageing is a multifaceted process encompassing biological, psychological, social, and spiritual aspects of human development. Viewing it merely as a result of biological functioning seems inadequate. An integrative model allows for a broader understanding of ageing, presenting opportunities to minimise physical, psychological, and spiritual risks throughout the developmental stages.

Care homes bear a significant responsibility to ensure the safety and wellbeing of their residents. Effective risk management is essential to meeting this obligation. By identifying specific risks, addressing challenges, and implementing thorough strategies, care homes can foster a safer and more enriching environment for their residents.

2.4 Conclusion

The review of literature has given the researcher a foundational understanding of the theoretical aspects and a comprehensive overview of the state of current research in the area of the care of the elderly. The researcher has found that, while quality of life and the strengths-based approach are much discussed, there is a glaring gap with regard to strengths-based interventions. Another gap found was in the area of risk management, especially in an institutional setting. Overall, it was also found that studies in the Indian context are comparatively less in most areas. Only 30% of all studies reviewed were from the Indian context. Considering the high projected growth of the elderly population in India, this signifies the urgent need to focus academic resources in this area of research.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The review of literature discussed in the previous chapter brings out the importance of elderly care in a world that is demographically shifting towards population aging. Old age is associated with many physical, psychological and social risks. With more and more elders requiring institutional care, it becomes a social priority to ensure the quality of life of elders in such homes.

The present study explores the prevalent risks in Elderly Care Homes and strives to identify from existing literature, the effect of risks on quality of life of the elderly. The study further aims to understand the feasibility of a risk management and strengths-based intervention to improve the quality of life of the elderly in residential care. The objectives of the study have been delineated into relevant hypotheses.

The first phase of the study was risk assessment. The researcher, after a comprehensive review of literature, has created a Risk Assessment questionnaire for Elderly Care Homes. The assessment was done in 62 care homes in Thrissur District. The data was analysed and adequacy scores were assigned to the homes.

A scoping review was undertaken to understand the effects of various risk factors on the quality of life of the elderly.

The second phase of the study was a risk management and strengths-based intervention to improve the quality of life of the elderly in care homes. In this phase, a Pre-test Post-test non-equivalent comparison group research design was used.

The strengths-based approach is particularly relevant for the elderly in the environment of a care home. This approach empowers the elderly to become collaborators of the care home system, thus facilitating maximum utilisation of resources in an often resource-constrained setting (Pattoni, 2012). In this manner, it is different from the traditional deficit-focussed approaches, where the onus is

completely on experts and caregivers to find and implement solutions, which puts a heavier load on the care system (Hammond, 2010).

The WHOQOL100 questionnaire was the tool used in the second phase to assess the quality of life of the participants. First, the strengths of the participants were assessed through purposeful personal interactions and the focus group discussion method. The WHOQOL100 questionnaire was administered to the experimental and comparison groups.

The intervention module was then developed, drawing conceptual bases from literature, discussing with experts and assessing the practical feasibility. The module was implemented for the experimental group over a period of 6 months. The same WHOQOL100 questionnaire was then administered once again to both experimental and comparison groups. The data was analysed using statistical tools and software.

The methodology adopted in this study is described in detail in this chapter. The chapter begins by exploring the problem, and identifying the problem statement. This is followed by the rationale of the study. The objectives and hypotheses are clearly stated, followed by conceptual and operational definitions of key concepts. The details of the pilot study are also explained. The next section elaborates on the research design, with sampling techniques, and tools for data collection and analysis. Then the challenges, limitations and ethical considerations of the study are mentioned. The chapter concludes by mentioning the reporting format or chapter-organisation of the thesis.

Throughout this study, the researcher has been aware of the vulnerability of the participant group and the sensitive nature of the issue addressed. The researcher has taken particular care to ensure that no stakeholder in this study has been offended or inconvenienced in any manner due to the demands of the study.

3.2 Problem Statement

Old age is a biological reality, beyond human control. It has its own dynamic (Gorman, 2000 in Kowal 2001). While WHO considers a ‘senior citizen’ as one who is above 65 years of age, the Government of India, in its National Policy for

Older persons 1999 has taken 60 years as the threshold. Though there are different concepts, theories and definitions for ageing, it is widely accepted that old age has a unique set of risks associated with it.

Physical health risks in old age include fragility, pain, sleeplessness, chronic diseases, polypharmacy, risk of fall, etc (Ünal & Özdemir, 2019). Older adults are also prone to psychological risks like depression, self-harm and self-neglect. They may also suffer loss of cognitive capacity, memory loss and confusion. Major social risks that the elderly face are loneliness, isolation and social exclusion (Minimol, 2016). These may be due to the 'empty nest syndrome', or due to lack of intergenerational bonding with the youngsters at home. Elder abuse, or the infliction of any kind of physical, emotional or financial harm on a senior citizen, is also on the rise in India. The elderly are also highly vulnerable to financial exploitation (Tewari, 2015).

Suicide is also seen as a risk for the elderly. In 2017, the global suicide mortality rate for the elderly (27.5 per 100,000) was almost three times the age-standardized suicide mortality rate for all ages that was 10.0 per 100,000 (He et al, 2021). In the US alone, suicide deaths rose 8.1% among people aged 65 and over, in the one-year period from 2021 to 2022. Loneliness, grief over lost loved ones, loss of self-sufficiency, chronic illness and pain, cognitive impairment and financial troubles are understood to be the major reasons for the suicidal tendency among older adults. (National Council on Ageing, 2024)

In India, with the rise of more nuclear families, older adults are finding it difficult to find care and support within the family system. This has led to the emergence of the 'Old Age Home' concept in India (Lamb, 2007). While care homes in the west are a conscious choice for the elderly, the situation in India is different. Here, old age homes are mostly intended for the poor who are abandoned or neglected by their families, and who have no other place to go. It is far from a wilful choice - it is rather an unfortunate compulsion (Nayar, 2016).

Old age is riddled with physical and psychological co-morbidities, and residential care providers face multi -sectoral challenges (Harbishettar 2021). Different studies

point out that there is a high prevalence of psychological and physical comorbidities in inhabitants of old age homes in India (Tewari et al, 2012; Kumar et al 2017). Poor physical and health infrastructure in old age homes, limited family association and restricted Activities of Daily Living (ADL) have been cited as some of the significant risk factors for psychiatric illnesses in residents of old age homes (Kumar et al, 2017).

In India, Old Age Homes are still found to be working on the welfare philosophy, which focuses on providing the basic needs like food, shelter medicine etc. Sufficient priority is not being given to identify and eliminate risks and to ensure a good quality of life for the elderly residents in Elderly Care Homes.

3.3 Rationale

Population aging being a major challenge globally, for developing nations like India, it brings forth many new challenges that demand greater attention.

The percentage of elderly in Kerala, at 10.5%, was the highest in India in 2011, even higher than the national average of 7.4% (Situational Analysis of Elderly in India, Central Statistics Office, Govt of India, 2011). As early as 1995, Kerala accounted for 20% of all the Old Age Homes in India. The number of old age homes in Kerala had increased by 69% in the 4-year period from 2010-2014 (The Hindu, Sept 20, 2015).

98% of the Elderly care homes in Kerala are owned by private organisations - NGOs, trusts or societies. As an unorganised sector, there were originally very few government regulations to start elderly care homes. This led many kind-hearted individuals and organisations to start elderly care homes purely out of a service mentality born out of compassion to the aged. Over the years, these homes have mobilised resources and supported thousands of aged who had no other place to go. Now, in the light of new legislations and compliances, these organisations need to bring more professionalism in their management and approach. They also need to upgrade their infrastructure according to safety standards. This is especially so in the case of care homes where the care home building has not been specifically constructed for this purpose, but has been converted from a regular house. This

study hopes to assess the risk factors in elderly care homes and point out the aspects requiring immediate attention and action.

Prevention is always better than cure. Identifying and alleviating risks will have very pronounced health benefits. For example, prevention of falls ensures that the older adult will not face the health risks that follow a major fall. This is highly significant because, with age, some health risks are not reversible completely. Even a slight fall in this age could result in permanent disability, due to other comorbidities or other physical and psychological factors that may compound the health issue. Moreover, investing in risk alleviation practices will lead to major savings in medical and hospitalisation costs that may result due to the health risks. There will also be the added costs of money and human resources incurred in taking care of a bed-ridden or disabled person, if such an eventuality arises due to the health risks. Hence, the cost-benefit analysis itself clearly brings out the need and importance of effective risk management practices.

Assessing risk is the first step in coming up with effective ways of managing and preventing risks. The findings of the risk assessment can be used to come up with suggestions for risk management. These learnings can be used to improve the quality of life of the elderly, not only in care homes, but also in the community at large.

There have been studies in recent years about the quality and service delivery in elderly care homes in India and in Kerala. These studies have mostly focussed on the satisfaction of basic physical needs of the residents in these homes. The emotional and social aspects have not received sufficient attention. The researcher, through the present study, aims to address the quality of life of the elderly in care homes, and develop an intervention model based on the strengths-based approach. This will help create an empowering environment, as well as engage the older adults purposefully to identify, access and improve their inherent strengths and resources.

The researcher salutes the dedicated and sincere efforts of the people who run and manage the care homes and serve the elderly, and hopes that this study will provide a guideline that will help them in framing their future policies.

This intervention, which is professionally designed and implemented based on scientific methods of research, will help to identify ways and means by which the quality of life of the elderly in institutionalised care can be significantly improved.

3.4 Objectives:

1. To identify the risk factors in residential care facilities for the elderly in Thrissur District
2. To explore how the quality of life of the elderly is affected by risk factors
3. To assess the quality of life of the elderly in two residential care institutions
4. To design and implement a risk management and strengths-based intervention in a residential care institution
5. To assess the effectiveness of the intervention in enhancing the quality of life of the elderly

3.5 Hypotheses:

3.5.1 Phase 1- Risk Assessment

The risks in Elderly Care Homes were grouped into 4 domains - namely infrastructure, hygiene, wellness and support. The homes were scored according to the adequacy of facilities available under each domain, and the overall adequacy. The homes were classified based on the target audiences - whether exclusively for men, exclusively for women, or for both. The following hypotheses were statistically tested:

- There is no difference in infrastructure adequacy among elderly care homes targeting different audiences.
- There is no difference in hygiene adequacy among elderly care homes targeting different audiences.
- There is no difference in wellness adequacy among elderly care homes targeting different audiences.

- There is no difference in support adequacy among elderly care homes targeting different audiences.

- There is no difference in overall adequacy among elderly care homes targeting different audiences.

3.5.2 Phase 2: Strengths-Based Intervention

The various dimensions of Quality of Life of the residents of the experimental home and the comparison home were tested in the pre-intervention stage. The following hypotheses were tested.

- There is no significant difference between the general quality of life of the residents of the experimental home and the comparison home before the intervention.

- There is no significant difference between the quality of life in the physical capacity domain of the residents of the experimental home and the comparison home before the intervention.

- There is no significant difference between the quality of life in the psychological domain of the residents of the experimental home and the comparison home before the intervention.

- There is no significant difference between the quality of life in the ‘social relationships’ domain of the residents of the experimental home and the comparison home before the intervention.

- There is no significant difference between the quality of life in the ‘environmental’ domain of the residents of the experimental home and the comparison home before the intervention.

- There is no significant difference between the quality of life in the ‘level of independence’ domain of the residents of the experimental home and the comparison home before the intervention.

- There is no significant difference between the quality of life in the ‘spirituality’ domain of the residents of the experimental home and the comparison home before the intervention.

- There is no significant difference between the total quality of life of the residents of the experimental home and the comparison home before the intervention.

The same questionnaire was administered post-intervention to both the groups. The following hypotheses were tested:

- There is no significant difference between the general quality of life of the residents of the experimental home and the comparison home after the intervention.

- There is no significant difference between the quality of life in the physical capacity domain of the residents of the experimental home and the comparison home after the intervention.

- There is no significant difference between the quality of life in the psychological domain of the residents of the experimental home and the comparison home after the intervention.

- There is no significant difference between the quality of life in the ‘social relationships’ domain of the residents of the experimental home and the comparison home after the intervention.

- There is no significant difference between the quality of life in the ‘environmental’ domain of the residents of the experimental home and the comparison home after the intervention.

- There is no significant difference between the quality of life in the ‘level of independence’ domain of the residents of the experimental home and the comparison home after the intervention.

- There is no significant difference between the quality of life in the ‘spirituality’ domain of the residents of the experimental home and the comparison home after the intervention.
- There is no significant difference between the total quality of life of the residents of the experimental home and the comparison home after the intervention.

3.6 Definition of Key Concepts:

3.6.1 Risk

Conceptual Definition:

According to Business Dictionary, risk is "a probability or threat of damage, injury, loss, or any other negative occurrence that is caused by external or internal vulnerabilities, and that may be avoided through preemptive action".

It can also be defined as the possibility of incurring misfortune or loss. (Collins 2020)

Risk is a situation or event where something of human value (including humans themselves) has been put at stake and where the outcome is uncertain. (Rosa 1998).

It refers to uncertainty about and severity of the events and consequences (or outcomes) of an activity with respect to something that humans value (Aven & Renn, 2009).

Operational Definition:

In the context of the care of elderly persons, 'risk' refers to the multifaceted potential for harm, vulnerability, or adverse outcomes that older adults may encounter. This encompasses a spectrum of factors, including but not limited to, physical health limitations such as chronic illnesses or disabilities, social isolation stemming from limited social networks or lack of community support, cognitive decline leading to diminished decision-making capacity, financial insecurity resulting in inadequate

resources for essential needs, and environmental hazards such as unsafe living conditions or inadequate access to healthcare services. Risk involves the likelihood of experiencing negative events or consequences that can significantly impact the overall wellbeing, safety, and quality of life of elderly individuals, necessitating comprehensive assessment, intervention, and support within the realm of social work practice.

3.6.2 Risk Management

Conceptual Definition:

Risk management is the identification, evaluation, and prioritization of risks (defined in ISO 31000 as the effect of uncertainty on objectives) followed by coordinated and economical application of resources to minimize, monitor, and control the probability or impact of unfortunate events or to maximize the realization of opportunities

Operational Definition:

Risk management is the process of minimizing the likelihood of adverse events in the life of the elderly, providing the opportunity for targeted interventions to minimize the causal factors to achieve the best possible outcome and deliver safe, appropriate, effective care.

3.6.3 Quality of Life

Conceptual Definition:

Quality of Life: WHO explains Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns"

Quality of life (QoL) is a concept which aims to capture the wellbeing, whether of a population or individual, regarding both positive and negative elements within the entirety of their existence at a specific point in time. For example, common facets of QoL include personal health (physical, mental, and spiritual), relationships,

education status, work environment, social status, wealth, a sense of security and safety, freedom, autonomy in decision-making, social-belonging and their physical surroundings. (Dac Teoli; Abhishek Bhardwaj. 2023)

Operational Definitions:

Quality of Life for elderly persons is operationally defined as a multidimensional construct encompassing physical, mental, emotional, social, and environmental wellbeing. It reflects the subjective perception of individuals regarding their overall life satisfaction, fulfillment of needs, and ability to engage in meaningful activities. Factors influencing QoL include but are not limited to health status, functional independence, social support networks, access to healthcare services, financial security, opportunities for social participation, and environmental conditions. A high quality of life implies a sense of dignity, autonomy, purpose, and positive social connections, while a low quality of life may manifest as dissatisfaction, isolation, dependency, and limited opportunities for personal growth and enjoyment.

3.6.4 Strengths based Approach

Conceptual Definition:

The strengths perspective demands a different way of looking at individuals, families and communities (Saleebey, 1996) – seeking to develop in clients their natural abilities and capabilities. It is based upon the assumption that clients come for help already in possession of various competencies and resources that may be tapped into that will improve their situation (Saleebey, 2006). Saleebey (2006) defines a client's strengths through three interlinked aspects, called "CPR". C represents competence, capacities and courage; P stands for promise, possibility, and positive expectations; and R means resilience, reserves, and resources.

Operational Definition:

An approach to Elderly Care which considers elders as resourceful individuals, and focusses on accessing, developing and utilizing their strengths for ensuring their

wellbeing. ‘Strengths’ involve the internal capacities of the individual, as well as the external resources and support systems available.

The Strengths-Based Approach involves a collaborative effort between the individual receiving services and those providing support. This collaboration enables them to work together in identifying outcomes that leverage the individual's strengths and assets (SCIE, 2015). Rather than focusing solely on problems and hopelessness, this approach emphasizes opportunities, hope, and solutions.

The strengths perspective requires a distinctive way of perceiving individuals, families, and communities (Saleebey, 1996). It aims to nurture the innate abilities and capacities of clients, operating under the assumption that individuals seeking help already possess various competencies and resources that can be utilized to enhance their situations (Saleebey, 2009).

This study derives its conceptual framework from the seven principles of the strengths-based approach. These principles are especially relevant in working with older people. (Blood & Guthrie, 2018)

1. Collaboration & Self-Determination:

The expert may have general competence, but the client has mastery over what he needs in his life. So the professional and the client need to work together to come up with viable solutions. This is in contrast to the usual approach where older people are considered disempowered within the care system, and decisions about them are made without consulting them.

2. Relationships are what matter most

Relationship is the key to working with people, understanding their needs and behaviours. For older people, the relationship itself is the service. They are prone to loneliness and isolation, and their self-concept may have suffered due to the sudden loss of independence. Here, building a trusting relationship is the only way to connect with them and draw out their strengths.

3. Everyone has strengths and everyone has something to contribute

Being in a situation of ‘needing to be helped’ is a cause of frustration and shame for many. Strengths-based approach focuses not on what a person cannot do, but instead on what he/she can do, and what he or she does not need help for. Older people are encouraged to utilise the strengths they have, and develop new strengths adapting to their changing situations in life. Being able to reciprocate help is a great boost to the self-concept of older persons.

4. Stay curious about the individual

Every individual is different, and the practitioner of strengths-based approach should not stereotype individuals. Every behaviour has a reason and the practitioner should stay curious about the individual to understand these reasons. Once people start aging, their behaviours are often dismissed as ‘losing their mind’ or ‘getting old’ etc. Hence this principle is very relevant in working with older adults.

5. Hope

It is never too late to learn new skills or mend broken relationships, and the practitioner should keep this hope alive in older clients, as it is very easy for them to despair that their time is running out.

6. Permission to take risks

The strengths-based approach recognises that sometimes risks are involved in doing things that matter to the client. The client is encouraged to utilise his resources to minimise risks, though it may not be possible to avoid risks altogether. Doing nothing is also a risk. Older people are usually treated like children and ‘protected’ all the time. Instead, the strengths-based approach allows them to take reasonable risks and live fully in the present moment.

7. Build resilience

Strengths-based approach focuses not on ‘protecting’ people, but on helping them build their capacities and strengthen their natural networks. This is particularly relevant to older people, as old age brings new challenges, to overcome which, new

skills and capacities need to be developed. Methods like motivational interview and mindfulness can help build resilience.

The researcher has applied these principles in the design and implementation of this study. She has also tried her best to imbibe the mindset and attitudes reflected in these principles.

3.7 Pilot Study:

Prior to commencing the study, it is essentially beneficial to check the feasibility of the study, and the suitability of the tools. This was done through a pilot study.

The researcher first approached the District Social Justice Office and held discussions with the officer, other staff and the counsellors, and sought their cooperation in getting the details of the care homes in Thrissur. These interactions also helped her understand the ground situations of some care homes. She also realised that the list of registered care homes in Thrissur District was yet to be consolidated and updated, and this would pose a challenge during the study.

The researcher regularly visited a renowned expert in the field of Geriatric Social work, who also runs a well-known Elderly Care Home in Thrissur. The discussions with her provided new insights on the different aspects of running a care home. Her wide exposure and long experience in the field were helpful in gaining an in-depth understanding of the geriatric care scenario.

During these visits, the researcher also spent time with the residents of the care home, and interacted with them. She was able to witness first hand the daily functioning of the care home. She also interacted with the care home staff, and was able to understand their challenges. These visits also gave the researcher a ‘feel’ for the environment of care homes, which would help her in conducting the actual study.

The researcher held discussions with different experts in other related fields like health, psychiatry, psychology, counselling, social work, etc. From these

interactions she was able to gain a deeper understanding of the bio-psycho-social challenges of the elderly.

Finally, the researcher also had detailed discussions with experts in social sciences research and statisticians to formulate the research design.

The researcher sought and obtained permission from WHO to use the WHOQOL100 tool for the study. The Risk Assessment questionnaire and the FGD questions were prepared by the researcher herself based on literature review and consultations with experts.

Once the tools were ready, the researcher visited a few homes, to test the Risk Assessment tool.

For phase 2 the researcher visited a few care homes and administered the WHOQOL100 questionnaire to a few residents. She also conducted focus group discussions in small groups.

Based on her own experiences and observations and further consultations with experts, the tools were finalised.

The pilot study proved that the research was feasible, and the researcher could also draw on her experiences from the pilot study in conducting the actual study.

3.8 Research Design:

Phase 1 of the study consisted of a risk assessment survey in 62 Elderly Care Homes in Thrissur District. The objective of this phase was to understand and quantify the adequacy of the homes in addressing potential risks, and to gain an in-depth understanding of the current situation on the ground, as it exists. It also helped to identify problems and variations in characteristics between institutions.

The researcher chose the descriptive research design for this phase, as it was the most appropriate. “Descriptive studies aim to examine individuals, events, or conditions in their natural state. Researchers do not manipulate variables but instead focus on describing the sample or variables as they are. These studies analyse the

characteristics of a population, identify existing problems within a group, organization, or population, and explore variations in traits or practices across institutions or countries." (Siedlecki, 2020). The data collected was analysed using basic statistical tools to arrive at a general picture, which formed the basis for the next phase.

A scoping review was undertaken to comprehend the findings of existing studies regarding the effects of risk factors on the quality of life of the elderly. The report of the scoping review was prepared according to the PRISMA-ScR format.

The second phase involved an interventional study. The setting of the intervention being residential care homes for the elderly, it is practically and ethically difficult to randomly assign participants to experimental and comparison groups. Hence a quasi-experimental research design was used (Lal Das, 2022). A Pre-test Post-test nonequivalent comparison group design was chosen.

Two homes were identified - with similar characteristics and number of inmates. One was chosen as the experimental home and the other as the comparison home. Data analysis from the pre-intervention questionnaire was used to ascertain that the quality of life across various domains was somewhat similar in both homes.

The research design may be shown diagrammatically as:

E	Y_0	X	Y_1
C	Y'_0	Non-X	Y'_1

Where:

DV ⟶ Quality of life of elders in institutions (Dependent variable)

IV ⟶ Intervention (Independent Variable)

E ⟶ Experimental Group

C ⟶ Comparison group

X ⟶ Intervention (Independent Variable)

Y_0 → Measurement of DV before Social Work Interventions of experimental group

Y_1 → Measurement of DV of experimental group after the completion of intervention

Y'_0 → Measurement of DV of comparison group before the implementation of Intervention

Y'_1 → Measurement of DV of comparison group after the implementation of Intervention

(Source: Lal Das, 2022)

3.9 Sampling

The highest number of old age and psychosocial homes of Kerala are in Ernakulam district. The district has 125 elderly care homes with more than 4,097 residents. In Thrissur, there are 95 institutions with 2,915 occupants, while Kottayam has 83 institutions and Thiruvananthapuram has 51 centres. Through the lottery method, Thrissur District was selected as the locale of the study.

The study was conducted in the government and unpaid private elderly care homes. The sampling is done in two steps for the study.

There are 95 elderly care homes in Thrissur District, which form the universe of the study.

A single Elderly Care Home in Thrissur District will be considered as a unit for the study.

Phase 1:

The first phase is a descriptive one aimed to understand the risks in Elderly Care. The population is relatively small and homogeneous, and the researcher found it relevant and feasible to conduct the study in all the homes. So the census method was used, after considering the inclusion and exclusion criteria.

Inclusion Criteria:

1. All unpaid Elderly care homes in Thrissur District were included.

Exclusion Criteria:

1. All paid elderly care homes in Thrissur District were excluded
2. Elderly care homes exclusively for the infirm were excluded
3. Elderly care homes where the management was not willing to give entry for the study were excluded.

62 Elderly care homes in Thrissur District adhering to the above criteria were selected for the study.

Phase 2:

Here the design of the study requires the selection of 2 homes - one as the experimental group and one as the comparison group.

Findings from Phase 1 of the study are used to delineate inclusion and exclusion criteria, in order to ensure the feasibility and effectiveness of the intervention.

Inclusion Criteria

1. Elderly Care Homes which participated in the Phase 1 study are included
2. Based on the scoring in phase 1, homes belonging to the two middle quartiles were included
3. Elderly Care Homes where the management is willing to cooperate with the intervention are included

Exclusion Criteria

1. Elderly Care Homes which were excluded according to the exclusion criteria of Phase 1 were excluded in Phase 2 also
2. Elderly Care Homes which did not participate in Phase 1 were excluded

3. Based on the scoring in phase 1, the homes belonging to the lowest and the highest quartiles were excluded

4. Elderly Care Homes where the management was not willing for the intervention were excluded

Two homes which adhere to the above inclusion-exclusion criteria, and which are similar in most respects are chosen.

Sandeepany Mathrusadanam, Guruvayur, was selected as the experimental home, and *Saketham Sevanilayam,* Mapranam was selected as the comparison home.

The *Sandeepany Mathrusadanam*, Guruvayur, the experimental institution, had 13 female residents aged between 61 to 91 years. 6 of them were married, and 7 unmarried. All had education up to class 10.

The comparison institution, *Saketham Sevanilayam,* Mapranam had 11 female residents aged between 66 and 85 years, of whom 9 were married and 2 unmarried. All were educated up to class 10.

3.10 Data Collection

3.10.1 Phase 1:

Since phase 1 of the research is a descriptive study, it aims to find out and quantify the real situations existing in the Elderly Care Homes in Thrissur.

So, the researcher developed a context-relevant Risk Assessment tool for the purpose, after review of literature and consultations with experts.

Risk Assessment Tool:

In preparing the Risk Assessment Tool the researcher referred to the following guidelines issued by the Government of India and the Government of Kerala.

1. Manual on Old age Homes prepared by Dr P K B Nayar, Centre for Gerontological Studies, for the Dept of Social Justice, Government of Kerala, 2016

2. Kerala Orphanage Control Board (OCB) Guidelines for old age homes GO dt 20th August 2016, issued by the Dept of Social Justice, Govt of Kerala
3. Model Guidelines for Development & Regulation of retirement homes issued by the Ministry of Housing & Urban Affairs, Govt of India, 2019

The researcher also referred to academic articles related to the risks and environmental hazards in Elderly Care Homes.

The tool consists of 129 questions pertaining to risk factors in 11 subdomains, namely Location, Exterior, Interior, Bathroom facilities, Cleanliness, Hygiene, Food, Health, Safety Training, General Environment factors & Relationships and Activities.

Data was collected by the researcher personally visiting the institutions and interacting with the management, staff and inmates. These interactions along with the researcher's own observations also helped to understand the ground situation and the challenges.

3.10.2 Phase 2:

A standardised and widely used tool to measure the quality of life across different domains has been developed by the World Health Organisation, the WHOQOL 100. It has proven responsiveness, validity and reliability. It can detect changes in quality of life over time and across interventions (Wong et al, 2018). It delves deep into personal and subjective aspects, which is very relevant for the present study.

For phase 2 data collection, the researcher selected the WHOQOL 100 tool. The WHOQOL100 was chosen, rather than the WHOQOL-BREF as the former is recommended for studies with a greater thrust on social aspects of quality of life (O'Carroll et al, 2000).

The WHOQOL 100 serves as a thorough tool for evaluating an individual's quality of life across diverse aspects such as physical health, psychological wellbeing, degree of independence, social connections, environmental factors, and spirituality/religion/personal beliefs. Comprising 100 items, it aims to provide a comprehensive and intricate insight into an individual's quality of life. Participants

typically rate their responses on a Likert scale, enabling them to convey their agreement or disagreement with each statement.

3.11 Data Analysis

The next stage in the research is to consolidate and compile the collected data, and scrutinise it so as to obtain relevant meaning. Data analysis is crucial as it helps the researcher to gain inferences that meet the purpose of the research. The following are the data analysis techniques utilised in this study:

3.11.1 Descriptive Analysis:

Descriptive analysis involves summarizing and presenting the main features of the collected data. In this study, the descriptive analysis was performed using frequency tables, graphs, and spider diagrams. Frequency tables display the count of observations in different categories, graphs provide visual representations of data patterns, and spider diagrams may be used to show multivariate data.

3.11.2 Phase 1 Analysis:

In the first phase of analysis, the focus was on determining the significance of dependencies within the data. This was accomplished using two statistical tests: the Mann Whitney U Test and One Way ANOVA (Analysis of Variance). The Mann Whitney U Test is a non-parametric test used for comparing two independent groups, while One Way ANOVA is used for comparing means among more than two groups. These tests help in understanding relationships and differences within the data set.

3.11.3 Phase 2 Analysis:

In the second phase of analysis, hypothesis testing was conducted using the t-test. The t-test is a statistical method used to compare the means of two groups and assess whether any observed differences are statistically significant. Hypothesis testing is a crucial step in research, allowing researchers to make inferences about population parameters based on sample data.

3.11.4 Statistical Tool:

The statistical tool R was employed for data analysis. R is a programming language and environment specifically designed for statistical computing and graphics. It provides a wide range of statistical and graphical techniques, making it a powerful tool for researchers to analyse and interpret their data.

In summary, the study followed a systematic approach to analyse the collected data. Descriptive analysis helped summarize the data, and in the first phase, dependencies were explored using Mann Whitney U Test and One Way ANOVA. In the second phase, hypothesis testing was conducted using the t-test. The entire analysis was facilitated using the statistical tool R.

3.12 Steps of the study

Figures 3.1 & 3.2 summarise the steps followed by the researcher in chronological order during Phase 1 and Phase 2 respectively

Figure 3.1 Steps in Phase 1

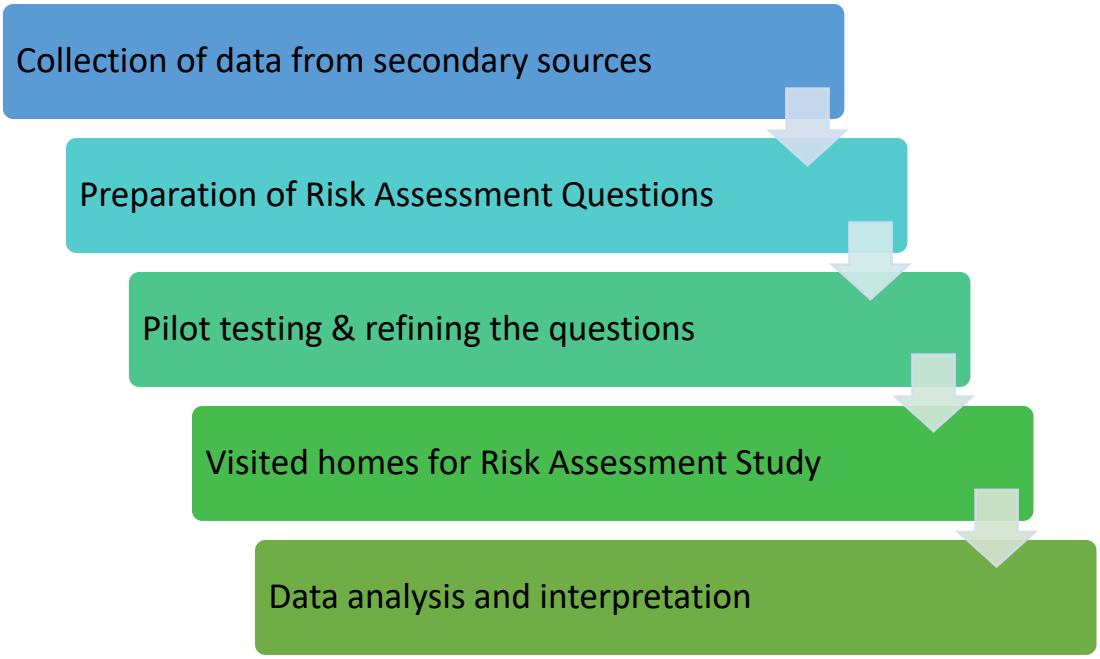
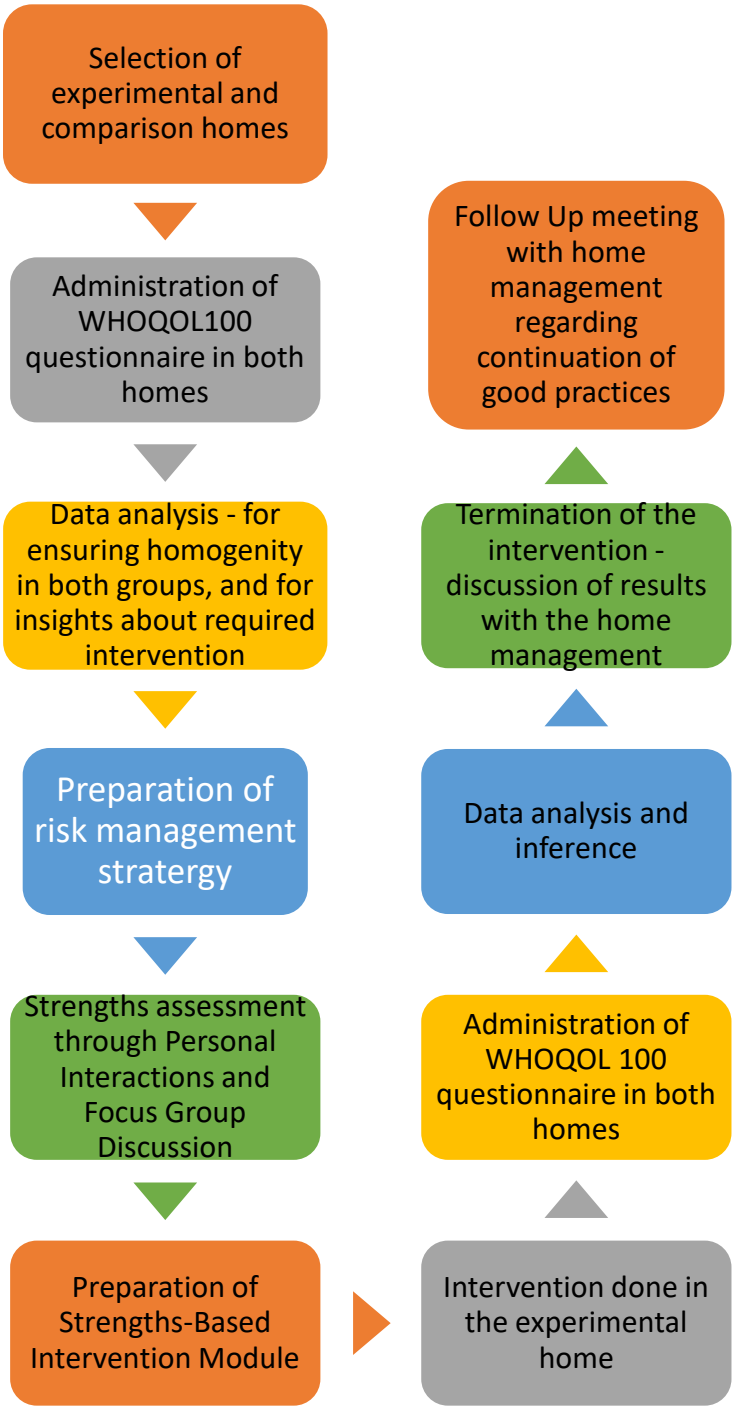


Figure 3.2: Steps in Phase 2



3.12 Challenges Faced

The major challenge in the first phase of the study was to obtain the cooperation of the Elderly Care Homes for the visit and the risk assessment. This was complicated further by the advent of the Covid-19 pandemic, which made the home

managements even more reluctant to let visitors in, due to obvious safety concerns. It was also difficult to gain the confidence of the home managers and staff. Since the questions asked are of a sensitive nature, they were often reluctant to give out information.

In the second phase, the major challenge was to work within the constraints of the existing systems in the care homes. It was also difficult to get the study participants to think or speak about their strengths, interests, etc, as they were generally in a resigned mood due to their life situations. However, the researcher was able to overcome these challenges to a large extent, by using the methods of social work practice, like rapport building, non-judgemental approach, open conversations, etc.

3.12 Limitations of the study

3.12.1 Geographical and Cultural Variations:

The study acknowledges that there could be regional, cultural, and environmental differences in other geographical areas, potentially influencing the outcomes. Hence the study's findings should be interpreted within the context of the specific district and Elderly Care homes under investigation.

3.12.2 Temporal Considerations:

The study emphasizes that it only examines the immediate effects of the intervention. It acknowledges the possibility of long-term implications that may not be captured in the current analysis. This temporal limitation suggests that the study provides a snapshot of the intervention's impact, and the long-term effects might require further investigation.

3.12.4 Data Sources and Potential Bias:

Data for the first phase of the study is based on responses from staff or management personnel in the care homes, supplemented by the researcher's own observations. This may lead to subjective bias in data collection and interpretation.

3.12.5 Contextual Impact of Covid-19:

The study timeline coincided with the onset of the Covid-19 pandemic. Some Elderly care homes were visited before the pandemic, and others were visited after. The Covid situation and associated protocols may have influenced certain aspects of the study.

3.13 Ethical Considerations

Ethical considerations are essential for maintaining the integrity, credibility, and societal impact of research, as well as for upholding the rights and wellbeing of research participants.

The ethical considerations of this study were presented before the Human Research Ethics Committee of Vimala College (Autonomous) Thrissur. The committee reviewed and evaluated the ethical suitability of the research undertaken. The committee granted approval of the research protocol which was presented.

The researcher, throughout the process, has followed the Code of Ethics put forth by National Association of Social Workers (2003) in section 5, Social Workers Ethical Responsibilities to the social work profession, under the sub section 5.02.

Since the study deals with older persons, it is very important to respect their sensitivities. They should not feel that they are simply the ‘subjects’ of a study. The researcher made special efforts to take the study participants into confidence and ensure that they did not suffer any physical or emotional distress during the study or the intervention.

The researcher was also conscious about reciprocity- The study should provide some benefits to the participants also, just as it benefits the researcher in her academic pursuit.

Keeping these in mind, the researcher followed the below mentioned ethical practices:

- During the data collection visits to elderly care homes in the first phase, the researcher mobilised resources through the non-profit organisation, ATMA Foundation, and supplied nutrition kits to all the residents of the visited homes.

- The caretakers of the visited homes were made aware of the purpose of the visit, and their consent was obtained for data collection/

- Before the intervention phase, the researcher visited the selected home many times, and informally interacted with the mothers there. This created a good rapport, and the researcher could build trust with the participants.

- The participants were informed of the purpose of the intervention, and their consent was obtained.

- The participants were reassured that they could withdraw from the intervention at any point, without any questions or explanations.

- The home management was also informed about the intervention and consent obtained.

- The researcher has assured the participants and the management that the data collected will be used only for academic purposes, and shared only with those who are professionally concerned with the research.

- The researcher has assured the participants of full confidentiality regarding the data obtained from them.

- All photographs and videos of the participants have been taken with their full consent.

- The researcher has reported the evaluation and findings accurately. No findings were fabricated and the researcher is ready to take steps to correct any errors later found in published data using standard publication methods.

- The researcher feels that the participants of the comparison group should also benefit from the intervention. So the researcher is ready to replicate the

intervention, with necessary changes, in the comparison home in the near future.

CHAPTERISATION

Chapter 1: Introduction

Chapter 2: Review of Literature

Chapter 3: Research Methodology

Chapter 4: Scoping Review

Chapter 5: Intervention module

Chapter 6: Data Analysis and Interpretation.

Chapter 7: Findings & Discussion

Chapter 8: Recommendations

Chapter 9: Conclusion

CHAPTER 4
SCOPING REVIEW

Title: Risk Factors and Quality of Life

Introduction

The first objective of this research study had been to identify the various risk factors in residential care facilities. The second objective is to understand how different risk factors affect the Quality of Life of the elderly - be it in a community setting or in an institutional setting. To achieve this objective, a scoping review was done to explore the relationship between risk and quality of life as evidenced in literature. The review also aims to understand the breadth and depth of research on this particular topic, and identify gaps if any. Finally, understanding how various risk factors affect the Quality of Life will enable the researcher to identify the protective factors and risk management areas, which will aid in designing an intervention to enhance the quality of life of the elderly.

Research Question: How do various risk factors affect the quality of life of the elderly

Methods

The scoping review was conducted in accordance with the PRISMA extension for scoping reviews (PRISMA-ScR).

Inclusion Criteria

- Studies focusing on risk factors and quality of life of the elderly.
- Both qualitative and quantitative studies.
- Studies assessing quality of life as an outcome.
- Studies focusing on individuals aged 60 and above.

Exclusion Criteria

- Empirical studies primarily addressing medical aspects without considering risk and quality of life.
- Articles without full-text access.
- Articles not in English.
- Studies that do not directly measure quality of life.

Information Sources

The following databases were searched:

- PubMed
- Google Scholar

Search Strategy

The search was conducted using the following keywords:

- “Risk and Quality of Life of Elderly”
- “Risk Management and Quality of Life”
- “Risks and Quality of Life”
- “Risks and Quality of Life of Institutionalized Elderly”

The search was limited to articles published in English between 2013 and 2023.

Data Charting Process

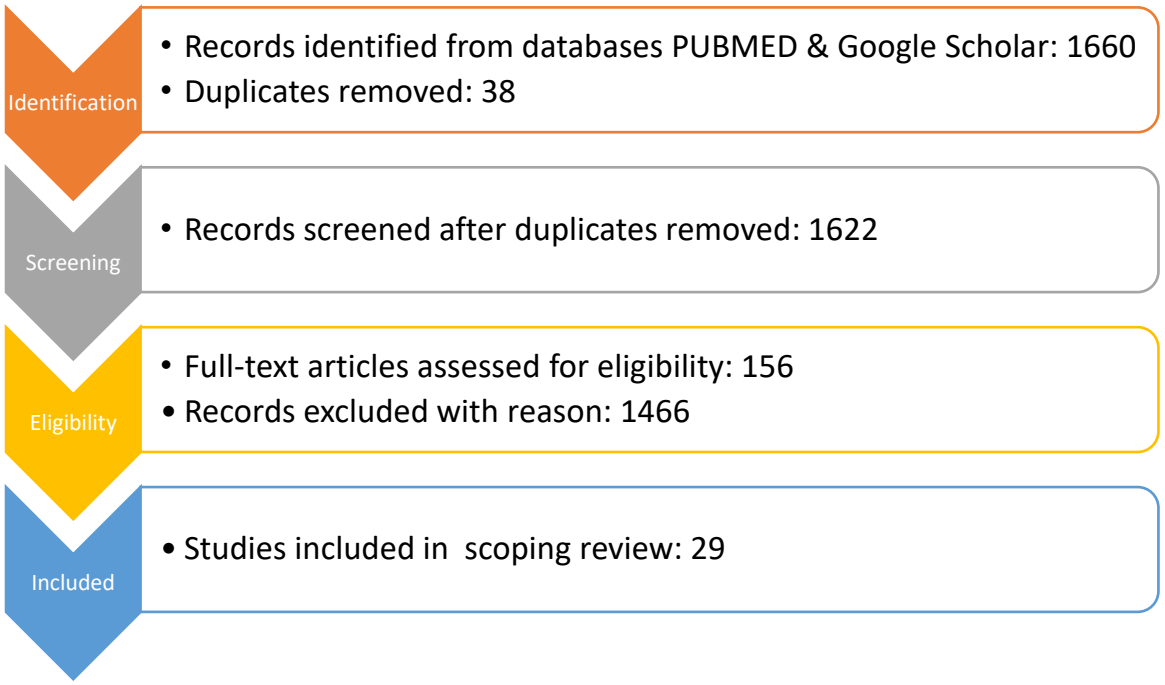
Data were extracted on the following variables:

- Author
- Year of publication
- Title
- Name of journal
- country
- Client Group/User group
- Sample
- Key findings

Selection of Sources of Evidence

The initial search results were imported into Rayyan, a cloud-based software, to organize, manage, and remove duplicates. Reviewer screened titles and abstracts. Full texts of selected studies were retrieved and exported to a Microsoft Excel database for further analysis.

Figure 4.1: Results from the literature search.



Results

A total of 1622 articles were found in the initial database search using the keywords. Of this, 156 articles were found to be potentially relevant. On screening the full text, 127 articles were rejected according to the inclusion/exclusion criteria. The remaining 29 articles have been included in this review.

This review includes articles which connect risk factors to quality of life. To gain a broader perspective, a few studies were chosen that included but were not limited to the elderly alone, if they have shown a conclusive relationship between risk factors and various aspects of QoL.

Table 4.1: Summary of Review

Sl No	Author	Year	Title of study	Journal	Country/ Place	Client/User group	Sample	Key findings/Position/Conclusion
1	Atkins, Joanna, Naismith, Sharon L, Luscombe, Georgina M, Hickie, Ian B.	2013	Psychological distress and quality of life in older persons: relative contributions of fixed and modifiable risk factors	BMC psychiatry - Volume 13, Issue 0, pp. 1-10 - published 2013-01-01.	Australia	>60 years	313	Variables that were found to be associated with lower QoL included higher levels of functional impairment and higher psychological distress.
2	Bakker MH, Vissink A, Spoorenberg SLW, Jager-Wittenaar H, Wynia K, Visser A.	2018	Are Edentulousness, Oral Health Problems and Poor Health-Related Quality of Life Associated with Malnutrition in Community-Dwelling Elderly (Aged 75 Years and Over)? A Cross-Sectional Study.	Nutrients - Volume 10, Issue 12, pp. - published 2018-12-12.	Netherlands	community-living elderly (≥75 years)	1325	Poor HRQoL is significantly associated with malnutrition

3	Bang KS, Tak SH, Oh J, Yi J, Yu SY, Trung TQ.	2017	Health Status and the Demand for Healthcare among the Elderly in the Rural Quoc-Oai District of Hanoi in Vietnam.	BioMed research international - Volume 2017, Issue, pp. 4830968 - published 2017-01-01.	Vietnam	people in the rural Quoc-Oai district of Hanoi aged 60 or older	713	Age, self-rated health status, BMIs, and the number of noncommunicable diseases (NCDs) were found to be significant determinants of HRQoL, after controlling for socioeconomic effects.
4	Campos, Ana Cristina Viana, e Ferreira, Efigênia Ferreira, Vargas, Andréa Maria Duarte, Albala, Cecilia.	2014	Aging, Gender and Quality of Life (AGEQOL) study: factors associated with good quality of life in older Brazilian community-dwelling adults	Health and quality of life outcomes - Volume 12, Issue 0, pp. 1-11 - published 2014-01-01.	Brazil	>=60 years	2062	Depressive symptoms, chronic diseases and family dysfunction are factors leading to a lower QoL. There are gender differences in QoL.
5	Chang HK, Gil CR, Kim HJ, Bea HJ.	2020	Factors Affecting Quality of Life Among the Elderly in Long-Term Care Hospitals.	The journal of nursing research: JNR - Volume 29, Issue 1, pp. e134 - published 2020-12-07.	South Korea	>65 yrs in LTC	202	The study found a correlation between quality of life and depression and care dependency.

6	Fernández-Mayoralas, Gloria, Rojo-Pérez, Fermina, Martínez-Martín, Pablo, Prieto-Flores, Maria-Eugenia, Rodríguez-Blázquez, Carmen, Martín-García, Salomé, Rojo-Abuín, José-Manuel, Forjaz, Maria-Joao.	2015	Active ageing and quality of life: factors associated with participation in leisure activities among institutionalized older adults, with and without dementia	Aging & mental health - Volume 19, Issue 11, pp. 1031-1041 - published 2015-01-01.	Spain	institutionalized people aged 60 and over	234 without dementia and 525 with dementia	The decline in physical and mental health, the weakening of family and social ties, and the loss of functional capabilities form a significant barrier to active ageing in an institutionalized context.
7	Gerino, Eva, Rollè, Luca, Sechi, Cristina, Brustia, Piera.	2017	Loneliness, resilience, mental health, and quality of life in old age: A structural equation model	Frontiers in psychology - Volume 8, Issue 0, pp. 310944 - published 2017-01-01.	Italy	65–90 years	290	Elderly people with high levels of loneliness are at an increased risk of experiencing low levels of mental health and low capacity to withstand stressors, resulting in low mental and physical QoL.
8	Hanmer J, Yu	2019	The diagnosis of	British	USA	adult	14308	Those who did not know about

	L, Li J, Kavalieratos D, Peterson L, Hess R.		asymptomatic disease is associated with fewer healthy days: A cross-sectional analysis from the national health and nutrition examination survey.	journal of health psychology - Volume 24, Issue 1, pp. 88-101 - published 2019-02-01.		participants in the 2011-2012 National Health and Nutrition Examination Survey (NHANES)		their health condition generally had the same health-related quality of life scores as those without health conditions. Conversely, those diagnosed with disease but not receiving treatment reported worse health-related quality of life.
9	Hao G, Bishwajit G, Tang S, Nie C, Ji L, Huang R.	2017	Social participation and perceived depression among elderly population in South Africa.	Clinical interventions in aging - Volume 12, Issue, pp. 971-976 - published 2017-01-01.	South Africa	men and women aged 50 years and above.	422	There is high prevalence of perceived depression and loss of interest. The rate is higher among those who reported difficulty in joining community activities. Addressing the barriers to engaging in community activities may help minimize burden of depression among the elderly population in South Africa
10	Henning-Smith C.	2016	Quality of Life and Psychological Distress Among Older Adults: The	Journal of applied gerontology: the official	USA	non-institutionalized adults aged 65 and older	4862	Older adults living alone or with others fare worse than those living with a spouse only. Women living with

			Role of Living Arrangements.	journal of the Southern Gerontological Society - Volume 35, Issue 1, pp. 39-61 - published 2016-01-01.				others are at greater risk of worse quality of life and serious psychological distress than men.
11	Hernández-Galiot, Ana, Goñi, Isabel.	2015	Quality of life and coping strategies among immigrant women living with pain in Denmark: a qualitative study.	Nutrition - Volume 35, Issue 0, pp. 81-86 - published 2017-01-01.	Denmark	older than 75 years	102	Chronic pain was perceived to have an extensive, adverse effect on all aspects of quality of life, including physical health, mental wellbeing and social relations. This included the ability to maintain activities of daily living and the ability to work. Chronic pain was further experienced as a cause of emotional distress, depression and altered personalities, which all had great consequences on women's social interactions, causing change and loss of social relations.
12	Hernández-	2017	Quality of life and	Nutrition -	Spain	older than 75	102	Results show the important

	Galiot, Ana, Goñi, Isabel.		risk of malnutrition in a home-dwelling population over 75 years old	Volume 35, Issue 0, pp. 81-86 - published 2017-01-01.		years		role of nutrition and eating habits in the quality of life of the elderly population. A significant negative association ($P < 0.05$) between the risk of malnutrition and index of quality of life was found.
13	Hutchinson A, Rasekaba TM, Graco M, Berlowitz DJ, Hawthorne G, Lim WK.	2013	Relationship between health-related quality of life, and acute care re-admissions and survival in older adults with chronic illness.	Health and quality of life outcomes - Volume 11, Issue, pp. 136 - published 2013-08-06.	Australia	older adults	210	Lower self-reported HRQoL was associated with an increased risk of readmission independently of comorbidity and kind of service provided, but was not an independent predictor of five-year mortality.
14	Inoue S, Kobayashi F, Nishihara M, Arai YC, Ikemoto T, Kawai T, Inoue M, Hasegawa T, Ushida T.	2015	Chronic Pain in the Japanese Community--Prevalence, Characteristics and Impact on Quality of Life.	PloS one - Volume 10, Issue 6, pp. e0129262 - published 2015-01-01.	Japan	adults aged ≥20 years	6000	Chronic pain is associated with mental health issues, decreased QoL and social loss due to absence from work.
15	Jayasinghe UW, Harris MF, Parker	2016	The impact of health literacy and lifestyle risk	Health and quality of life outcomes -	Australia	patients from 30 general practices across	739	There are negative associations between low health literacy and physical and mental

	SM, Litt J, van Driel M, Mazza D, Del Mar C, Lloyd J, Smith J, Zwar N, Taylor R.		factors on health-related quality of life of Australian patients.	Volume 14, Issue, pp. 68 - published 2016-05-04.		four Australian states		domains of HRQoL. Addressing health literacy related barriers to preventive care may help reduce some of the disparities in HRQoL. Recognising and tailoring health related communication to those with low health literacy may improve health outcomes including HRQoL in general practice.
16	Jerez-Roig J, Souza DL, Andrade FL, Lima BF Filho, Medeiros RJ, Oliveira NP, Cabral SM Neto, Lima KC.	2016	Self-perceived health in institutionalized elderly.	Ciencia & saude coletiva - Volume 21, Issue 11, pp. 3367-3375 - published 2016-11-01.	Brazil	Elderly residents in LTIE (Long Term Care Institutions for Elderly)	127	The prevalence of negative self-perceived health was associated with weight loss , rheumatic disease and not-for-profit LTIE. Actions must be developed to promote better health conditions in LTIE, such as nutrition consulting and physical therapy, to improve quality of life.
17	Jiménez-Redondo S, Beltrán de Miguel B, Gómez-Pavón J, Cuadrado	2014	Non-institutionalized nonagenarians health-related quality of life and nutritional status:	Nutricion hospitalaria - Volume 30, Issue 3, pp. 602-8 - published	Spain	>=80 years	98	Risk of malnutrition is a factor associated to health-related quality of life.

	Vives C.		is there a link between them?	2014-09-01.				
18	Jones JD, Vogelman JS, Luba R, Mumtaz M, Comer SD.	2017	Chronic pain and opioid abuse: Factors associated with health-related quality of life.	The American journal on addictions - Volume 26, Issue 8, pp. 815-821 - published 2017-12-01.	USA	Individuals with dual diagnoses of chronic pain and opioid use disorder	47	Insufficient pain management and depression are significant variables contributing to lower quality of life among individuals with chronic pain and opioid use disorder.
19	Jones SM, Gell NM, Roth JA, Scholes D, LaCroix AZ.	2015	The Relationship of Perceived Risk and Biases in Perceived Risk to Fracture Prevention Behavior in Older Women.	Annals of behavioral medicine: a publication of the Society of Behavioral Medicine - Volume 49, Issue 5, pp. 696-703 - published 2015-10-01.	USA	Women over age 55	2874	Higher perceived risk was related to lower quality of life and self-reported health, more medication and calcium use, increased bone density scan use, and less walking.
20	Laires PA, Laíns J, Miranda LC,	2017	Inadequate pain relief among patients with	Revista brasileira de reumatologia	Portugal	Patients ≥50 years with primary knee	197	Despite the use of analgesics, over half of patients reported moderate to severe knee pain.

	Cernadas R, Rajagopalan S, Taylor SD, Silva JC.		primary knee osteoarthritis.	- Volume 57, Issue 3, pp. 229-237 - published 2017-05-01.		OA who were receiving oral or topical analgesics		These patients also reported worse outcomes regarding other symptoms of knee OA, general health and quality of life than patients with no or mild knee pain.
21	Ostrowska, Bożena, Kozłowski, Paweł, Skolimowska, Beata, Bugaj, Rafał.	2023	Assessment of the frequency of falls and attendant risk factors, in conjunction with self-perceived quality of life, in elderly residents of nursing facilities in Wroclaw, Poland	Physiotherapy Quarterly - Volume 31, Issue 3, pp. - published 2023-01-01.	Poland	nursing home residents aged 63 - 99	44	The frequency of falls was established to affect the individual perception of overall quality of life, both mentally and physically. The individuals who had sustained a larger number of falls in the past also rated their overall quality of life as lower. Self-assessment of overall quality of life among the nursing home residents was low.
22	Pascut S, Feruglio S, Crescentini C, Matiz A.	2022	Predictive Factors of Anxiety, Depression, and Health-Related Quality of Life in Community-Dwelling and Institutionalized Elderly during the	International journal of environmental research and public health - Volume 19, Issue 17, pp. - published	Italy	65–89 year-old adults	282	A worsening of their social life and a moderate/high fear of COVID-19 were predictors of higher anxiety, while spiritual wellbeing and the possibility to get out of the house/institution emerged as protective factors against anxiety and for preserving quality of life.

			COVID-19 Pandemic.	2022-09-01.				
23	Şahin, Deniz Say, Özer, Özlem, Yanardağ, Melek Zubaroğlu.	2019	Perceived social support, quality of life and satisfaction with life in elderly people	Educational Gerontology - Volume 45, Issue 1, pp. 69-77 - published 2019-01-01.	Turkey	>=65 years	517	Perceived social support of people aged 65 years and older has a significant and positive effect on quality of life
24	Sivertsen, Heidi, Bjørkløf, Guro Hanevold, Engedal, Knut, Selbæk, Geir, Helvik, Anne-Sofie.	2015	Depression and quality of life in older persons: a review	Dementia and geriatric cognitive disorders - Volume 40, Issue 5, pp. 311-339 - published 2015-01-01.	NA	NA	NA	This review found a significant association between severity of depression and poorer QoL in older persons, and the association was found to be stable over time, regardless which assessment instruments for QoL were applied.
25	Spira AP, Kaufmann CN, Kasper JD, Ohayon MM, Rebok GW, Skidmore E, Parisi JM, Reynolds CF 3rd.	2014	Association between insomnia symptoms and functional status in U.S. older adults.	The journals of gerontology. Series B, Psychological sciences and social sciences - Volume 69,	US	Adults	6050	Among older adults, insomnia symptoms are associated with a greater odds of limitation in household activities and of restricted participation in valued activities. Insomnia interventions may improve functioning and quality of life among elders.

				Issue 0, pp. S35-41 - published 2014-11-01.				
26	Stenhagen, Magnus, Ekström, Henrik, Nordell, Eva, Elmståhl, Sölve.	2014	Accidental falls, health-related quality of life and life satisfaction: a prospective study of the general elderly population	Archives of gerontology and geriatrics - Volume 58, Issue 1, pp. 95-100 - published 2014-01-01.	Sweden	60–93 years	1321	Falls predict a long-term reduction in the physical component of HRQoL in the general elderly population. Fallers had a notable chronic lowered score in both HRQoL and Life Satisfaction, compared to non-fallers.
27	Su P, Ding H, Zhang W, Duan G, Yang Y, Chen R, Duan Z, Du L, Xie C, Jin C, Hu C, Sun Z, Long J, Gong L, Tian W.	2016	The association of multimorbidity and disability in a community-based sample of elderly aged 80 or older in Shanghai, China.	BMC geriatrics - Volume 16, Issue 1, pp. 178 - published 2016-10-27.	China	residents aged 80 or older	2058	The quantity of chronic conditions had relatively strong association with both ADL and IADL disability, which affects QoL. Initiating prevention of additional chronic conditions and interventions on clusters of diseases may decrease the potential risk of ADL/IADL disability.
28	Thiem, Ulrich, Klaaßen-Mielke, Renate,	2014	Falls and EQ-5D rated quality of life in community-dwelling seniors	Health and quality of life outcomes - Volume 12,	Germany	community-dwelling seniors aged ≥ 72 years	1792	Falls are negatively associated with EQ-5D rated quality of life independent of a variety of chronic diseases and

	Trampisch, Ulrike, Moschny, Anna, Pientka, Ludger, Hinrichs, Timo.		with concurrent chronic diseases: a cross-sectional study	Issue 0, pp. 1-7 - published 2014-01-01.				conditions.
29	Wham CA, McLean C, Teh R, Moyes S, Peri K, Kerse N.	2014	The BRIGHT Trial: what are the factors associated with nutrition risk?	The journal of nutrition, health & aging - Volume 18, Issue 7, pp. 692-7 - published 2014-07-01.	New Zealand			Sixty two percent of participants were identified to be at moderate or high nutrition risk. Protective factors independently related to low nutrition risk were living with others, higher physical and social health related QoL and higher functional status. WHOQOL environmental and psychological factors were not associated with nutrition risk when other predictive factors were taken into account. Those at low nutrition risk had a better functional status and physical and social health related QoL.

Discussion

Fall

Fall is considered as a major risk factor for the elderly and there is an abundance of fall-related literature in medical journals. For this review, only those studies were considered, which directly associate falls with Quality of Life.

In a six-year longitudinal study conducted by Stenhagen et al. (2014) among 1321 older adults in Sweden, it was found that individuals who experienced falls had a significant decrease in their SF-12 Physical Component Summary (PCS) scores over time. However, since severe injuries from falls were uncommon, the decline in PCS could not be solely due to physical injury, but more due to the feelings of insecurity and the tendency to avoid activities, which subsequently lead to reduced physical capacity.

Thiem et al (2014), in their study among community-dwelling senior adults in Germany, observed that falls had a negative impact on quality of life as measured by the EQ-5D tool, independent of other conditions like chronic diseases. Fear of falling and depression were also identified as significant factors influencing the quality of life.

More recently, Ostrowska et al. (2023) in Poland have reported that individuals who experienced falls rated their quality of life as lower, with more frequent falls correlating with worse assessments of quality of life. The frequency of falls impacted both the physical and mental dimensions of life satisfaction. Falls had negative effects on physical functioning, vitality, social activity, and perceptions of physical and mental health.

Pain

The effect of chronic pain on quality of life has been studied for different age groups. The elderly being more vulnerable to conditions that may cause pain, this becomes a significant risk factor for them.

A qualitative study among immigrant women from non-Western countries in Denmark who are suffering from chronic pain (Hernández-Galiot and Goñi, 2015) reports that the pain leads to physical disabilities, difficulties in performing daily

activities, sleep disorders, emotional distress, depression, and social isolation, all of which contribute to a lower quality of life.

A Japanese study of people aged 20 to 99 years (Inoue et al., 2015) found that those suffering from chronic pain reported lower utility values on the EQ-5D scale.

In a survey of 197 patients over 50 years old receiving treatment for osteoarthritis in Portugal, Laires et al (2017) found that patients with Inadequate Pain Relief (IPR) had significantly lower quality of life across all eight domains of the SF-12. Their overall Physical Component Summary (PCS) and Mental Component Summary (MCS) scores were also significantly lower compared to the non-IPR group.

Jones et al. (2017), in a study among individuals in the US with both chronic pain and opioid use disorder, found that poor pain management and depression were significant factors associated with a lower quality of life.

Nutrition

Nutrition is another important factor that pertains to Quality of Life, especially with respect to health and physical aspects. Studies have identified malnutrition or the risk of malnutrition as one of the factors negatively impacting QoL.

A study among independently living nonagenarians in Spain (Jiménez-Redondo, et al 2014) assessed their nutritional status using the standard Mini Nutrition Assessment tool and a dietary assessment, and correlated it with Quality of Life measured using EQ5D. It was found that risk of malnutrition is strongly associated with Health- Related Quality of Life.

This result has been further validated by a study in Spain (Hernández-Galiot & Goñi, 2017) among older adults, which found that nutritional status, assessed using the Mini Nutritional Assessment (MNA), was strongly correlated with quality of life, measured by the EQ-5D. Individuals who were malnourished or at risk of malnutrition had lower EQ-5D scores.

On the other hand, there are studies which have taken nutritional status as the dependent variable, and proved that a lower Quality of Life points towards a higher risk of malnutrition. The Brief Risk Identification Geriatric Health Tool (BRiGHT Trial), a Randomised Control Trial involving 3,893 older adults in New Zealand

(Wham et al, 2014) concluded that physical and social factors of WHOQOL were found to be predictive of nutritional risk. Similarly, a study among community-living elderly in the Netherlands (Bakker et al, 2018) found that Poor HRQoL, as indicated by EQ-5D and EQ -VAS is strongly associated with malnutrition.

Other Risk Factors

There are many other risk factors that are closely associated with Quality of Life of the Elderly, but are less extensively explored in non-medical literature.

Health Literacy : A study among Australian adults without prior diagnoses of vascular disease or diabetes, found that individuals with lower Health Literacy (HL) reported significantly worse physical and mental health compared to those with higher HL (Jayasinghe et al, 2016). There is a negative association between low health literacy and the physical and mental aspects of health-related quality of life (HRQoL).

Psychological risks: A study among older adults in Australia (Atkins et al, 2013) finds that psychological distress has a significant impact on QoL. Addressing factors that contribute to psychological distress - like improving social support, ensuring better sleep, and treatment of depression & anxiety- can improve QoL in both the community dwelling as well as the institutionalised elderly. A systematic review of literature on Depression and quality of Life in Older Persons (Sivertsen et al, 2015) revealed a strong association between the severity of depression and poorer quality of life (QoL) in the elderly. This relationship was consistent over time, and independent of the instruments used to assess QoL. A study among the elderly in Long Term Care Hospitals in South Korea (Chang et al, 2020) came up with a regression model that used depression and care dependency as predictor variables to explain 25.7% of the variance in quality of life.

Diseases and Chronic Conditions: A study among those aged 80 and above in Shanghai (Su et al, 2016) found a strong association between the number of chronic conditions and disabilities pertaining to Activities of Daily Living, which directly affects quality of life. Another study in rural Vietnam (Bang et al, 2017) has reported the number of non-communicable diseases as a determinant for HRQoL.

Insomnia: It has been reported that among older adults, symptoms of insomnia were linked to greater limitations in household activities and restricted participation in

valued activities, which directly had a negative association with QoL (Spira et al, 2014)

Living arrangements: A study on the role of living arrangements in the Quality of Life of community-dwelling older adults in the USA (Henning-Smith, 2016) has found that older adults living alone or with others fared worse than those living solely with a spouse. Women living with others faced a higher risk of poor quality of life and serious psychological distress compared to men. This finding points out the challenges involved in promoting the concept of "ageing-in-place" - it is important to address the vulnerabilities of older adults living alone or with others in the community.

A study conducted in Brazil to find associations between QoL and various physical and psycho-social factors (Campos et al, 2014) finds depressive symptoms, chronic diseases and family dysfunction as factors leading to a lower QoL. It also demonstrates gender differences in the QoL of the elderly in the community studied.

Mediating & Indirect factors of Risk

While many risk factors have been proven to affect the Quality of Life of the elderly, the relationships involved are more complex and interwoven. There are many mediating factors which, when understood and addressed, not only help in minimising risk, but also in finding and strengthening the protective factors.

A study (Gerino et al, 2017) examining how resilience and mental health mediate the relationship between loneliness and the mental and physical quality of life (QoL) in elderly Italians, found that individuals experiencing high levels of loneliness struggle to cope with adversity, trauma, or stress, leading to lower resilience, which in turn threatens their mental health. This situation can result in reduced mental and physical QoL. Thus, mental health acts as a mediator between resilience and QoL, while resilience partially mediates the relationship between loneliness and mental health.

Similar relationships have been found among loneliness, social life, involvement with the community and leisure activities.

During the third wave of COVID-19, a study among community-dwelling and institutionalised elderly (Pascut et al, 2022) found that a decline in social life and moderate to high fear of COVID-19 predicted higher anxiety levels. Conversely,

spiritual wellbeing and the ability to leave the house or institution emerged as protective factors against anxiety and in maintaining quality of life.

A study in South Africa (Hao et al, 2017) reported a high prevalence of perceived depression and loss of interest among the elderly. The rate was higher in individuals who reported difficulty joining community activities, and hence, addressing barriers to community engagement may help reduce depression.

Another study examining leisure activity levels in institutionalised older adults in Spain, (Fernández-Mayoralas, 2015) found that health and functioning-related factors were the most significant predictors of activity level, including the ability to perform self-care and usual activities, current perceived health state, number of chronic medical conditions, and cognitive functioning. Important socio-demographic factors included gathering with family and friends outside the nursing home, receiving visits from relatives and friends, and educational level. The study highlights the risks to active ageing and improved quality of life in institutionalised settings posed by declining physical and mental health, weakened social ties, and loss of functional capabilities.

Self-perception

A cross-sectional study among the residents of 10 Long Term care Institutions for the Elderly (LTIE) in Brazil showed that living in a not-for-profit LTIE is associated with negative self-perceived health (Jerez-Roig, 2016). This could be due to the greater onus given to medical care, which eventually leads to lack of social integration and social abandonment.

In a study on the effect of diagnosis of asymptomatic disease on HRQoL in the US, it was found that those who did not know about their disease generally had the same HRQoL scores as those without the disease (Hanmer et al, 2019). However, those diagnosed with disease but not receiving treatment reported much lower scores. A study of women over the age of 55 in the US found that women who perceived themselves to be at a higher risk for fracture reported a poorer QoL, regardless of whether this perception accurately reflects the actual risk. A study among the patients enrolled in the NA-HARP complex needs service in Australia (Hutchinson et al, 2013) found that lower self-reported HRQoL was associated with an increased risk of readmission. Patients with a higher score for the psychological wellbeing

component of QoL were less likely to be readmitted. A Turkish study reported that perceived social support of the older adults accounted for 22.1% of the total variance in their quality of life (Şahin et al, 2019).

These studies indicate how important self-perception is, in determining the quality of life as well as in modifying the risk factors affecting it. This emphasises the importance of adopting holistic intervention models addressing the bio-psycho-socio-spiritual needs of the elderly.

Research Gaps

This scoping review has brought to light the limited availability of literature pertaining to the relationship between risks and quality of life of the elderly. More studies have been done in the medical field, and non-medical literature is sparse. Most of the existing studies are quantitative. Considering that Quality of Life is a very subjective concept, there is a need for more qualitative research into this area, which can reveal the real concerns, needs and aspirations of the elderly.

Very limited research seems to have been done on institutionalised elderly. The few existing studies in this area focus on nursing homes housing older adults with some kind of disability. With the increasing aged population across the globe, and with the family-care system disappearing even in developing countries, there is a large population that needs residential care facilities even though they are otherwise healthy. Hence the study of risk associated with care homes for the aged is an emerging necessity.

Another observation of this scoping review is the complete absence of literature from an Indian setting. Though there are numerous studies on Old Age care, none of them focus on discerning the risks that may affect the Quality of Life of the elderly, whether in the community or in an institution. This may point to the fact that Risk Management is not yet a seriously considered factor in old age care in India, in which case, it is all the more essential to have more studies in this area.

Conclusion

This scoping review has summarised the findings from 29 studies based on the effect of various risk factors on the Quality of Life of the elderly. It brings forth clear evidence that different kinds of physical, environmental and psycho-social risks negatively impact the Quality of Life of the elderly. It also highlights the importance of non-medical factors, including self-perception in enhancing health

related QoL. However, the risk factors identified through this review are by no means exhaustive. Potential and existing bio-psycho-social risks may be community-specific, and comprehensive risk assessments are needed to list them out. However, from an intervention point of view, it can be logically concluded that reducing, eliminating or managing risks will enhance the Quality of Life of the elderly. It must also be noted that, considering the complex interactions and mediations between the various factors, innovative interventions must be designed to achieve intended results. The researcher has identified the strengths-based approach as such an intervention strategy in tandem with risk-management practices to improve the quality of life of the elderly in institutional care.

CHAPTER 5

INTERVENTION MODULE

5.1 Introduction

The second phase of the study involves a strengths-based intervention to improve the quality of life of the elderly residing in Elderly Care Homes.

An intervention is a purposely implemented change strategy. Considering the systems approach in the context of this study, the individual is part of a system that includes all bio-psycho-social and environmental factors in the care home. While the purpose is to bring change at the individual level, the interventions may be targeted at other levels also. (Fraser & Galinsky, 2010).

To ensure successful implementation, the intervention should be designed specifically according to the setting. (Fraser & Galinsky, 2010). Here, the intervention is designed for the experimental group of 13 elderly women at the *Sandeepany Mathrusadanam*, Guruvayur. The development and implementation of the module is detailed in this chapter.

Interventions can reduce risks in two ways - by decreasing vulnerability or by strengthening protective factors which can act as a buffer against the risks (Fraser & Galinsky, 2010). The second aspect, that is, strengthening protection, relates to the strengths orientation (Saleeby 2005 in Fraser & Galinsky 2010).

This study has drawn upon existing literature, especially the works of Dennis Saleeby, Venkat Pulla, Vishal Viswanath, James Caiels, Rosemary Chapin, Emily W S Tsoi, Lydia Guthrie, Imogen Blood and S P Rajeev.

The conceptual framework for the intervention was derived from the early works of Saleeby (1996, 2009) on the strengths- based approach, and expanded from the works of Chapin (2006), Tsoi (2022), Guthrie and Blood (2018). The relevance and application of this approach in the specific case of the elderly was derived from the works of Pulla (2012) and Rajeev (2020). The stages of the intervention were designed based on the 3-step approach of Caiels (2021). The focus group discussion

for strengths assessment was based on Saleeby's model. The design of the intervention module itself was based on Vishal's (2018) concepts of Strengths-Based Protective and Strengths-Based Engagement intervention.

5.2 Objectives of the Intervention:

The main objective of the intervention is to improve the quality of life of the residents of the Elderly Care Home, *Sandeepany Mathrusadanam*, the experimental home. The intervention module is to be developed using the strengths-based approach.

5.3 Risk management as an Intervention

Adopting a strengths-based approach does not imply disregarding potential risks. The researcher's scoping review points out that risks can significantly and adversely affect the quality of life of the elderly. Therefore, addressing these risks becomes essential to enhancing their overall well-being.

In phase 1 of the study, a few distinct risks were identified within the experimental home. A detailed overview of the risk management interventions implemented to address these risks is provided in Table 5.1. For interventions that required substantial infrastructural modifications or significant financial investments, the researcher compiled recommendations for the management to consider, ensuring a comprehensive and sustainable approach to improving the living environment for the elderly.

Table 5.1: Risks identified & Managed in the Experimental Home

	Risk Identified	**Resolution of Risk**
1	Emergency lighting, an inverter, or a generator is unavailable in case of a power outage.	Generator purchased by management
2	Absence of an alert system at the bedside.	An alert system has been implemented.

3	Lack of ramps at key entry and exit points.	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
4	Incorrect/unsuitable slope of ramps	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
5	Slippery floor	Anti-skid mats are provided and utilized in the home.
6	Uneven floor between room(slipping and tripping hazard)	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
7	Furniture stability risks	Recommendations were made to the management for further changes and modifications which they agreed to implement.
8	Wash basins are inaccessible for wheelchair users.	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
9	No hand shower in toilets	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
10	The facility does not support bathing while seated in a wheelchair.	Recommendations were made to the management for further changes and

		modifications, which they agreed to implement.
11	Lack of fire safety training for staff	Session given on fire & safety basics
12	No mosquito nets for all windows	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
13	No ambulance readily available	Connected with an ambulance service
14	Exercise is not part of the daily routine	Yoga teacher made available. Regular classes going on
15	No motivation to participate in the exercise routine	Yoga teacher made available. Regular classes going on
16	No health insurance for residents	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
17	Group counselling sessions are not conducted regularly	Group counselling sessions arranged
18	Activities are not chosen according to the residents' interests	Games, temple visits, spiritual sessions introduced, Interactive activities
19	No social activities	Helpful strategies discussed with the management for implementation
20	No income-generating activities	Helpful strategies discussed with the management for implementation
21	Lack of activities to enhance active	Engaged through new activities, diverse

	engagement	interactions happening
22	Unsupervised visit to outside/ inhibition to ask support from caretakers	Discussed with management to ensure safety during visits
23	Inmates' birthdays/ special days are not celebrated	Initiated celebrations
24	Inadequate ventilation in store rooms	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
25	Inadequate sunlight in store rooms	Recommendations were made to the management for further changes and modifications, which they agreed to implement.
26	No consultation with a dietician or health professional to plan diet	Guidance from health professional facilitated
27	Provision for a special diet tailored to health conditions is unavailable.	Guidance from health professional facilitated
28	No policy for checking safety of food from external sources.	Management agreed to change policy
29	Inmates lack cordial relationships among themselves	Sessions on interpersonal relationships conducted
30	Inmates lack cordial relationships with staff	Sessions on interpersonal relationships conducted
31	A provision to address the complaints of inmates is not available.	As per the researcher's suggestion, Management is conducting regular meetings to hear inmates' grievances

Table 5.2: Summary

Total factors identified	31
Recommended to management as it involves infrastructure changes/ large scale resource mobilisation	11
Participants not ready for change	3
Action taken for risk management	17

5.4 Strengths-Based Intervention

The Social Care Institute of Excellence, UK defines Strengths Based Approach as one focussing on the strengths of individuals, and not on their deficits. It is based on the primary principle that every individual has strengths. Strength includes not only the personal resources of the individual, but also the social networks and community resources which help the attainment of desired outcomes for the individual.

These interventions try to leverage the personal competencies of the client and the resources available and accessible to them. (Caiels et al, 2021). This helps the clients to compensate for what they cannot do, with the capabilities that they have, and thus obtain a sense of greater wellbeing.

Strengths-based intervention is not a glorified version of positive thinking, and is not about finding the good in even the worst situations. It does not ignore real problems, nor does it re-label weaknesses as strengths. (Pulla, 2012) It is not limited to some tools and methods, rather, it is an approach and an attitude. (Social Care Institute of Excellence, 2017)

Strengths based intervention draws upon the individual's ability to change, and concedes the importance of self-determination to direct this change. It is based on the observation that people, in their worst situations, have displayed their strengths (Pulla, 2012).

Strengths-based practices are specially relevant in the context of care-giving institutions. Here, it emerges as a collaborative practice between the receivers and givers of care, enabling the people availing care to co-create the services, rather than just taking the benefits (Pattoni, 2012). This improves their self-worth as well as develops a sense of ownership for the services created.

While engaging in strengths-based practices, it is important that the social worker adopts the same approach for self-development also. Identifying and developing one's own strengths will help the social worker to truly understand and discover the client strengths. This self-exploration transforms the social worker herself into a powerful tool of change for the client (Pulla, 2012).

The researcher, during the planning and implementation of this interventional study, has explored her own strengths, with special focus on those which will help in planning and delivering this intervention. This includes the ability to build trust and rapport with older people, ability to maintain good relationships, curiosity about each individual, appreciation of the wisdom and life experiences of older people and a strong belief that they deserve a happy life.

5.4 Strengths Based Intervention in the Elderly

Using the strengths-based approach with the elderly involves exploring and bolstering existing resources, while also assertively developing additional needed resources when required. (Chapin, 2006)

Table 5.3 explains how the general principles of the strengths-based perspective can be interpreted in its practice with the elderly. (Rajeev, 2020)

Table 5.3: Strength based Perspectives and Practice with the Elderly

General principles of Strengths Perspective	*Practice with older adults*
All individuals possess strengths	Discover, recognize and build on the strengths of the elderly
All experiences provide an opportunity for growth	Acknowledge the older adult's capacity to learn, grow, and change
Collaboration and not coercion leads to client engagement	Developing rapport with older adults
Not limiting but expanding capacity is the aim of the intervention	Facilitating the participation of the elderly in making choices, decisions and determining the helping process
Environment has resources	Acquiring resources for the elderly

Source: (Rajeev, 2020)

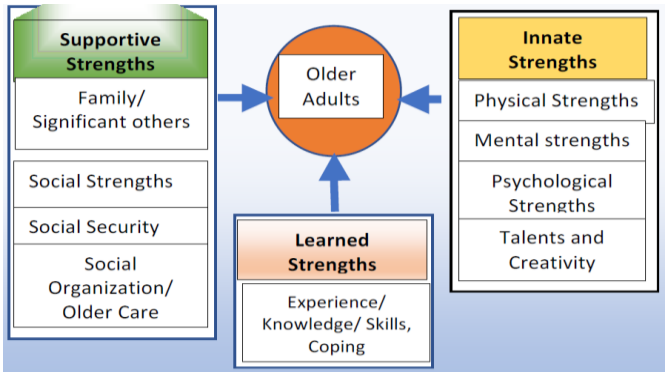
The strengths of older adults can be classified into 3 domains (Vishal, 2018).

Innate strengths - Those strengths present in the person naturally. These include their physical strengths, mental strengths, talents, creativity, etc.

Learned strengths - Those strengths which have been acquired through their personal and professional life experiences, like professional skills, maturity, wisdom, etc.

Supportive strengths - Strengths from the environment, like family, friends, caregivers, leisure activities, etc.

Figure 5.1: *Strengths of Older Adults*



Source: (Vishal, 2018)

The elderly, especially those residing in care homes, may feel that their strengths, especially innate and learned strengths, are subdued due to age. This may prevent them from recognising, utilising or accessing these strengths initially. In this context, supportive strengths are very significant.

Supportive strengths that can help improve the quality of life of the elderly can include the following (Tsoi et al, 2022):

- Family supports:
    - Family engagement (receiving love, care and respect as an elder in the family, shouldering family responsibilities, being part of the decision making process etc)

- Social Support
    - Professional helpers like nurse, counsellor, social worker etc
    - Networks - friends, retirees association, music groups, residents' association etc - being able to socialise, engage in activities of interest, discharge duties responsibly
- Spiritual/ Religious supports:
    - Beliefs (Trust in God, values, etc)
    - Religious rituals (Going to places of worship, taking part in rituals, etc)
    - Self-reflection (introspection about meaning of human life, will of God, etc)
- Leisure activities
    - Exercise
    - Music & dance
    - TV
    - Reading
    - Other activities

Strengths based intervention in older adults can be of two types, Strengths Based Protective and Strengths Based Engagement (Vishal, 2018).

a) Strengths - Based Protective (SB - P)

Protective intervention aims to preserve the existing strengths of the older adults and utilise it to solve their current problems or enhance their capacities. It also involves improving their existing strengths wherever possible.

b) Strengths - Based Engagement (SB - E)

Engagement intervention aims to engage and connect the older adults to available support systems. This may also involve breaking psychological barriers so that they themselves are able to access these support systems, or their own hidden strengths.

Both these approaches have been utilised by the researcher in this study.

5.5 Stages of Intervention

The development of an intervention module has been approached in different ways by different authors. However, all these models are characterised by three key stages. The first stage is a comprehensive evaluation of the client's situation. The second stage is the development of the intervention objectives, and the final stage is the direct action. (Caiels et al, 2021). In conducting the present intervention, the researcher has used this 3-stage approach.

The three stages incorporate the 7 steps of the Generalist Intervention Model.

Table 5.4: Intervention flow chart.

Stage 1: Comprehensive Evaluation of the Client's Situation	Engagement
	Assessment
Stage 2: Development of the intervention module	Planning
Stage 3: Direct Action	Implementation
	Evaluation
	Termination
	Follow Up

The meanings of certain important terms, as used in this chapter, are as follows:

- Participants - the 13 elderly mothers who are residing at the *Sandeepany Mathrusadanam*, the experimental home

- Management - the decision makers who are the board members of the *Sandeepany Seva Samithi* trust that runs the home

- Caretakers - the staff who are employed for discharging the different duties responsibly like cooking, cleaning, taking care of the daily needs of the mothers and the counsellor

5.6 Stage 1: Evaluation of the Participants' Situation

The context of this study is characterised by two main features - the limited self-determination possibility of the participants as they are in a care home, and the practical difficulty in exploring and implementing personalised solutions.

Hence, the researcher used personal interactions based on the 'blossoming conversations' tool, and focus group discussion based on Saleeby's model to evaluate the participants' situation and to assess their strengths.

The researcher first interacted personally with the participants through a 'blossoming conversation', and then administered the pre-intervention questionnaire (WHOQOL 100). This was followed by a focus group discussion aimed at strength assessment.

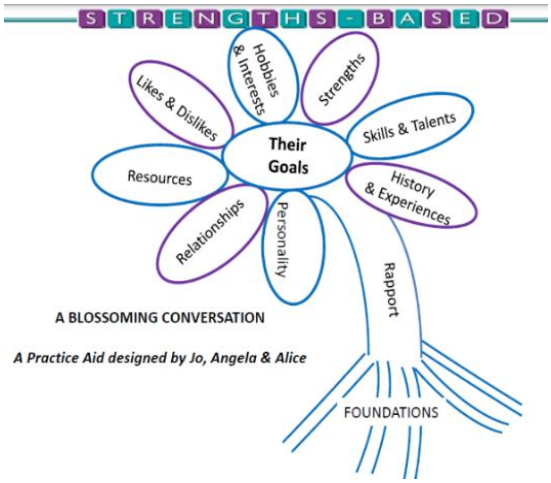
5.6.1 Personal Interaction

Engagement with the participants was done through personal interactions over a period of 8 weeks. The researcher regularly visited the *Sandeepani Mathrusadanam*, the experimental home and interacted with the participants individually and in groups.

The objectives of the personal interaction were to develop rapport, build trust and enable open communication with the participants.

The researcher used the 'Blossoming Conversations' practice aid (Figure 5.2) in her interactions with the participants, to generate strengths-based conversations. These conversations were natural, friendly and pleasant, and helped develop the initial rapport required between the researcher and the participants.

Figure 5.2: Blossoming Conversations



Source: City of Wolverhampton Council, (2017)

The researcher used the skills of active listening, empathy, observation, open dialogue and rapport building to make the interactions effective and purposeful.

5.6.2 Administration of the pre-intervention questionnaire

The researcher administered the pre-intervention questionnaire (WHOQOL100) individually to all the participants of the experimental home and the control home.

The researcher did not want to make the process tedious or stressful for the respondents. The researcher was aware that adhering to rigid interview protocols may block the smooth expressions of older people, and prevent an effective engagement. Hence a collaborative approach is better, allowing an interactional exchange between the researcher and the participant (de Vries et al, 2014).

The researcher took care to administer the questions in a natural way, taking care not to cause any undue distress to the participants. Because the researcher had already established a rapport with the respondents, they were very cooperative and active in their participation, and the pre-intervention questionnaire could be administered effectively.

5.6.3 Focus Group Discussion

Focus groups are planned discussions to elicit the perceptions of a group on a particular theme, through guided interactions (Krueger & Casey, 2000). The focus group promotes discussion among the participants, guided by a semi- structured open- ended questionnaire. it helps to elicit not only information, but the feelings, reactions, agreements, shared experiences and exceptional cases of the participants (Gaižauskaitė, 2012).

Since the discussion involved personal questions, the researcher chose a group size of 3-4. Based on the personal interactions, participants of each group were selected by the researcher, ensuring as much as possible, similar backgrounds but diversity in attitudes (De Carlo, 2018).

The objectives of the FGD were to understand the strengths of the group and to identify potential intervention areas.

The researcher used her skills for framing relevant questions, active listening, prompting, elucidating and facilitation.

The questions for the FGD were framed based on the model given by Saleeby (2009)

Table 5.5: Questions used in the FGD

Survival Questions	How have you managed to adjust to the environment in this home? What capacities have you utilised?
Support Questions	Who are the special people on whom you can depend now? How have people around you helped you overcome challenges?
Exemption Questions	Before coming here, what all did you enjoy doing?

Possibility Questions	What are your special talents and abilities? What would you like to do to make yourselves happy? What are the things you manage well?
Esteem Questions	What good things do other people say about you? What good things do you like about yourself? What are you feeling good about?
Perspective Questions	What do you think about your current situation? How do you perceive the people around you?
Change Questions	What has worked in the past to bring a better life for you? What have you learned so far that could be helpful moving forward?

Responses of FGD:

The key responses that emerged in the FGD are summarised below.

Survival Questions

"I have accepted my current situation"

"God will help those who have no other support"

"I hope that someday my family will take me back"

"This home is like a family too"

Support Questions

"A particular member of the Management Committee"

"Caretaker"

"Counsellor"

"He/she listens to me"

"He/ she takes care of all my needs"

"He/ she is loving and caring"

Exemption Questions

"Job"

"Taking care of children"

Possibility Questions

"I would like to go to Guruvayur temple"

"I like spiritual retreats"

"Music & dance"

"Talking to people"

"Games"

"Watching TV"

Esteem Questions

"I have a good sense of humour"

"I write poetry"

"I sing nicely"

"I like acting"

Perspective Questions'

"I am safe here"

"At least I get food and shelter"

"The people who run the home are nice"

"We don't hold grudges against anyone for long"

Change Questions

"Having a job"

"Being independent"

"I have learnt to have faith in God"

Findings

The findings from the FGD, personal interactions and the researcher's own observations are described below.

Most of the participants have accepted their situation, and are satisfied with the way they are living, but a few, especially those who have families of their own, are expecting that their children will take them home someday. They love the care and affection of the staff and authorities of the home. They have placed great trust on the authorities.

The participants can manage their daily routines well. They can independently take care of personal needs like bathing, washing clothes, drying clothes in the facility upstairs, having food, etc. They are also capable of doing some simple physical exercise like walking, playing with a ball, etc. Their main aspiration is to be independent in taking care of themselves, without creating difficulties to other staff or inmates. They wish to have physical strength and sensory abilities to be able to do this.

The researcher has also observed that the participants are well dressed and take care of personal hygiene.

The participants enjoy singing, dancing and acting. They are active in helping in the kitchen. They love spending time talking to children and adults and reading books. They enjoy cracking jokes and conversations with tit for tat responses. They also have practical wisdom.

They are deeply religious. They have ardent faith in God. Every evening, they come together in the prayer hall, and they chant hymns together. They like visiting nearby temples. A visit to the famous Guruvayur temple, which is nearby, makes them especially happy - it defines their best day. Their faith in God helps them in facing challenges.

Some strengths of the participants identified from these findings are summarised in Table 5.6

Table 5.6: Strengths of the participants identified

Innate Strengths	Learned Strengths	Supportive Strengths
Ability and urge to be independent in Activities of Daily Living Wish to have physical strength & sensory abilities Sense of personal hygiene Self-care Interest in games Creativity Love for children	Acceptance Maturity Forgiveness Helping nature Socialising Sense of humour Wisdom	Management Caretakers Community Leisure activities Spirituality and faith in God.

5.7 Stage 2: Developing the Intervention Module

Based on the strengths identified in stage 1, the researcher developed an intervention plan which consisted of both SB-P and SB-E components. The objectives were translated into sessions focussing on specific activities. These sessions were developed after consultation with experts in yoga, ayurveda, naturopathy, allopathic medicine, physiotherapy, geriatric care, psychology, counselling and social work. The theoretical bases for the sessions were derived from extensive review of literature.

These sessions, while focussing on particular strength areas, may also have multiple positive benefits, and may help in developing new strengths, decreasing vulnerability, mitigating risks, and solving existing problems. The sessions also address and help to develop the bio-psycho-social and spiritual domains of life of the participants. The resources accessed for facilitating each session are also noted, as they indicate potential strengths of the future.

A brief outline of the sessions are given in Table 5.7 & 5.8

The sessions are explained in section 5.8.

5.7.1 Strengths Based - Protective Intervention

These sessions are aimed at conserving and enhancing the existing strengths and resources within and outside the individual. Here active strengths can be promoted, and also utilised to protect the other capacities of the individual and to resolve the challenges of daily life.

Table 5.7: Strengths-Based - Protective Intervention

Sl No	Domains addressed	Focus strength area	Intervention	Strengths developed	Resources accessed
1	Physical/Psychological/ Spiritual	Ability and urge to be independent in Activities of Daily Living Wish to have physical strength & sensory abilities	Yoga (Collins, 1998; Rao, 2018; Hoy et al, 2020).	physical strength, calmness, silent introspection	personal (interest in yoga, readiness to engage, interest in meeting new persons), social network (resource person)
2	Physical/Psychological	Ability and urge to be independent in Activities of Daily Living	General health check-up (Ayurveda) (Sharma, 2016; Rao, 2018)	enhancing physical health by resolving recurring illnesses, pain, sleeplessness etc.	Community (facilitation of the camp by home management)

		Wish to have physical strength & sensory abilities		Resultant improvement in mental health & happiness.	
3	Physical	Ability and urge to be independent in Activities of Daily Living Wish to have physical strength & sensory abilities	Eye check up (Tielsch et al, 1995; Keller et al, 2001; Umfress & Brantley, 2017)	enhancing vision by addressing eye care issues	Community (facilitation of the camp by community members)
4	Physical/Psychological	Ability and urge to be independent in Activities of Daily Living Wish to have physical strength & sensory abilities	Guided chair-based exercise (Robinson et al, 2016; Cordes et al. 2021; Natalie et al, 2021)	physical strength, pain management, mobility, balance	Personal (availability for the sessions) social network (resource person)
5	Psychological/	Acceptance	Counselling	emotional disclosure,	personal (ability to engage),

	Social	Forgiveness	(Hill & Brettle, 2005; Bhar et al, 2015; Chapman, 2018)	sharing and understanding feelings, interact more freely with co-inhabitants	social networking (counsellor)
6	Psychological/ Spiritual	Spirituality & faith in God	Spiritual retreat (Koenig, 2012; Erichsen & Bussing, 2013)	self-awareness, faith, values, introspection	personal (ability to listen, interact and clarify)
7	Physical/Psychological	Sense of personal hygiene and self-care	Health education session (Rochon et al, 2002; Scottish Executive, 2001; Kececi et al, 2012)	self-care, taking responsibility for one's health, ability to express health difficulties clearly	personal (ability to gain and utilise new knowledge, interest in meeting new persons) social network (resource person)
8	Physical/Psychological	Sense of personal hygiene and self-care	Nutritional counselling (Arvanitakis et al, 2009; Kaur et al,	Self-care, interest in cultivating a kitchen garden, understanding nutritional value of food	personal (ability to gain and utilise new knowledge, clarify doubts, connect with previous experiences)

			2019)	items	
9	Physical	Wish to have physical strength & sensory abilities Sense of personal hygiene and self-care	Physical risk management tips (Institute of Medicine, US, Division of Health Promotion and Disease Prevention, 1992; Minimol, 2016)	awareness of good practices for reducing health & environmental risks	personal (readiness to acquire & utilise new knowledge)
10	Physical	Ability and urge to be independent in Activities of Daily Living	Environmental modifications - anti skid mats inside and outside bathrooms, grab bar, walkway in the garden, alarm bell, basic other necessities (Pynoos et al, 2010; Lim, 2018)	ability to avert risks, happiness with modified environment	community (support to make the necessary changes)
11	Psychological/	Maturity	Talk on Living in	building better	personal (availability &

	Social	Wisdom Sense of humour	harmony (Umberson & Montez, 2010; Villar et al, 2021)	relationships, understand self and others, expressing clearly	interest), social network (resource persons)
12	Physical/ Psychological/Social	Caretakers Management	Session for caretakers and management personnel (Kloppers et al, 2015; Sezgin et al, 2022)	helping develop a better caregiving environment in the care home with more understanding personnel	readiness of the home management to attend the sessions, social network (resource persons)

5.7.2 Strengths Based - Engagement Intervention

These interventions aim to engage the participants with the available resources within and around them. It helps build connectivity, overcome psychological barriers, and access available strengths and resources as required. It may also lead to revealing hidden strengths, which can then be developed and accessed.

Table 5.8: Strengths-Based – Engagement Intervention

Sl No	Domains addressed	Focus strength area	Intervention	Strengths developed	Resources accessed
1	Psychological/ Social	Leisure activities Community Socialising	Zumba demonstration ("The Aston Gardens Senior Living Community, Florida," 2021)	love towards physical activity, enjoyment, confidence, breaking their inhibitions	personal (interest in meeting new persons and interacting with children) social network (resource group)
2	Physical/ Psychological/ Social	Interest in games Helping nature	Simple games (Sala, 2019; Hedayati, 2019; Zhang et al, 2021; Watts, 2022)	Group cohesion, fun, free interactions with others	personal (ability to engage in a group game) community (participation in the games)
3	Social/ Spiritual	Spirituality & faith in God Community	Temple visits (Koenig, 2012; Zimmer, 2016)	faith, interaction with seniors from other homes, personal happiness, sense of wellbeing	social networking, community (arrangements for the trips)

4	Social	Creativity Socialising	Interaction with Artists, authors (Tiernan et al, 2013; Boamah et al, 2021)	ability to interact with persons from outside, happiness in seeing their favourite stars, hope, joy	Community (organising the programme)
5	Psychological/ Social	Love for children Maturity	Intergenerational interaction with children having special needs (Chapin, 2006; Vishal, 2018)	empathy, love, care, contextualising own difficulties	community (organising the interaction with children)
6	Psychological/ Social	Leisure activities	Screening of film (Schulenberg, 2003; Fernandez-Aguilar, 2018; Breckenridge, 2020)	relaxation, fantasy, emotional involvement, happiness	community (arranging the show)

7	Social/ Psychological	Creativity Love for children Socialising	Celebration of Mother's Day (Robbins et al, 2002; Niveau et al, 2021)	interaction with youth, feel good about oneself as a 'mother', expressing creativity	Community (organising the programme)
8	Psychological/ Social	Socialising Helping Nature	Group support & group discussions (Simard, J., & Volicer, L. (2020; Seppala, 2013 in Suragarn, 2021)	ability to bond with others, friendships, mutual support	social networking among the participants
9	Psychological	Self-care acceptance	Mindfulness (Kabat-Zinn, 1994; Keng et al, 2011)	awareness, being in the present, calmness	personal (availability, readiness to learn) Social network (resource persons)
10	Social/ Psychological	Love for children Socialising Sense of humour Maturity	Intergenerational interaction with children of Children's Home	ability to bond, express their creativity, love and care for children, appreciate children's	community (organisisng the interaction with children from Child Care Institution)

			(Bagnasco, 2019)	creativity, happiness	
11	Psychological	Creativity Love for children	Wall painting demonstration (Bagan, 2009 in Hathorn 2013)	interest in creative art, self-expression through art	personal (ability to appreciate art), social network (availability of artiste to engage the participants)
12	Psychological	Creativity Leisure activities	Programmes for Youtube (Fisher & Specht, 1999 in Flood & Phillip, 2007)	confidence, happiness, feeling important, self-worth	personal (expressing creativity), social network (making arrangements)
13	Psychological	Acceptance Wisdom	Reminiscence intervention (Woods et al, 2018; Asiret, 2018; Tam et al, 2021)	self-image enhancement	personal (ability to recall past experience, ability to share with clarity), social networking (people willing to listen and encourage)

5.8 Stage 3: Direct Action

The intervention module was implemented at the *Sandeepani Mathrusadanam*, Guruvayur, over a period of 6 months. The process flow of each session, its rationale based on existing literature and participant feedback are given below.

Strengths Based - Protective Intervention

1. **Yoga**

Objective:

To improve the physical and mental health of the participants through regular practice of Yoga

Rationale for the intervention:

Yoga is an ancient Indian discipline that involves physical postures, breathing techniques and meditation. Yoga has proven physiological effects and can be used in mind-body fitness therapies (Collins, 1998). Regular practice of Yoga helps mitigate different health problems like high blood pressure, high cholesterol, asthma, varicose vein, back pain etc. Hence Yoga is highly recommended for older adults. (Khan et al, 2023). Yogic practice also helps reduce chronic stress, depression, anxiety and chronic pain, improves sleep patterns and increases overall quality of life and wellbeing (Rao, 2018). It also helps improve cognition in older adults (Hoy et al, 2020).

Considering these benefits, the researcher organised a series of Yoga sessions for the participants, by expert practitioners.

Domains addressed: Physical/ Psychological/ spiritual

Strengths developed: Physical strength, calmness, silent introspection

Resources accessed: personal (interest in yoga, readiness to engage, interest in meeting new persons), social network (resource person)

Session Flow:

The researcher organised 3 sessions on consecutive days. The yoga teachers were experts in their field, and were able to understand the needs and limitations of the participants well. For the session, they chose exercises the older adults could easily do, without any pain or discomfort. They also developed a good relationship with the participants.

Feedback:

The participants reported that they realised the benefit of doing yoga. They decided to continue yoga practice. This led the management of the home to arrange regular Yoga classes, which continued even after the intervention period.

2. General Health Check Up (Ayurveda)

Objective:

To improve the quality of life of the participants by resolving their immediate health issues and physical discomforts

Rationale for the intervention:

The Indian system of Ayurveda has many time-tested therapies for healthy ageing (Rao, 2018). It has a specialised branch for dealing with ageing-related issues - like improving physical and cognitive strength, increasing longevity, dealing with chronic illnesses etc. Through a holistic approach, Ayurveda helps to keep older adults active and healthy, and therefore improves their quality of life (Sharma, 2016).

The participants, hailing from Kerala, strongly believe in the Ayurvedic system of medicine. They are convinced that the age-related health issues that they are suffering from, can be effectively resolved through Ayurveda. So, the researcher chose to include consultation with an Ayurvedic physician as a part of her intervention module.

Domains addressed: Physical/ Psychological

Strengths developed: enhancing physical health by resolving recurring illnesses, pain, sleeplessness etc. Resultant improvement in mental health & happiness

Resources accessed: Community (facilitation of the camp by home management)

Session Flow:

The ayurvedic physician gave individual consultation to all the participants. She patiently listened to all their health concerns and present physical discomforts, and prescribed medicines. She was compassionate to the difficulties of the older adults, and gave medical advise accordingly. For example the participants had said that it was difficult for them to apply oils which are usually prescribed in ayurveda. So instead, she prescribed ointments which are easy to use. She also took the time to talk to the participants and developed a good rapport with each.

Feedback:

The participants reported that they felt heard about their pains and other physical discomforts. This was a comfort to them.

3. Eye Check up

Objective:

To improve the quality of life of the participants by resolving vision-related problems

Rationale for intervention:

Poor vision is a root cause for many risk factors in older adults. It leads to physical and functional disabilities, and sharply increases the risk of falls. Vision loss causes difficulties in ADL, and may accentuate depression and anxiety, which further leads to physical decline. Simple corrective measures like treatments for refractive errors and cataract may greatly enhance vision, and thereby the quality of life. (Umfress & Brantley, 2017)

The elderly in institutionalised care are at a greater risk for vision impairments compared to their community-dwelling counterparts (Tielsch et al, 1995). They also may not be receiving regular eye-care and eye-checkups that could prevent vision loss by giving the right treatment at the right time (Keller et al, 2001).

This prompted the researcher to organise an Eye-check up camp for the participants, as part of the intervention module.

Domains addressed: Physical

Strengths developed: enhancing vision by addressing eye care issues

Resources accessed: community

(facilitation of the camp by community members)

Session flow:

The eye camp was conducted by a reputed Eye-care hospital. The camp was open to the neighbouring community also. Many eye problems were identified through the check-up - like cataract, issues with the power of spectacles etc. The doctor gave a report to the management and explained to them the existing problems of each participant, and how it could be resolved. Based on this information, the management contacted the Taluk Hospital and got the remedies done free of cost.

Feedback:

The participants reported that they were very happy because their eye-sight has improved after the treatments. Now they are able to see better and read more easily, and feel more confident and relaxed.

4. Guided chair-based exercise

Objective:

To increase physical activity among the participants through suitable exercises.

Rationale for intervention:

Chair based exercises (CBE) are usually suggested for older adults who have mobility issues and are hence unable to do regular standing exercises. CBE has a positive effect on the physical, cognitive and psycho-social functions of nursing home residents (Cordes et al.2021). Natalie et al (2021) have enumerated balance, gait speed, and grip strength as some of the benefits of CBE. They also suggest that CBE can be used as a simple routine, to overcome the negative impact of physical inactivity in older adults. older people like to participate in CBE not only for improved physical and mental health, but also as an engaging activity that improves their confidence and gives opportunities for socialisation and friendship (Robinson et al 2016).

The researcher organised a session on Guided Chair Based Exercise, which the participants could continue as part of their daily routine.

Session flow:

Initially the participants were a bit apprehensive about the word 'exercise'. The faculty reassured them and gave them confidence. She demonstrated some very simple exercises, which they were able to follow. On the second day the participants were more enthusiastic and confident. The faculty concluded the session by requesting them to continue doing these exercises daily if possible.

Domains addressed: Physical, Psychological

Strengths developed: Physical strength, balance, pain management, gait speed, confidence

Resources accessed:

- Personal - availability for the session, ability to overcome initial inhibitions
- Social network - the faculty is a part of the social network of the elderly care home, and was ready to share her time and knowledge for the mothers.

Feedback:

The participants said that they enjoyed the session. They said that they were initially worried about doing exercises, but later they enjoyed it. They also said that it increased their confidence about their own physical capabilities.

5. Counselling

Objective: To resolve the immediate emotional concerns of the participants

Rationale for intervention:

In spite of high rates of mental health problems, the residents of Elderly Care Homes rarely get access to professional help (Bhar et al, 2015). Counselling is effective in addressing issues like depression and anxiety in older adults (Hill & Brettle, 2005). Older people may not even be aware of what counselling is, and how it can help them, so they will not ask for counselling support by themselves. Even though counselling may not be able to change their situation or solve their problems, it may still help to make them more cheerful, peaceful and happier (Chapman, 2018).

Hence, the researcher decided to address the mental health needs of the participants by arranging counselling sessions for them.

Domains addressed: Psychological/ social

Strengths developed: Emotional disclosure, sharing and understanding feelings, interact more freely with co-inhabitants

Resources accessed: Personal (ability to engage), social networking (counsellor)

Session flow:

The counsellor first interacted with the participants as a group, and developed a rapport with them. Then she gave individual sessions to the participants, where they could open up and freely share their thoughts and feelings.

Feedback:

The participants reported that they felt good after talking to the counsellor. They felt that there was someone to listen to them and support them. This made them feel more relaxed and calm.

6. Spiritual Retreat

Objective: To build resilience in the participants by reinforcing their spiritual beliefs

Rationale for intervention:

The elderly living in care homes have spiritual needs that are not usually recognised, and hence not addressed (Erichsen & Bussing, 2013). Spiritual beliefs help older adults to perceive negative life events in a positive way, and find meaning and purpose in life. Religious scriptures provide examples of persons suffering from similar situations and how they were protected by a caring and compassionate God (Koenig, 2012).

The researcher arranged a one-day spiritual retreat for the participants, where they could listen to stories from scriptures. Since all the participants belong to the Hindu faith, the chosen resource person was also of the same faith.

Domains addressed: psychological/ spiritual

Strengths developed: self-awareness, faith, values, introspection

Resources accessed: personal (ability to listen, interact and clarify)

Session flow:

The session was handled by a young priestess, who is very knowledgeable in Hindu philosophy and religion. She interacted with them, and told them stories from Hindu scriptures. She answered their questions on spirituality. She also taught them simple musical hymns.

Feedback:

The participants were full of wonder that such a young person could be so learned in religion, and they bonded with her very easily. They were very involved with the stories, and felt very happy and positive after the session.

7. Health education session

Objective: To create sustainable change in the participants by making them feel responsible for their own health

Rationale for intervention:

Healthcare is a shared responsibility (Rochon et al, 2002). Older adults can be involved in their own healthcare regime, especially in the management of chronic diseases like diabetes. For this, they should have access to information about healthy lifestyles. (*Adding life to years: report of the expert group on healthcare of older people*. Scottish Executive, 2001). Health education increases an individual's knowledge about health and healthcare and helps them make informed choices in this regard (Kececi et al, 2012).

So, the researcher organised a health education session for the participants and the caretakers of the experimental home.

Domains addressed: Physical/Psychological

Strengths developed: self-care, taking responsibility for one's health, ability to express health difficulties clearly

Resources accessed: personal (ability to gain and utilise new knowledge, interest in meeting new persons) social network (resource person)

Session flow:

The session was handled by a qualified and experienced doctor. She started the session with a short talk, giving general health tips. This was followed by an

interaction, where the participants shared their queries and concerns. These queries were addressed by the resource person from a lifestyle perspective.

Feedback:

The participants had many queries and they felt relieved when their concerns were addressed.

8. Nutritional Counselling

Objective:

To bring about healthy nutrition practices in the care home

Rationale:

Due to reduced food intake in old age, nutritional deficiencies are common, and this may affect the physical, mental and social quality of life of the elderly. Undernutrition can also lead to chronic diseases (Kaur et al, 2019). Creating awareness among the elderly, modifying the care home management and kitchen activities can help in tackling undernutrition (Arvanitakis et al, 2009).

The researcher organised a nutritional counselling session for the participants and the care home staff, to create awareness about healthy nutrition practices and inspire them to adopt the required changes.

Domains addressed: Physical/ Psychological

Strengths developed: Self-care, interest in cultivating a kitchen garden, understanding nutritional value of food items

Resources accessed: personal (ability to gain and utilise new knowledge, clarify doubts, connect with previous experiences)

Session flow:

The session was handled by a senior nutrition expert. He gave the participants tips on healthy diet, timing of food intake, quantity of each type of food, etc. The

participants liked most of the recommendations, but had some resistance to changing their routines. They were also concerned whether the recommendations would be viable in a care home setting. The resource person addressed their concerns, and helped them to come up with practical options. The researcher facilitated a separate discussion between the nutrition expert and the management and convinced the management to implement certain viable changes for ensuring better nutrition.

Feedback:

The participants accepted that the inputs were logical, and said that they would follow them as much as possible. But they expressed some difficulty in changing the routines and food habits that they have been following so far.

9. Physical risk management tips

Objective: To bring in behavioural changes in the participants to avoid preventable risks

Rationale for intervention:

The risks faced by older adults can be related to physical, cognitive, environmental, health, social relationships and other domains (Minimol, 2016). Some risks can be prevented by behavioural changes alone. This can include avoiding high risk activities, enhancement of personal and environmental resources to maintain desirable activities, etc (Institute of Medicine, US, Division of Health Promotion and Disease Prevention, 1992). A strengths-based approach to risk management focuses on involving the client in the decision-making process to develop their internal and external resources. (Minimol, 2016)

The researcher conducted a discussion with the participants on potential bio-psycho-social risks and their strengths-based management.

Domains addressed: Physical

Strengths developed: awareness of good practices for reducing risks

Resources accessed: personal (readiness to acquire & utilise new knowledge)

Session Flow:

The session consisted of a discussion on the risks that the participants face or feel they may face in future. The researcher motivated the participants to share their thoughts and ideas on how these risks could be prevented. The researcher also facilitated a sharing about their inner strengths as well as external resources and how they could access these to minimise the risks.

Feedback:

The participants reported that they got more clarity about risks and risk management. They felt that the discussion helped them to consolidate their own knowledge and incorporate it into their daily routines. They felt confident in their own capabilities and in being able to help others also.

10. Environment modification

Objective:

To enable better performance of ADL through minor environmental modifications

Rationale for intervention:

The risk of fall is a major challenge for older adults. Modifying the environment according to the specific functional needs of the elderly can avert this risk to a large extent, while retaining their mobility and independence (Pynoos et al, 2010). Environmental modifications enable better performance of ADL in older adults and improve their Quality of Life (Lim, 2018).

Domains addressed: Physical/ Psychological

Strengths developed: ability to avert risks, happiness with modified environment

Resources accessed: community (support to make the necessary changes)

Modifications done:

The researcher provided anti-skid mats inside and just outside the bathrooms. The researcher convinced the management to fix the already existing grab bars and to provide grab bars in other areas too. The researcher also sought the management's support to create a vegetable garden in the compound, and provide a walkway through it. The researcher also gave the management a list of potential easy to do modifications for the care home, and potential funding sources.

11. Talk on Living in Harmony

Objective: To enable better relationships among the participants and to empower them to handle the challenges of life positively.

Rationale for intervention:

Having emotionally significant human relationships is a basic human need. In a care home setting, even though many people are inhabiting the same space, the possibilities for intimacy and closeness are severely restricted due to various factors (Villar et al, 2021). Social relationships have also been found to impact physical and mental health (Umberson & Montez, 2010).

The researcher decided to organise a session for the participants on developing healthy relationships. From her experience, she felt that the concept of 'Living in Harmony', developed by a renowned Life Coach, was most appropriate to empower the participants to build good relationships among themselves.

Domains addressed: Psychological/ Social

Strengths developed: building better relationships, understand self and others, expressing clearly

Resources accessed: personal (availability & interest), social network (resource persons)

Session flow:

The resource person gave the participants some tips on how they can make their day to day lives happier, and how they can develop good relationships with each other.

In a friendly and humorous way, he convinced them that one's happiness is one's own choice. It is determined by our response to the experiences that life gives us.

Feedback:

The participants loved the session, and were full of joy and hope at the end of it. They also joked with the resource person, and developed a very good rapport with him. They said that they felt a positive energy after the talk.

12. Session for caretakers and management personnel

Objective:

To convince and motivate the caretakers and management personnel to play an active role in improving the quality of life of the participants

Rationale for intervention:

In many care homes, the caregivers have no formal training, and take up the job simply out of passion. (Kloppers et al, 2015) Increasing the motivation of caregivers can improve the quality of the care process. (Sezgin et al, 2022). Good interpersonal relationships and effective communication are very important in the caring process. Managerial support is also essential to ensure smooth functioning of the care home (Kloppers et al, 2015)

The researcher decided to conduct sessions for the caretakers and management personnel of the home, to involve them in making changes for improving the quality of life of the residents.

Domains addressed: Physical/ Psychological/Social

Strengths developed: developing a better caregiving environment in the care home with more understanding personnel

Resources accessed: readiness of the home management to attend the sessions, social network (resource persons)

Session flow:

The researcher had an open discussion with the caretakers and management personnel regarding the proposed changes and the interventions being conducted. She listened to their difficulties and challenges. She facilitated the discussion to find workable solutions.

Feedback:

The caretakers and managers were happy that the researcher understood their problems and that she appreciated their efforts. They were happy to cooperate with the intervention.

Strengths Based - Engagement Intervention

1. **Zumba Demonstration**

Objective:

To enable the participants to break their inhibitions about physical exercise

Rationale for intervention:

Zumba is recommended for older people due to its multiple benefits. It is an exercise that can be catered to their level of competence; it involves moving along with music, which helps to decrease anxiety and lift one's mood; and it promotes interaction, which is a good remedy for the social isolation of old age. ("The Aston Gardens Senior Living Community, Florida," 2021)

The researcher decided to organise an interactive demonstration of Zumba dance, which would motivate the participants to try it themselves.

Domains addressed: Psychological, Social

Strengths developed: Love towards physical activity, enjoyment, confidence, breaking their inhibitions

Resources accessed: personal (interest in meeting new persons and interacting with children) social network (resource group)

Session flow:

The Zumba demonstration was given by a trainer along with her students, who were of different age groups. Initially the participants watched the dance, and interacted with the group. By the end of the session, some of the participants joined in the dance, swaying to the music.

Feedback:

The participants said that they enjoyed the music and felt calm. Those who joined the dance, said that their confidence in their physical fitness increased. All participants expressed their happiness in interacting with the dancers, especially the children.

2. Simple Games

Objective:

To enable the participants to consider physical activity as fun and engage more in such activities.

Rationale for intervention:

Engaging in leisure activities helps improve the physical, mental and cognitive functions in older adults (Sala, 2019). It is also seen that leisure activities enhance mental strength by expanding social support and reducing perceived stress (Zhang et al, 2021). All types of physical activity help in improving longevity, so finding and doing an activity that they enjoy, can improve the health of the elderly (Watts, 2022). Simple games create motivation for movement in the elderly, so that slowly, they become ready for more physical activity (Hedayati, 2019).

The participants, during the interaction, had said that they enjoyed playing with a ball. So, the researcher used simple ball games as an intervention.

Domains addressed: Physical/ Psychological/ Social

Strengths developed: Group cohesion, fun, free interactions with others

Resources accessed: personal (ability to engage in a group game) community (participation in the games)

Session flow:

The researcher played a few sessions of simple ball games with the participants. In each session, she introduced some variations to the game, to make it more interesting and challenging. The researcher also included some younger visitors and volunteers in some of the sessions, to play with the older adults.

Feedback:

The participants expressed their joy and excitement during these sessions. They said that they felt energised and looked forward to these game sessions.

3. Temple visits

Objective:

To reinforce the participants' sense of wellbeing and hope by visiting places of worship along with agemates

Rationale for intervention:

Religion and spirituality are found to be important coping mechanisms for the elderly to deal with life changes (Koenig, 2012). A place of worship is not only a source of spiritual strength, but also a place for social interaction where families gather, friends meet, and supportive activities happen (Zimmer, 2016).

Domains addressed: Social/ Spiritual

Strengths developed: faith, interaction with older adults from other homes, personal happiness, sense of wellbeing

Resources accessed: social networking, community (arrangements for the trips)

Session flow:

The researcher organised trips for the participants to nearby temples, along with the residents of other Elderly care homes. This gave an opportunity for the participants to interact with their peers from a similar background.

Feedback:

The participants reported that they were delighted with the opportunity to visit the temple. They also enjoyed spending time with the residents of other homes, and sharing stories. They said that being in the temple gave them a positive feeling and a sense of peace and wellbeing.

4. Interaction with Artists, authors

Objective:

To enable interaction of the participants with prominent members of the neighbouring community.

Rationale for intervention:

Social isolation is a major risk factor for the elderly. In a care home setting, residents may lose all contact with their existing social networks, and also with the broader community (Boamah et al, 2021). Community engagement is one of the factors that contribute to wellbeing in older adults (Tiernan et al, 2013).

During the intervention, community interaction of the participants was promoted through a series of sessions where the participants could interact with prominent members of the community.

Domains addressed: Social

Strengths developed: ability to interact with persons from outside, happiness in seeing their favourite stars, hope, joy

Resources accessed: Community (organising the programme)

Session flow:

The sessions involved visits by well-known members of the community, like authors, artistes, etc, to celebrate some special personal occasion. Some of the participants were familiar with their works (books, movies, etc). Others knew them by reputation. The guests shared their experiences and thoughts with the participants, and spent some time with them in informal interactions. The participants felt privileged that such eminent dignitaries were sharing their special days with them.

Feedback:

The participants said that it was very exciting to meet people whom they had read about in newspapers, or seen on TV. They were very happy with the interaction.

5. Intergenerational Interaction with children having special needs

Objective:

To enable the participants to access their inner strengths of empathy, compassion, patience and acceptance

Rationale for intervention:

The strengths-based approach to Elderly care acknowledges that older adults have resources and strengths (Chapin, 2006). A strengths-based engagement intervention can help the elderly to recognise and access their inner strengths by engaging with suitable external stimuli (Vishal, 2018)

As part of such an intervention, a session was organised where the participants could engage with the children having special needs from a nearby childrens' home.

Domains addressed: Psychological

Strengths developed: Empathy, love, care, contextualising own difficulties

Resources accessed: community (organising the interaction with children)

Session flow:

A visit by a group of children with special needs who were residing in a nearby Children's Home was organised. The children presented some entertainment programmes. The participants in turn presented some programmes themselves. The older adults and the children spent some time together, with the support of the children's caretakers. This was the first trip outside for the children after the pandemic. The participants were seen to be affected by the children's situation, and expressed their concern and love for the children.

Feedback:

The participants reported that it was their first experience in interacting with children having special needs. They were touched by the situation of the children, and were empathetic.

6. Screening of Film

Objective:

To invoke positive emotions through watching a movie

Rationale for intervention:

Film clips are very effective in inducing emotions (Fernandez-Aguilar, 2018). Movies have also been recommended for therapeutic use, as they can affect attitudes, behaviours and learning (Schulenberg, 2003). When screening movies in a group, the shared spectatorship has social and emotional benefits for the viewers. Films have the potential to prompt reminiscence, promote wellbeing and enhance social connectivity (Breckenridge, 2020).

The participants had expressed their wish to watch a recently released movie involving a child and a spiritual context. The researcher felt that this movie would be ideal to stimulate positive emotions in the participants.

Domains addressed: Psychological/ Social

Strengths developed: relaxation, fantasy, emotional involvement, happiness

Resources accessed: community (arranging the show)

Session flow:

The researcher arranged the screening of a popular movie with spiritual content, on a big screen, giving a movie theatre experience to the participants at the care home.

Feedback:

The participants were very touched with the storyline of the movie. They became very emotional and sincerely thanked the researcher for giving this opportunity.

7. Celebration of Mother's Day

Objective:

To boost the self-esteem of the participants through social interaction

Rationale for intervention:

Self-esteem is an important requisite for quality of life (Niveau et al, 2021). It is seen that self-esteem increases throughout the lifespan, and declines sharply in old age (Robbins et al, 2002). Interventions promoting social interactions have been found to be effective in enhancing self-esteem (Niveau et al, 2021).

Culturally, Indian women, irrespective of their marital status or whether they have children of their own, feel respected when considered as a 'mother'. So, the researcher utilised the occasion of Mothers' Day to conduct an intergenerational social intervention to boost the self-esteem of the participants.

Domains addressed: Social/ Psychological

Strengths developed: interaction with youth, feel good about oneself as a 'mother', expressing creativity

Resources accessed: Community (organising the programme)

Session flow:

The Mothers' Day programme involved an interactive session with social work students from different colleges. The students presented different entertainment programmes. The participants also expressed their creativity through various presentations. The youngsters and the older adults played simple games. The youngsters wished the participants a happy Mothers' Day.

Feedback:

The participants said that they felt energised after the session. During the session, they felt good that they could also present programmes at par with the youngsters.

8. Group support & group discussions

Objective:

To promote social connection between the participants in the care home

Rationale for intervention:

Social connection is commonly characterized as a personal perception of having intimate and positive associations with others. Older individuals tend to develop positive social connections with those who express care and when they feel appreciated or are able to exchange emotional experiences. (Seppala, 2013 in Suragarn, 2021)

For the residents of care homes, they themselves are a social group. However, it is seen that in spite of living in a group setting for a long time, the residents still experience loneliness (Simard, J., & Volicer, L. (2020)

The researcher felt that the group within the care home is a resource for the older adults, if harnessed effectively. So, the researcher conducted an intervention to foster social connection within the group.

Domains addressed: Psychological/ Social

Strengths developed: ability to bond with others, friendships, mutual support

Resources accessed: social networking among the participants

Session flow:

The session involved a guided group sharing among the participants. They expressed their concerns, difficulties, interests, etc. The participants talked about themselves, their concerns, interests, observations on life, observations on self and others, etc. The session was pleasant and humorous, as the participants traded witty conversations.

Feedback:

The participants accepted that they felt good about sharing their emotions, and felt more connected to each other now.

9. Mindfulness

Objective: To develop awareness and calmness in the participants

Rationale for intervention:

Mindfulness involves focusing attention deliberately, with intent, on the current moment, devoid of judgment. This mindful attention cultivates heightened awareness, clarity, and a more accepting stance towards the reality of the present moment (Kabat-Zinn, 1994)

Mindfulness is believed to bring about various positive effects, including improved self-control, increased objectivity, enhanced tolerance of emotions, greater flexibility, a state of calmness, heightened concentration, and clearer mental awareness. It is also thought to contribute to the development of emotional intelligence, fostering the ability to relate to oneself and others with kindness, acceptance, and compassion (Keng et al, 2011)

The researcher therefore arranged a session on mindfulness for the participants.

Domains addressed: Psychological

Strengths developed: awareness, being in the present, calmness

Resources accessed: personal (availability, readiness to learn), Social network (resource persons)

Session flow:

The resource person guided the participants through a relaxation process. She asked them to focus on their breathing for some time. Then she helped them to do a body scan meditation, where the participants focussed on different parts of their body. They were able to identify sensations like stress, pain etc in the body, and tried to consciously relax and alleviate the difficulties. This was followed by another stretch of simple relaxation and the session concluded.

Feedback:

The participants reported that they felt very relaxed. They were surprised that we usually do not notice simple things like our body sensations, breathing etc during a regular day.

10. Intergenerational interaction with children of Children's Home

Objective:

To foster the love for children as a strength to enhance self-esteem in the participants

Rationale for intervention:

Love for children had been revealed as a strength area of the participants during the focus group discussions. So, the researcher used an intergenerational intervention session to harness this love, and enhance the happiness and self-esteem of the participants.

Intergenerational interventions have been proven to have broadly positive effects on the older and the younger generations. Such interactions are energising and uplifting for the older adults, simulate family-type interactions, and increase their self-esteem (Bagnasco, 2019).

Domains addressed: Social/ psychological

Strengths developed: ability to bond, express their creativity, love and care for children, appreciate children's creativity, happiness

Resources accessed: community (organisisng the interaction with children from Child Care Institution)

Session flow:

The children from a nearby children's home visited the participants. The participants were reminded of their own grandchildren. The children, who were from socially disadvantaged backgrounds and had no family of their own, addressed the elders as 'grandma'. The children and the 'grandmothers' sang and danced together. They spent some time in playful interactions. The participants were overwhelmed with the love and joy shared with the children.

Feedback:

The participants said that their day had been spent fruitfully. Of all the interventions done so far, they said that this was the most enjoyable one.

11. Wall Painting Demonstration

Objective:

To engage the participants with visual art

Rationale for intervention:

Both viewing and making art are beneficial to the elderly (Hathorn, 2013). When we look at a painting, for example, it stimulates the brain to form new synapses, increasing the communication among brain cells, and enhancing the brain reserve capacity (Bagan, 2009 in Hathorn 2013).

The participants in the care home did not report to have skills in visual arts. So, to engage them with visual art, the researcher chose art viewing as an option.

Domains addressed: Psychological

Strengths developed: interest in creative art, self-expression through art

Resources accessed: personal (ability to appreciate art), social network (availability of children to engage the participants)

Session flow:

The children from a neighbouring children's home painted beautiful pictures with spiritual themes on the walls of the care home. The participants watched in awe and delight as the children did the paintings. Looking at these pictures, the mothers, for whom spirituality has already been identified as a strength, would feel calm and content. They would also remember that this has been done for them by children, thereby bringing an element of intergenerational interaction also into the intervention.

Feedback:

The participants acknowledged that they felt very happy on seeing the pictures of their favourite Gods everyday as soon as they woke up.

12. Programme for youtube

Objective:

To enhance the self-image of participants by bringing out a presentation of their talent in performing arts

Rationale for intervention:

Older adults who engage in creative activities are strengthening a sense of self that is competent, efficacious, and capable of doing (Fisher & Specht, 1999 in Flood & Phillip, 2007). Therefore, in terms of novel productions, it is not only the end result, but the process of getting there that benefits the older adult. (Flood & Phillip, 2007).

The participants had already expressed their strong interest in performing arts, so the researcher decided to use this strength to enhance their self-image.

Domains addressed: Psychological

Strengths developed: creativity, confidence, happiness, feeling important, self-worth

Resources accessed: personal (expressing creativity), social network (making arrangements)

Session flow:

The researcher initiated a discussion with the participants on whether they would like to present a performance and broadcast it on YouTube. The participants were very enthusiastic and started planning and preparing the programme, costumes etc. When they were ready, the performance was captured on video and shared on YouTube. They gave a very energetic performance. It was obvious that they were thoroughly enjoying the whole process.

Feedback:

The participants told the researcher that they were doing this for her!

13. Reminiscence intervention

Objective:

To increase self-esteem, hope and life satisfaction in the participants through reminiscence

Rationale for intervention:

Reminiscence Therapy (RT) is a non-pharmacological intervention for treating different psycho-social problems in older adults. RT involves discussing events and experiences from the past - reflecting, evoking memories and stimulating mental activity. It can be done individually or in groups. (Woods, et al 2018). It has been found that RT is effective in reducing sleep disturbances, depression and anxiety in older adults, and increasing sleep quality, sense of wellbeing, self-esteem, hope and

life satisfaction (Asiret, 2018; Tam et al, 2021). Reminiscence intervention is especially recommended for older adults living in care homes (Asiret, 2018)

The researcher chose the occasion of Environment Day as a prompt to engage the participants in RT.

Domains addressed: Psychological

Strengths developed: self-image enhancement

Resources accessed: personal (ability to recall past experience, ability to share with clarity), social networking (people willing to listen and encourage)

Session flow:

On the occasion of Environment Day, the participants were engaged in a discussion about their yesteryears' memories of nature. This proved to be a rich prompt, as this enabled the older adults to delve deep into their past and invoke happy memories and experiences of their childhood.

Feedback:

The participants said that they enjoyed the session, and felt good about their past. They were happy to recall the climate, the environment and the natural beauty of their childhood years. One participant recited a poem on Nature which she had written herself.

5.9 Conclusion

The development of the intervention module and its implementation has been a core aspect of this study. This intervention has tried to identify and build on the strengths of the residents of the experimental home. When applied in a different setting, some of these strengths may be different. However, considering that female residents of an Elderly Care Home share many commonalities with regard to their age, gender, situation, responses, experiences and many such aspects, this intervention strategy will be largely applicable to any similar home.

By designing and conducting the intervention in an elderly care home, the researcher has clearly demonstrated that such an effort is feasible within the constraints of an institution. Data analysis based on the pre-test and post-test scores of the experimental and comparison homes will prove the effectiveness of the intervention.

CHAPTER 6

DATA ANALYSIS AND INTERPRETATION

6.1 Introduction

Any study becomes meaningful only when the data obtained is analysed to arrive at logical conclusions. In this study, the data analysis is done separately for each phase.

Phase 1 consists of a risk assessment in the elderly care homes in Thrissur District. The risk factors are classified into 11 subdomains- namely Location, Exterior, Interior, Bathroom Facilities, Cleanliness, Hygiene, Food, Health, General environment factors & Relationships, Safety and Activities. The responses of the homes to the questions in each subdomain are coded and analysed with the help of tables and graphs. Statistical tools like Mann Whitney U Test and One Way Anova are also used to interpret the data.

Phase 2 is the intervention phase of the study. Here, two homes are selected according to the sampling criteria mentioned in Chapter 3 - one as the experimental home and the other as the comparison home. The WHOQOL100 tool is administered to the residents of both homes. The WHOQOL100 lists 6 domains for the quality of life - Physical Capacity Domain, Psychological Domain, Social Relationships Domain, Level of Independence Domain, Environmental Domain and Spiritual Domain. There are also a few questions related to the overall quality of life and health. The data pertaining to each domain is coded and analysed. The quality of life with regard to each domain, and the Overall Quality of Life are determined. The t-test is done to ensure that there is no significant difference in the quality of life of the residents of both homes in the pre-intervention phase.

The strengths-based intervention is planned and implemented in the experimental home. The WHOQOL100 questionnaire is once again administered to both groups. The t-test is used to determine whether there has been a significant increase in the quality of life of the participants in the experimental home as compared to the comparison home, determining whether the intervention has been effective.

6.2 PHASE 1: RISK ASSESSMENT

For the first phase of research, risk assessment was conducted in 62 elderly care homes in Thrissur district. A risk assessment tool was prepared by the researcher, based on the guidelines submitted by Dr P K B Nair for the Social Justice Department, Govt. of Kerala, the Kerala Orphanage Control Board Guidelines for old age homes and the Model Guidelines for Development & Regulation of retirement homes by Ministry of Social Justice & Empowerment, Govt of India.

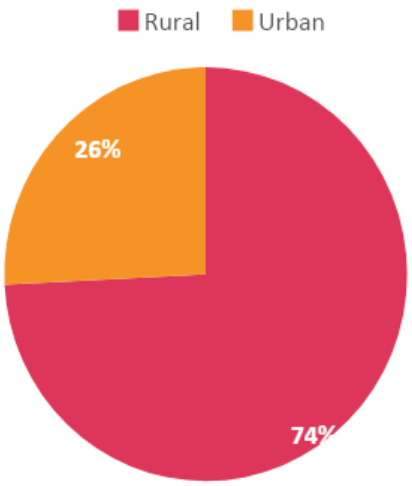
The researcher also referred to academic articles related to the risks and environmental hazards in Elderly Care Homes (Carter et al, 1997; Minimol, 2016).

The researcher directly visited the homes and administered the tool to the personnel of the homes. This also enabled the researcher to observe the homes and gain deeper insights into the situations on the ground.

6.2.1 Basic Institutional Data

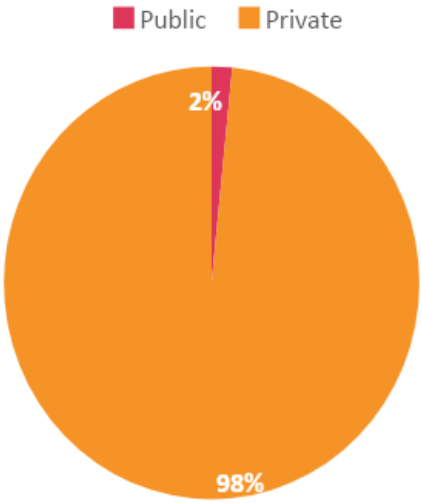
In Thrissur district out of 62 elderly care homes 26% homes are in urban areas and 74% homes are in Rural areas. (Figure 6.1)

Figure 6.1: Distribution of Elderly care homes by Location



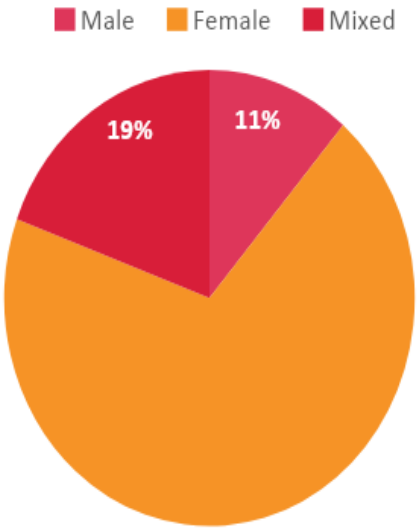
According to ownership only 2% are directly owned by the government while 98% are owned by private organisations and NGOs. (Figure 6.2)

Figure 6.2: Distribution of Elderly care homes by Ownership



70% homes are exclusively for women and 19% for men. 11% of homes provide facilities for both men and women. (Figure 6.3)

Figure 6.3: Distribution of Elderly care homes by Target Beneficiaries

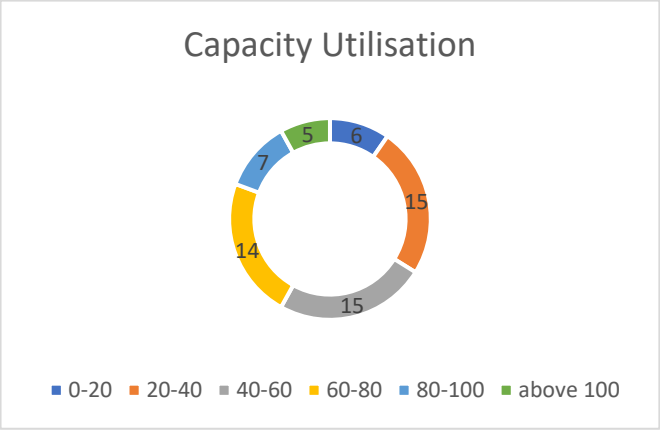


The current strength versus sanctioned strength of the elderly care homes was studied, and the percentage occupancy of the homes was calculated. (Table 6.1)

Table 6.1: Percentage Occupancy

Occupancy %	No of homes
0-20	6
20-40	15
40-60	15
60-80	14
80-100	7
Above 100	5

Figure 6.4: Capacity Utilisation



It is seen that only seven homes are utilising 80% or more of their sanctioned capacity. 14 homes have a current strength that is between 60-80% of sanctioned strength. 15 homes are between 40- 60% and 15 homes between 20- 40%. 6 of the 62 homes, that is nearly 10% of the homes in Thrissur district, have a strength that

is less than 20% of their sanctioned strength. 5 homes have a strength that is above the sanctioned capacity of the home.

6.2.2 Risk Assessment Survey

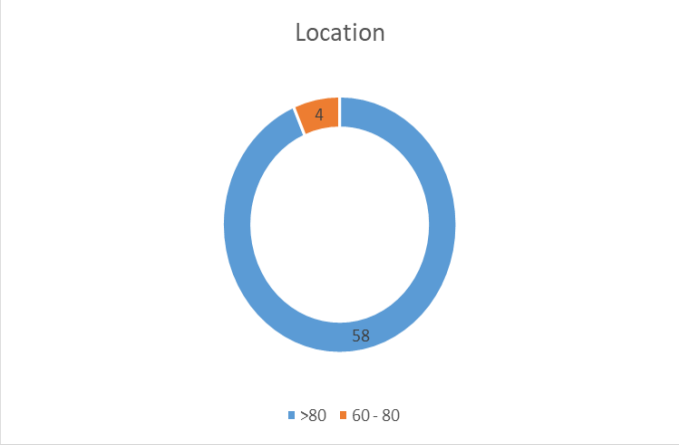
1. Location Score

Table 6.2: Location Score

Questions	Responses	
	Yes	No
Location of the home is safe from natural calamities	52	10
Public transport facility is easily available	61	1
Location has access to health services	60	2
Location has access to markets and shops	62	0
Vehicle is readily available for emergencies, either owned by the institution or by other dependable private persons	61	1
The home is located on property owned by the management, (it is not rented or leased)	59	3

It is seen that a large majority of the homes have minimal risk from location-related factors. Access to health services, transport, supplies, and emergency responses are present in most of the homes.

Figure 6.5: Location Score



This inference is further justified by the performance scores of the homes in the Location aspect. 58 of the 62 homes have scored above 80%, while the remaining four homes have scored between 60-80%. There are no homes with scores below 60%, which clearly shows that there is minimal risk to the home with respect to location-related factors.

The major risk identified in this index is the vulnerability to natural calamities, which 10 homes have reported that they face.

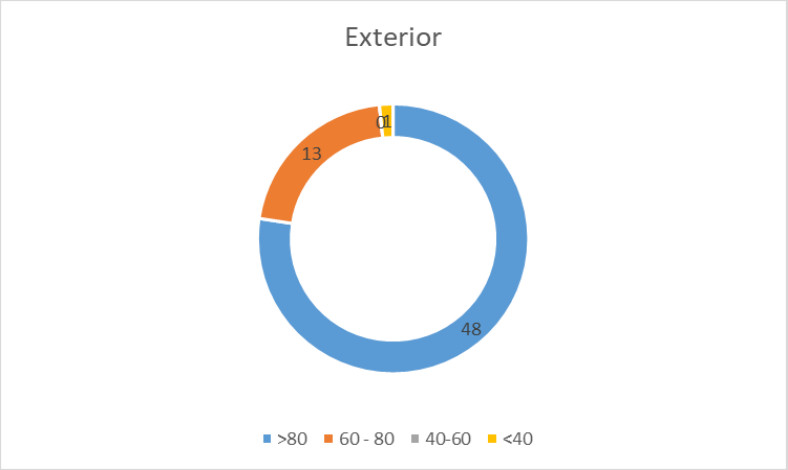
2. Exterior Score

Table 6.3: Exterior Score

Questions	Responses	
	Yes	No
Presence of compound wall for the premises	61	1
Space available in the compound for walking	57	5
Facilities for using wheelchair in the compound	51	11
The grounds are non-Slippery	57	5
The compound is free from sharp stones or similar obstacles	60	2
The compound is free from water logging	61	1
There is a garden in the compound	44	18
The compound is free from large trees which may pose a risk to people	61	1

It is seen that for six of the eight questions, a majority of homes have answered positively.

Figure 6.6: Exterior Score



48 homes have scored more than 80% in the exterior aspect, while 13 of them are still above 60%. Only one home has gone into the below 40% score.

11 homes do not have wheelchair facilities for moving in the compound, and 18 homes do not have a garden. These are the two major risks identified in this subdimension. These two factors, though they do not directly pose any threat to the safety of the residents, are however related to their ease of mobility and wellbeing, and are hence considered risk factors in this study.

3. Interior Score

Table 6.4: Interior Score

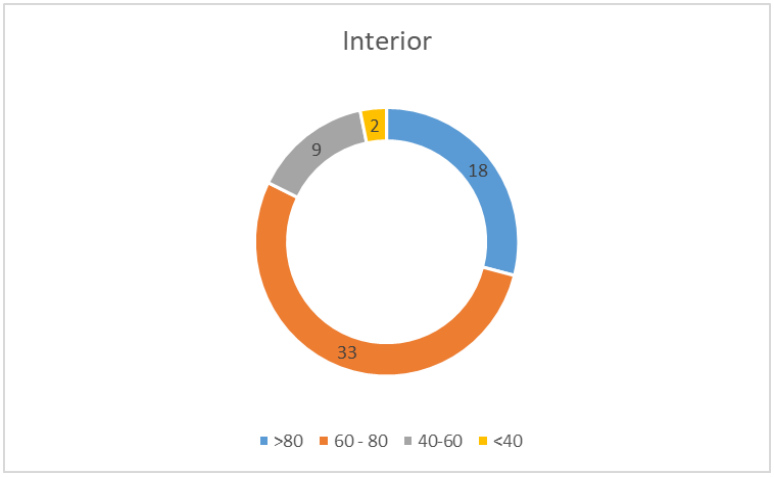
Questions	Responses	
	Yes	No
There are possibilities in the building for future modifications	41	21
The rooms have cross ventilation	51	11
The rooms have natural light	51	11
The building has energy backup	57	5
The switches in the rooms are in easily accessible locations	48	14

The rooms have alarm bells for the residents to call for help	7	55
The building has multiple exits	56	6
There are ramps in the entry/exit areas	24	38
The slope of the ramp is convenient for easy passage	24	38
The floors are even	59	3
The floors are non-slippery	43	19
The colour of the floor is such that visibility is easy	59	3
The rooms are free from obstructing thresholds	51	11
Passage between rooms is unobstructed, and without steps.	61	1
The corridors are wide	47	15
The doorways are wide	51	11
The rooms are easy-to-use	57	5
The rooms are free from obstructions	53	9
The corridors are free from obstructions	55	7
There are handrails in the corridors	13	49
There are handrails in the rooms	21	41
The furniture is sturdy	8	54
The furniture is of the right height	62	0
The furniture is of the right texture (not too soft/hard)	31	31
The interiors are free from sharp edges	62	0
The interiors and furniture are free from glass fixtures	62	0
The floor mats are non-slippery	62	0
There is provision for residents to get into and out of the bed easily	62	0
There is ample spacing between the beds in rooms or dormitories	49	13

There is provision to adjust the beds	44	18
The mattress is comfortable and of good quality	46	16
The wash basin is of the right height	62	0
The washbasin can be used while sitting in a wheelchair	11	51

It is seen that for three factors, there is a high negative response (more than 50 out of 62 homes).

Figure 6.7: Interior Score



Scoring the homes individually on the Interior Score, it is seen that only 18 of the 62 homes have a score above 80%. 33 homes have scored between 60 - 80%. Nine homes are between 40-60% and two homes are below 40%.

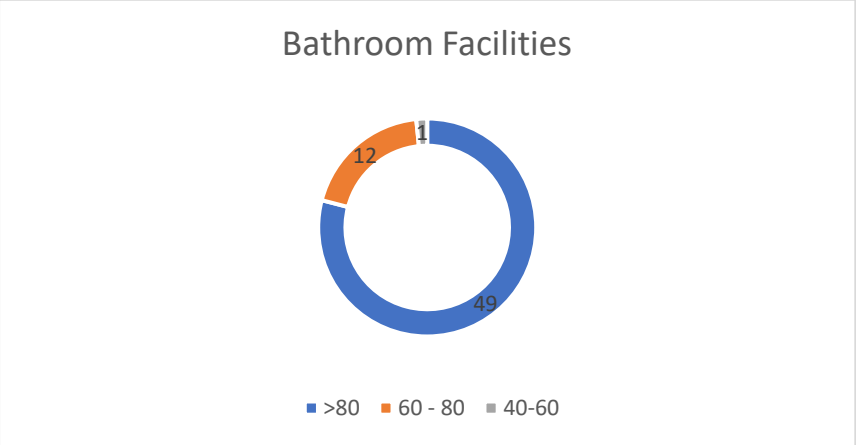
The major risks identified here include the absence of alarm bells in the rooms for residents to quickly call for help (55 negative responses), lack of sturdiness in the furniture (54), washbasins not being accessible by wheelchair (51) and absence of handrails in corridors (49) and rooms (41). These factors are directly related to the safety of the residents, and are therefore of key importance.

4. Bathroom Facilities Score

Table 6.5: Bathroom Facilities Score

Questions	Responses	
	Yes	No
There are enough toilets to have a ratio of one toilet for 6 inmates	62	0
There are enough bathrooms to have a ratio of one bathroom for 8 inmates	62	0
The bathrooms are inside the building	60	2
The toilets are inside the building	60	2
Bathrooms are toilets are easily accessible	60	2
Floors are non-slippery	61	1
The floor pattern and colour are conducive to easy visibility	62	0
There are grab bars in the bathrooms and toilets	29	33
The bathrooms and toilets are separate	62	0
The grab bars are well fixed	29	33
The grab bars are of suitable height	29	33
There is sufficient light inside the bathroom	62	0
The taps and showers are at suitable height	62	0
There is proper drainage	62	0
Warn water is available	61	1
Toilets have European closets	61	1
Hand shower is available	35	27
The buckets and mugs are at the right height	62	0
There is provision to take bath in a sitting position	62	0
There is provision to take bath in a wheelchair	0	62
The bathroom mat is non - slippery	62	0

Figure 6.8 Bathroom Facilities Score



It is seen that 49 out of 62 homes scored above 80%. 12 homes have scored between 60-80%. One home scored between 40-60%. There are no homes which have scored below 40%.

None of the homes have facilities for inmates to take bath in a wheelchair (62 negative responses). 33 homes have no grab bars in the bathroom. Of these two major risks, the first one, not having a wheelchair facility in the bathroom, may not directly affect all residents, but the second one, not having grab bars is a serious risk to all residents.

5. Cleanliness Score

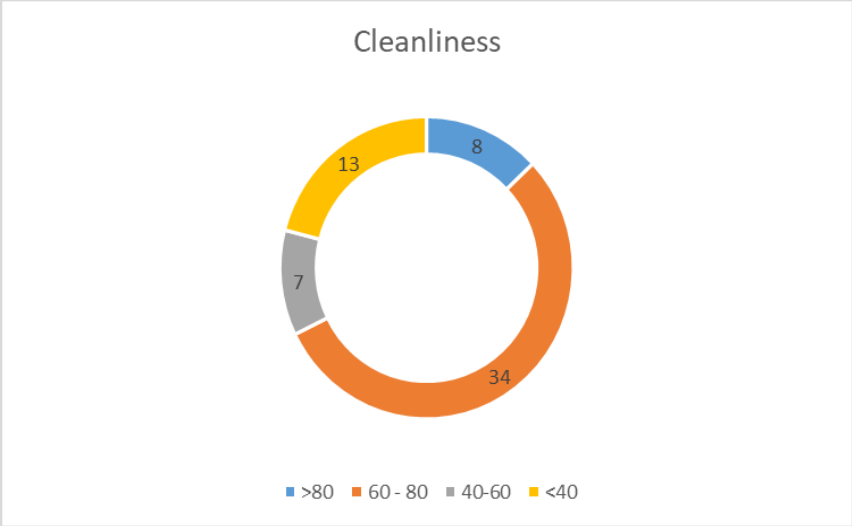
Table 6.6: Cleanliness Score

Questions	Responses	
	Yes	No
The rooms are clean	54	8
The rooms are uncluttered	43	19
The rooms are dust free	47	15
The storeroom is clean	52	10
The storeroom is well ventilated	11	51
The storeroom has sufficient light	4	58

The living area is free from foul smell	47	15
The bathrooms and toilets are free from foul smell	43	19

Out of the eight factors here, more than 50% homes have given positive responses for six. For two factors, more than 80% homes have given a negative response.

Figure 6.9 Cleanliness Score



It is seen that only eight homes scored above 80%. 34 homes have scored between 60-80%. Seven homes have scored between 40-60%. 13 homes scored below 40%.

Here the major risk factors seem to be associated with the storeroom. While the storerooms are generally clean (52 positive responses), there is lack of sufficient light and sufficient ventilation (51 and 58 negative responses respectively). This is a risk that could directly affect the residents' health and also applies to all residents as well as the caregivers.

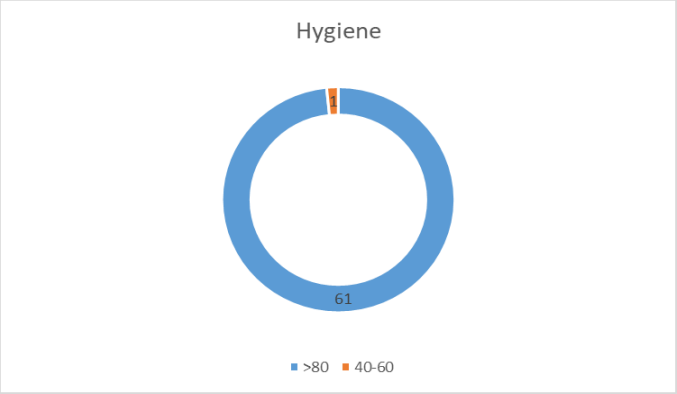
6. Hygiene Score

Table 6.7: Hygiene Score

Questions	Responses	
	Yes	No
Sufficient availability of water	60	2
Inmates have facility to wash their own clothes	61	1
Availability of laundry facilities for inmates who cannot wash clothes on their own	61	1
There is proper facility to dry the washed clothes	61	1
There is proper facility for sewage disposal	62	0
There are mechanisms to ensure personal hygiene of inmates	53	9
There are mechanisms to ensure personal hygiene of staff	62	0

In the hygiene aspect, more than 60 homes have responded positively to six of the seven factors. For one factor only 53 homes have responded positively.

Figure 6.10: Hygiene Score



In the individual scores, we can see that 61 out of 62 homes scored above 80%. Only one home scored between 40-60. The major risk (nine negative responses)

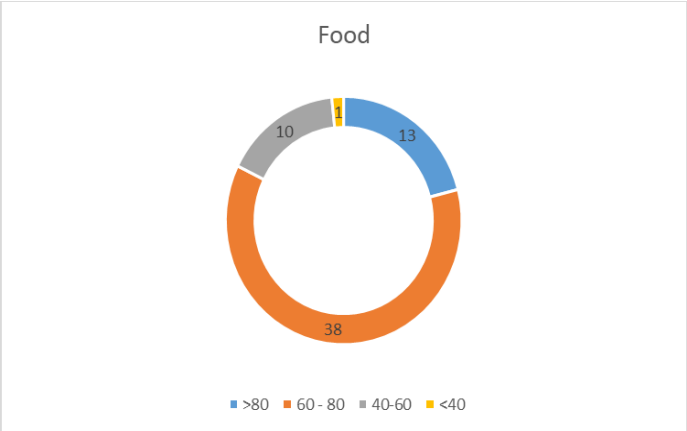
here is the lack of a mechanism to ensure that the inmates take care of their personal hygiene. Since older people may have some genuine difficulty in this regard, this is a factor that has considerable significance.

7. Food Score

Table 6.8: Food Score

Questions	Responses	
	Yes	No
There is a diet plan for the inmates	59	3
The services of a dietician/ health professional are utilised in preparing the diet plan	0	62
The food is tasty	62	0
Accepting cooked food from outside	18	44
Special diets are maintained for inmates with health issues	45	17
Pure drinking water is available	62	0

Figure 6.11: Food Score



Only 13 homes scored above 80%. 38 homes scored between 60-80%. 10 homes scored between 40-60%

None of the homes utilise the services of a nutrition expert in preparing the diet plan. This is the major risk factor here, and has a direct bearing on the residents' health. Other relevant risks here are accepting cooked food from outside (44 homes accept this), which may negatively alter the diet plan, and not having a special diet for inmates with special needs. There is also a risk of food safety standards being compromised.

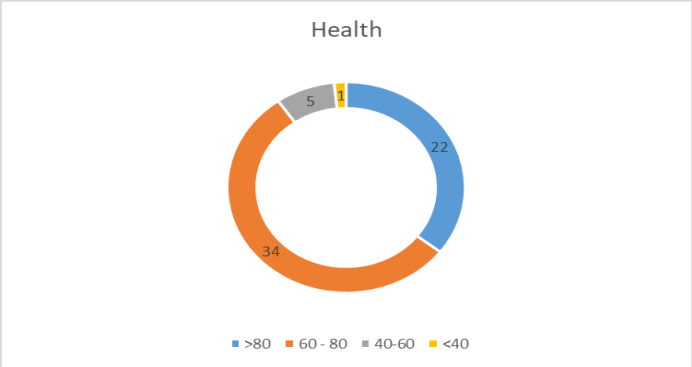
8. Health Score

Table 6.9: Health Score

Questions	Responses	
	Yes	No
The windows have Mosquito Nets	8	54
There is a separate sickroom	54	8
Adequate beddings are provided	62	0
Beddings are washed regularly	62	0
Adequate clothes and undergarments are provided	62	0
There is a doctor on call	55	7
There is a nurse on call	54	8
Regular medical checkups are conducted for inmates	61	1
There is a provision to ensure that all inmates take their medicines on time	62	0
Ambulance is available at any time	23	39
Exercise is part of the daily routine	31	31
Inmates participate in the exercises	27	35
Individual medical history records are maintained	62	0
There is provision for palliative care - within or outside the home	62	0
Inmates have health insurance	0	62
There is a counsellor on call	53	9
Individual counselling sessions are conducted regularly	53	9
Group counselling sessions are conducted regularly	42	20
Psychiatric treatment is provided to inmates who need it	61	1

More than 50% of the homes have answered positively to 16 of the 19 factors. None of the homes have responded positively for the availability of health insurance to the inmates.

Figure 6.12: Health Score



22 homes scored above 80%. 34 homes scored between 60-80%. Five homes scored between 40-60%. One home scored below 40.

None of the homes have enrolled their residents in a health insurance plan. This is the major risk in this subdimension, and has direct bearing on the availability of proper treatment in case of serious illnesses. Lack of mosquito nets in 54 homes is another risk factor - especially in Kerala where the climate and environmental conditions are favourable to mosquito propagation. Non availability of ambulances (39 homes) is also a risk. Lack of a proper exercise regime for residents (31) and non-participation of residents in such exercise regimes (35), though not safety threats, are potential long term risks to the health of the residents.

9. General environment factors & Relationships

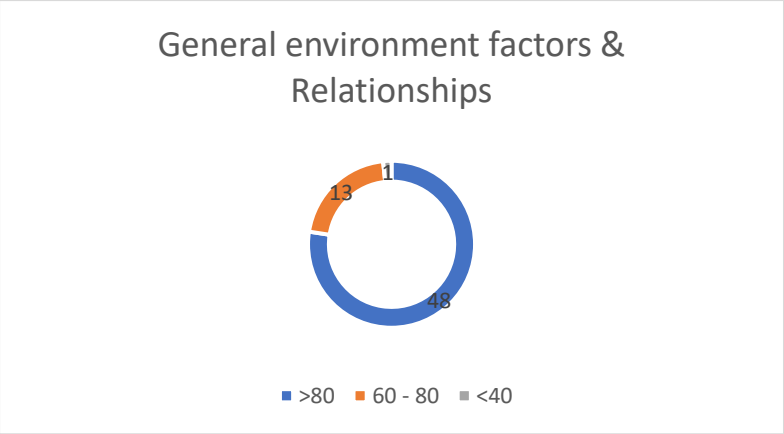
Table 6.10: General Environment Factors & Relationships

Questions	Responses	
	Yes	No
Staff members have basic training in psychology	60	2
Staff members are pleasant and friendly to the inmates	59	3
Staff members have a support system to ventilate their	61	1

feelings		
There is a cordial relation between staff and inmates	56	6
There is a cordial relation among the inmates	47	15
The complaints of inmates are satisfactorily attended to	41	21
The money and belongings of inmates are safely stored	62	0
These are provided when needed	62	0

All the factors have been positively responded to by more than 40 homes. For four of the eight factors, more than 60 homes have given a positive response.

Figure 6.13: General Environment Factors & Relationships Score



48 homes scored above 80%. 13 homes scored between 60-80%. One home scored below 40%.

Here the major risk factors are identified as lack of a proper system of grievance redressal of the residents (21) and lack of cordial relations among the residents (15). These, in the long term, can be very detrimental to the effective running of the home, and in worst case scenarios, may even lead to legal issues.

10. Safety Score

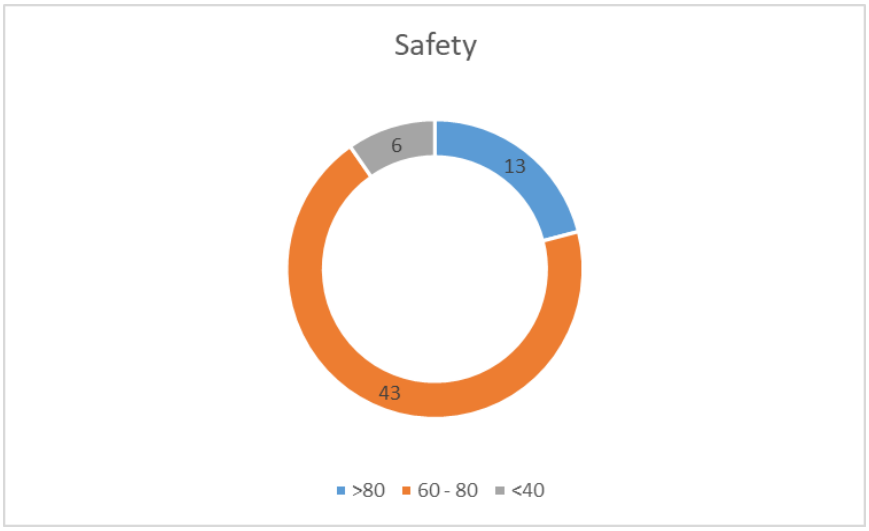
Table 6.11: Safety Score

Questions	Yes	No
The staff are trained in basic fire and safety measures	13	49
There is an electrician on call	59	3
The staff have basic training in first aid	57	5

57 and 59 homes respectively have responded positively to two of the three factors, while only 13 have done so for the third factor.

The major risk here is that the staff in 49 homes are not trained in basic fire safety measures.

Figure 6.14: Safety Score



13 homes scored above 80%. 43 homes scored between 60-80%. Six homes scored below 40%.

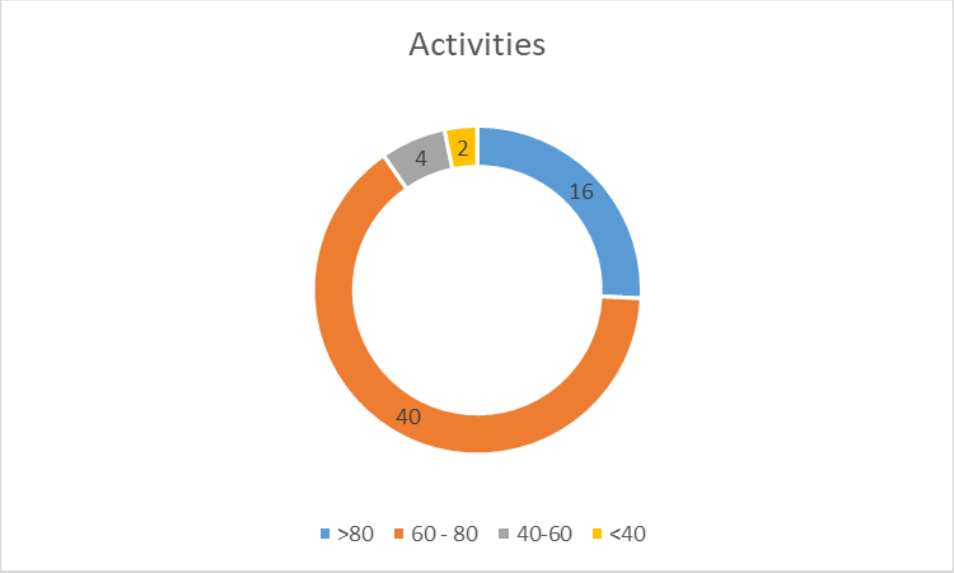
11. Activities Score

Table 6.12 Activities Score

Questions	Yes	No
The home has activities to engage the inmates	60	2
These activities are chosen according to the inmates' interest	57	5
These activities have social impact	59	3
These activities are income generating	5	57
The inmates are engaged on all days	53	9
There are opportunities for inmates to interact with outsiders	61	1
The inmates are regularly taken for outings	35	27
The inmates have the freedom to go out on their own	1	61
There are celebrations involving the inmates	62	0
Inmates' birthdays or special days are celebrated	19	43

53 and above homes have given positive responses to 6 of the 10 factors. For two factors, less than 5 homes have responded positively.

Figure 6.15 Activities Score



16 homes scored above 80%. 40 homes scored between 60-80%. Four homes scored between 40-60%. 2 homes scored below 40%.

The major risk factor here pertains to the independence of the residents, as in 61 homes the residents are not allowed to go out on their own. This also affects their strengths of self-esteem and self-reliance. Lack of income generating activities in which the residents can play a role is another significant risk factor (57 homes), which again, while not a safety threat, undermines self-esteem eventually. Not celebrating the personal special days of the residents (43 homes) is also a psychological risk, as it may affect their happiness and self-concept in the long run.

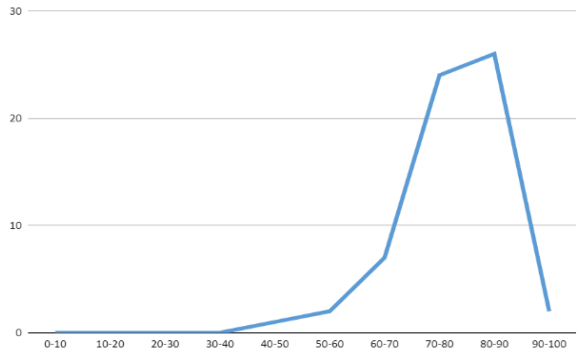
12. Total Score

It is seen that of the 62 homes studied, only 2 have secured a high score of 90% or above. 26 homes have secured between 80-90% and 24 between 70-80%. 7 and 2 homes have respectively come in the subsequent score ranges of 60-70% and 50-60%. While 1 home has scored in the 40-50% range, none have gone below the 40% score.

Table 6.13 Total Score

Score (%)	No of homes in the score range
0-10	0
10-20	0
20-30	0
30-40	0
40-50	1
50-60	2
60-70	7
70-80	24
80-90	26
90-100	2

Figure 6.16: Total Score



Comparison

The 129 facilities which would support risk reduction were compared based on 2 factors -Rural vs Urban differences and differences based on target beneficiaries. The data was coded and analysed using spider diagrams.

Figure 6.17: Individual Subdimensions across Location

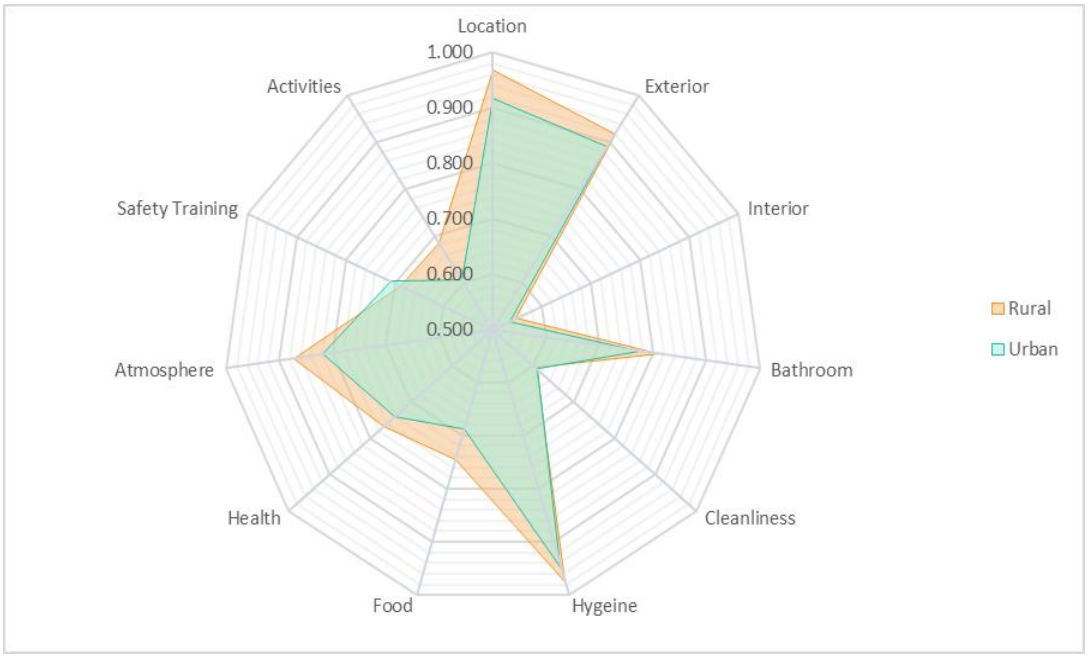


Figure 6.17 shows the distribution of index values for the individual dimensions of the adequacy index across old-age homes in rural and urban areas. It can be inferred from the spider diagram that across nearly all dimensions, old-age homes in rural areas are better equipped than those in urban areas. The gap was negligible in the

case of interiors, and virtually the same for cleanliness. It was only in the dimension of safety training that old-age homes in urban areas were marginally better than their counterparts in rural areas.

Figure 6.18: Individual Subdimensions across Type of Elderly care home

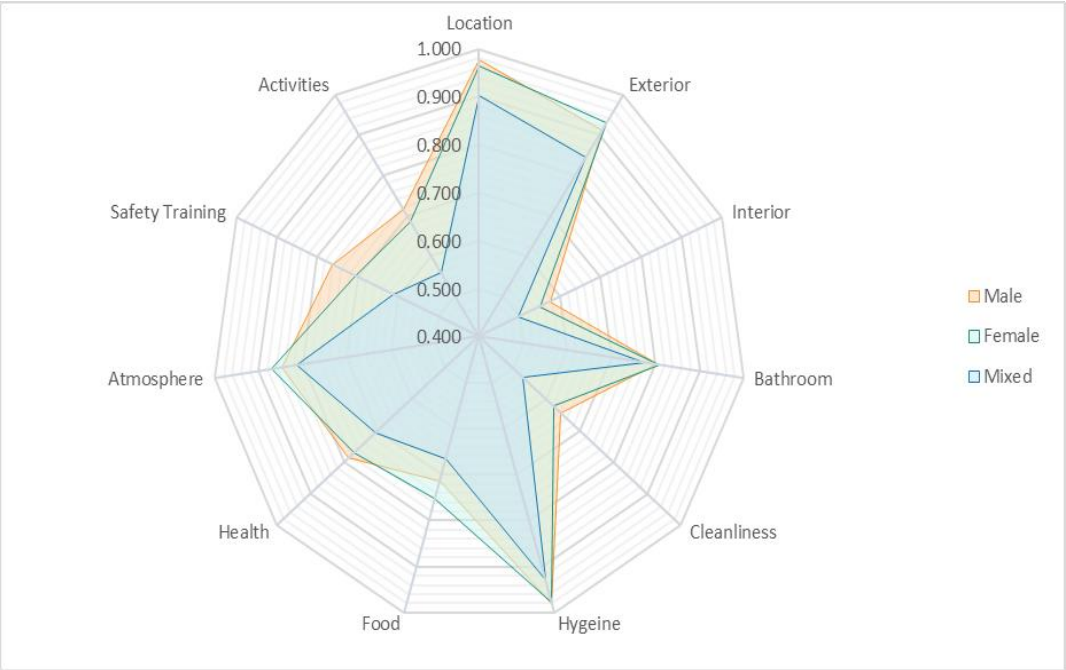


Figure 6.18 shows the distribution of index values for the individual dimensions of the adequacy index across types of old-age homes (Male, Female and mixed). It can be inferred from the spider diagram that across nearly all dimensions, old-age homes for male and female residents are equally equipped. It was only in the dimension of safety training that old-age homes for male residents were marginally better than female homes. The mixed homes are less equipped compared with male and female homes.

For a more concrete analysis, the 11 subdimensions were grouped into 4 major indices as follows:

Table 6.14: Indices and their subdimensions

Infrastructure	Location, Exterior, Interior, Bathroom
Hygiene	Hygiene, cleanliness
Wellness	Food, Health
Support	General environment factors & Relationships, Safety training, Activities

Figure 6.19: Dimensions of Adequacy Index across Location

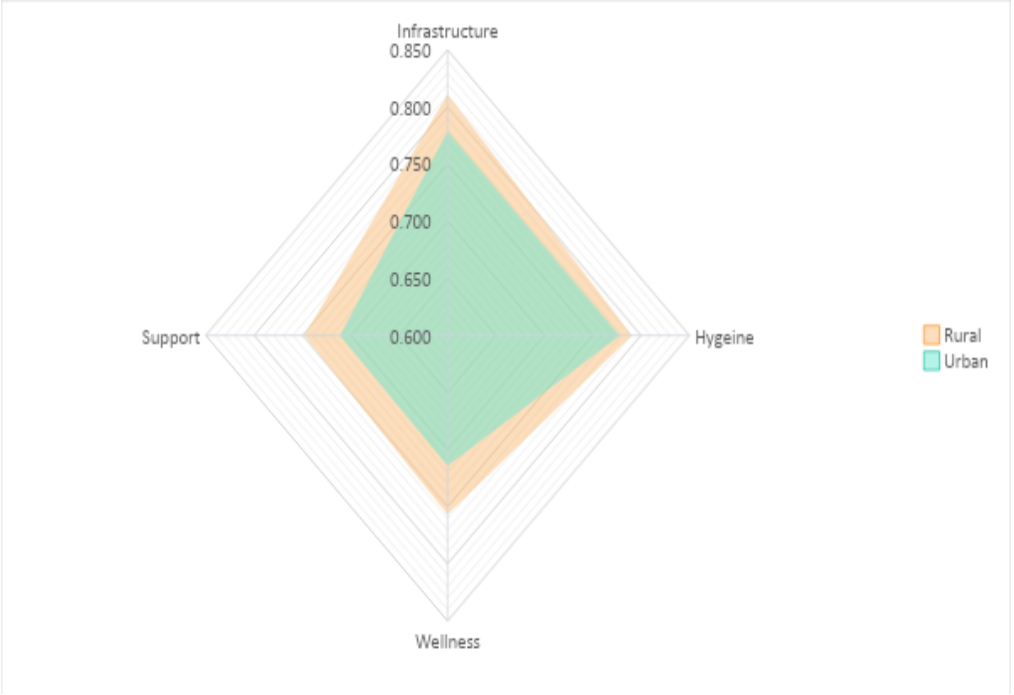


Figure 6.19 shows the distribution of index values for the individual dimensions of the adequacy index across elderly care homes in rural and urban areas. It can be inferred from the spider diagram that across nearly all dimensions, elderly care homes in rural areas are better equipped than those in urban areas.

Table 6.15 shows the results of the Mann-Whitney U test for each major component of the adequacy index for elderly care homes in rural and urban areas.

Table 6.15: Mann-Whitney U-Test Results – Sub-components (Location)

	Infrastructure	Hygiene	Wellness	Support
Total N	62	62	62	62
Mann-Whitney U	423.50	373.00	453.00	399.50
Wilcoxon W	1504.50	1454.00	1534.00	1480.50
Test Statistic	423.50	373.00	453.00	399.50
Standard Error	62.138	60.426	62.133	61.857
Standardized Test Statistic	0.893	0.083	1.368	0.509
Asymptotic Sig (2-sided test)	0.372	0.934	0.171	0.611

The test results are not significant for any of the four components, and hence we may accept the null hypothesis that the dimensions do not significantly differ between the old-age homes based on their location.

Table 6.16: Mann-Whitney U-Test Results – Overall Adequacy (Location)

	Adequacy Index
Total N	62
Mann-Whitney U	415.00
Wilcoxon W	1496.00
Test Statistic	415.00
Standard Error	62.161
Standardized Test Statistic	0.756
Asymptotic Sig (2-sided test)	0.450

Table 6.16 shows the overall adequacy index of elderly care homes in rural and urban areas. The test result is not significant, so we accept the null hypothesis that there is no significant difference across location

Figure 6.20: Dimensions of Adequacy Index across Type of Elderly care home

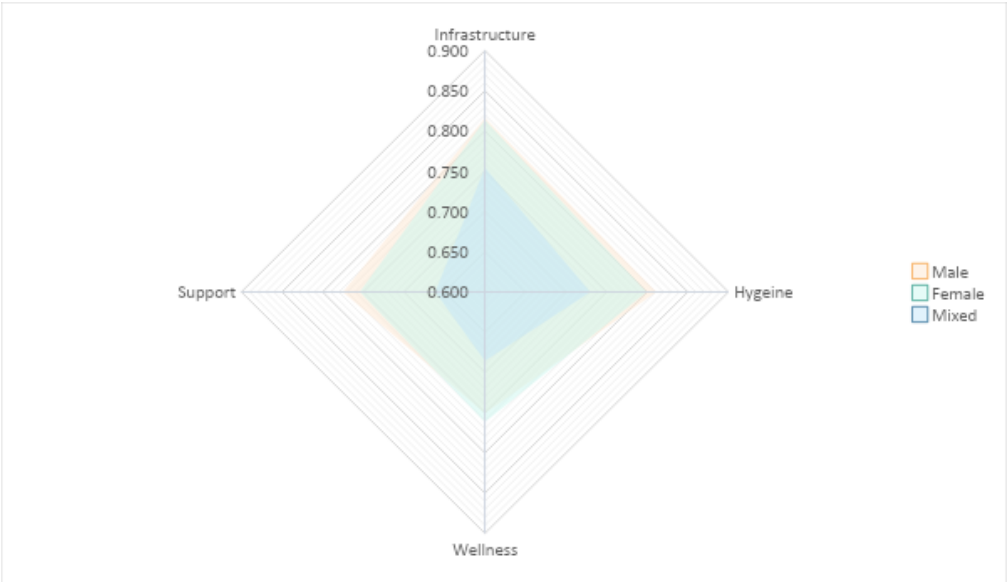


Figure 6.20 shows the distribution of index values for the individual dimensions of the adequacy index across types of elderly care home. It can be inferred from the spider diagram that across nearly all dimensions, elderly care homes of male and female are equally equipped. The mixed homes are less equipped compared with male and female homes.

The significance of the variations between the groups were tested using One-way Anova.

Table 6.17 shows the results of a One-way ANOVA to test for variation in the average values of the four major components and overall values of adequacy index based on their target beneficiaries.

Table 6.17: One-way ANOVA (Index*Target Audience)

		Sum of Squares	df	Mean Square	F	Sig.
Infrastructure Index	Between Groups	0.034	2	0.017	2.671	0.078
	Within Groups	0.381	59	0.006		
	Total	0.415	61			
Hygiene	Between Groups	0.050	2	0.025	1.085	0.344

Index	Within Groups	1.355	59	0.023		
	Total	1.405	61			
Wellness Index	Between Groups	0.054	2	0.027	2.952	0.060
	Within Groups	0.540	59	0.009		
	Total	0.594	61			
Support Index	Between Groups	0.092	2	0.046	3.582	0.034
	Within Groups	0.755	59	0.013		
	Total	0.847	61			
Overall Index	Between Groups	0.055	2	0.028	3.178	0.049
	Within Groups	0.511	59	0.009		
	Total	0.566	61			

The ANOVAs are run with the following null hypotheses:

H_{0A}: There is no difference in the value of infrastructure index among old-age homes targeting different audiences.

H_{0B}: There is no difference in the value of hygiene index among old-age homes targeting different audiences.

H_{0C}: There is no difference in the value of wellness index among old-age homes targeting different audiences.

H_{0D}: There is no difference in the value of support index among old-age homes targeting different audiences.

H_{0E}: There is no difference in the value of overall adequacy index among old-age homes targeting different audiences.

The test results in table 29 indicate that at 95% significance level, only the values for support index ($p = 0.034$) and overall adequacy ($p = 0.049$) show a significant difference. Therefore, we may reject null hypotheses H_{0D} and H_{0E}, while retaining the other three null hypotheses. However, at the 90% significance level, H_{0A} and H_{0c} may be rejected as well, since the F-values are statistically significant for infrastructure index and wellness index. It is only the null hypothesis H_{0B}, which

pertains to the hygiene index, that is not significant at either 90% or 95% confidence level.

Figure 6.21: Mean Index Values

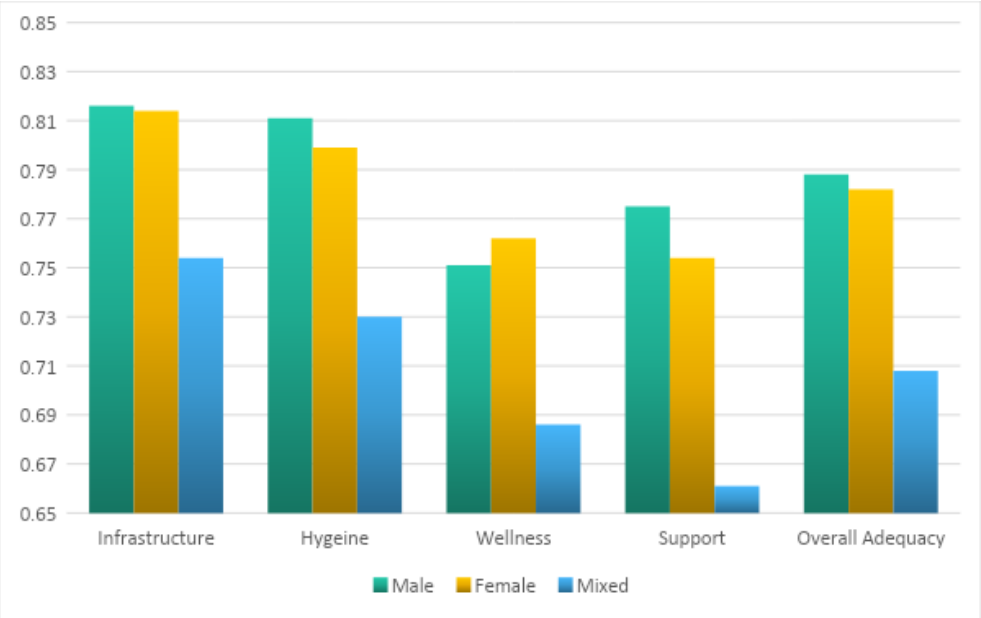


Figure 6.21 shows a graphical representation of the mean index values.

In the 4 indices where a significant difference exists, it is seen that the mean values for male and female homes are very similar, but those for the mixed homes are consistently much lesser. In infrastructure, support and overall adequacy, the male homes are slightly better, while in the case of wellness, female homes are better.

6.3 PHASE 2: INTERVENTION STUDY

The homes were arranged in increasing order of the total score obtained in Phase 1. The lowest 25% and highest 25% were not considered for the second phase. From the middle 50%, two homes were selected through random sampling, for Phase 2 of the study.

One of them, *Sandeepany Mathrusadanam*, Guruvayur, was chosen as the experimental home. *Saketham Sevanilayam*, Mapranam was chosen as the comparison home.

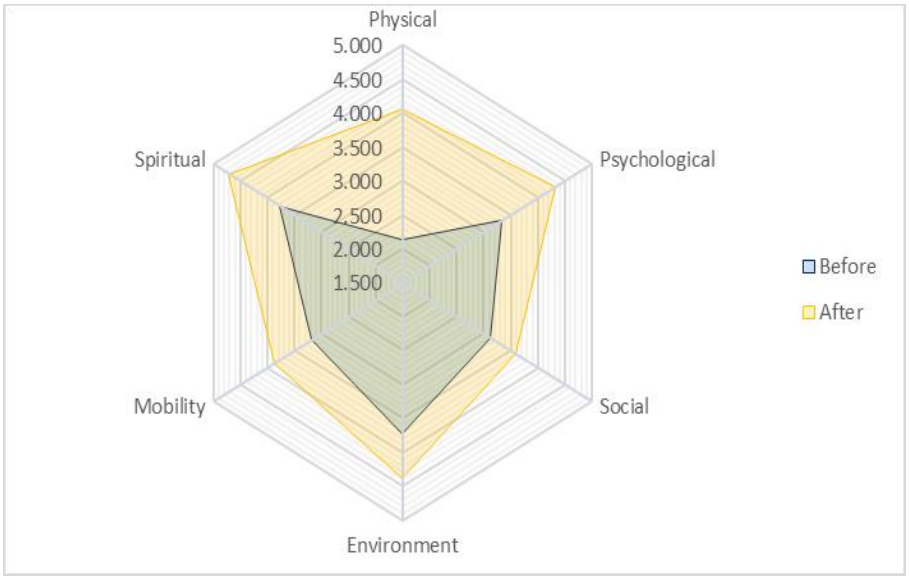
A pre-intervention test was conducted at both homes, using WHOQOL100 questionnaire. An intervention module was developed and implemented at the experimental home, while the comparison home was left as such. After the intervention, the same questionnaire was administered to the inmates of both homes, as a post- intervention test.

The responses were coded, organised and compared to find the changes in the Quality of Life brought about as a result of intervention.

The data was analysed with respect to 6 indices- Physical, Psychological, Social, Environment, Mobility and Spiritual

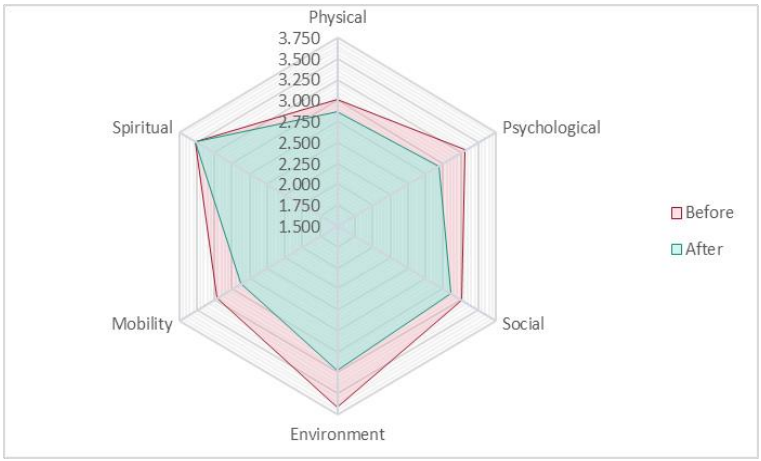
Pre & Post Intervention comparison

Figure 6.22: QoL Dimensions (Experimental Home)



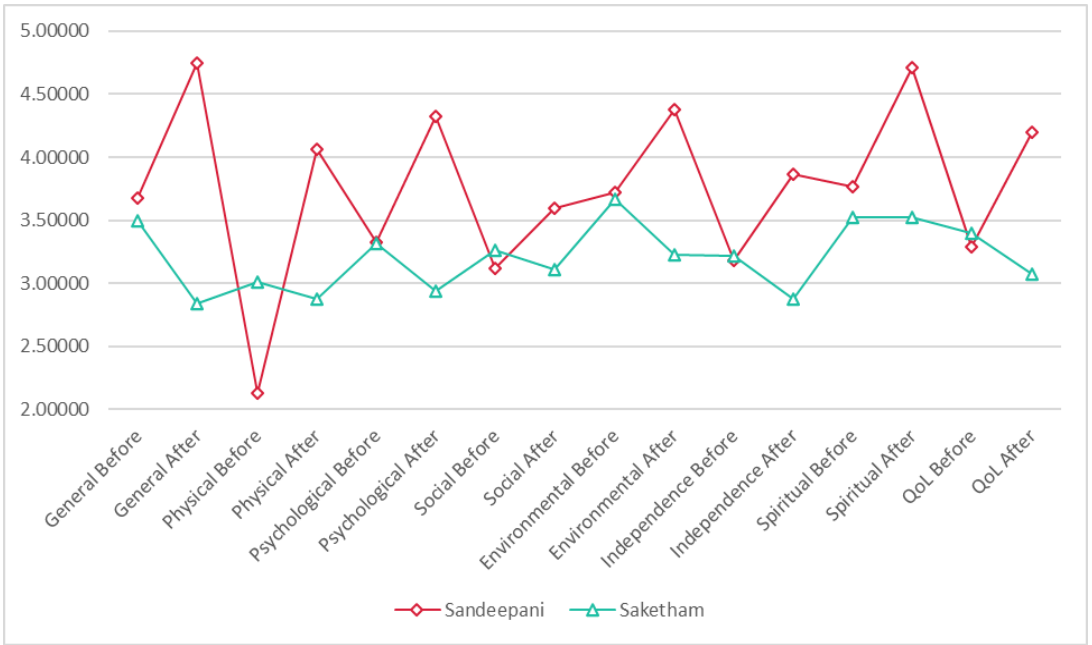
From the spider web it is evident that the quality of life has improved across all dimensions after the intervention of the residents of experimental home *Sandeepany Mathrusadanam*, Guruvayur.

Figure 6.23: QoL Dimensions (Comparison Home)



In the spider web for the residents of the comparison home *Saketham Sevanilayam*, Mapranam, the quality of life across all dimensions is showing a slight decrease within a period of 6 months.

Figure 6.24: Mean Values (QoL Index Components)



The line graph shows that the mean values of QoL components were nearly similar in both homes before the intervention. After the intervention there is a sharp increase for the values of the experimental home whereas the values for the control are actually showing a slight decrease.

The significance of these differences was analysed using the t-test.

Table 6.18: t-test Results (QoL Index Components)

		t-test for Equality of Means		
		t	df	Sig. (2-tailed)
Overall Quality of Life Before	Equal variances assumed	1.034	22	0.312
	Equal variances not assumed	1.030	20.996	0.315
Overall Quality of Life After	Equal variances assumed	9.291	22	0.000
	Equal variances not assumed	9.073	18.414	0.000
Physical Index Before	Equal variances assumed	-5.228	22	0.000
	Equal variances not assumed	-5.458	19.699	0.000
Physical Index After	Equal variances assumed	5.159	22	0.000
	Equal variances not assumed	5.269	21.892	0.000
Psychological Index Before	Equal variances assumed	0.068	22	0.946
	Equal variances not assumed	0.068	20.924	0.946
Psychological Index After	Equal variances assumed	7.121	22	0.000
	Equal variances not assumed	7.239	21.994	0.000
Social Index Before	Equal variances assumed	-0.956	22	0.349
	Equal variances not assumed	-0.950	20.736	0.353
Social Index After	Equal variances assumed	4.031	22	0.001
	Equal variances not assumed	4.099	21.992	0.000
Environmental Index	Equal variances assumed	0.552	22	0.586

Before	Equal variances not assumed	0.555	21.661	0.585
Environmental Index After	Equal variances assumed	13.135	22	0.000
	Equal variances not assumed	13.134	21.341	0.000
Level of Independence Before	Equal variances assumed	-0.203	22	0.841
	Equal variances not assumed	-0.208	21.552	0.837
Level of Independence After	Equal variances assumed	5.454	22	0.000
	Equal variances not assumed	5.847	15.058	0.000
Spiritual Index Before	Equal variances assumed	1.097	22	0.284
	Equal variances not assumed	1.111	21.973	0.279
Spiritual Index After	Equal variances assumed	5.720	22	0.000
	Equal variances not assumed	5.473	15.364	0.000
Total Before	Equal variances assumed	-0.932	22	0.362
	Equal variances not assumed	-0.947	21.992	0.354
Total After	Equal variances assumed	8.928	22	0.000
	Equal variances not assumed	9.153	21.701	0.000

The t-test was run with the following hypotheses:

H_{0A}= There is no significant difference between the overall quality of life of the residents of the experimental home and the comparison home before the intervention.

H_{0B}= There is no significant difference between the quality of life in the physical capacity domain of the residents of the experimental home and the comparison home before the intervention.

H_{0C}= There is no significant difference between the quality of life in the psychological domain of the residents of the experimental home and the comparison home before the intervention.

H_{0D}= There is no significant difference between the quality of life in the 'social relationships' domain of the residents of the experimental home and the comparison home before the intervention.

H_{0E}= There is no significant difference between the quality of life in the 'environmental' domain of the residents of the experimental home and the comparison home before the intervention.

H_{0F}= There is no significant difference between the quality of life in the 'level of independence' domain of the residents of the experimental home and the comparison home before the intervention.

H_{0G}= There is no significant difference between the quality of life in the 'spirituality' domain of the residents of the experimental home and the comparison home before the intervention.

H_{0H}= There is no significant difference between the total quality of life of the residents of the experimental home and the comparison home before the intervention.

H_{0I}= There is no significant difference between the overall quality of life of the residents of the experimental home and the comparison home after the intervention.

H_{0J}= There is no significant difference between the quality of life in the physical capacity domain of the residents of the experimental home and the comparison home after the intervention.

H_{0K}= There is no significant difference between the quality of life in the psychological domain of the residents of the experimental home and the comparison home after the intervention.

H_{0L}= There is no significant difference between the quality of life in the 'social relationships' domain of the residents of the experimental home and the comparison home after the intervention.

H_{0M}= There is no significant difference between the quality of life in the 'environmental' domain of the residents of the experimental home and the comparison home after the intervention.

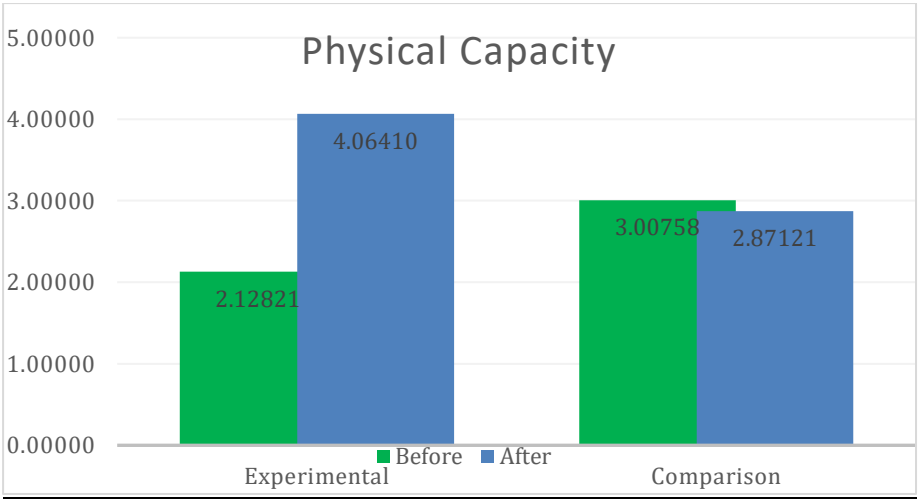
H_{0N}= There is no significant difference between the quality of life in the 'level of independence' domain of the residents of the experimental home and the comparison home after the intervention.

H_{0O}= There is no significant difference between the quality of life in the 'spirituality' domain of the residents of the experimental home and the comparison home after the intervention.

H_{0P}= There is no significant difference between the total quality of life of the residents of the experimental home and the comparison home after the intervention.

Physical Capacity Domain

Figure 6.25: QoL Score before and After -Physical capacity



The mean value of the Physical Capacity Index before the intervention was 2.12 for the experimental home and 3.00 for the comparison home.

The T- test shows $p<0.05$, so the null hypothesis H_{0B} is rejected. We accept the alternate hypothesis that there is a significant difference between the quality of life in the physical capacity domain of the residents of the experimental home and the comparison home before the intervention.

That is, the physical capacity index of the experimental home before the intervention is significantly lower than that of the comparison home.

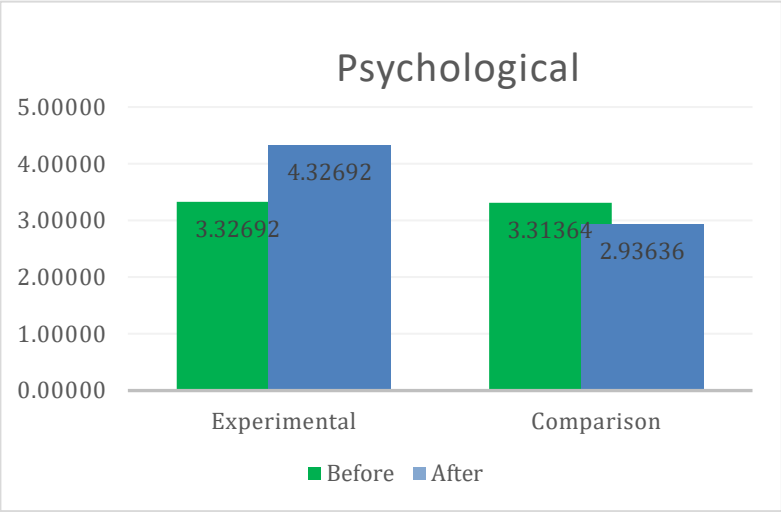
After the intervention, the mean value of the physical index for the experimental home is found to be 4.06, while that of the comparison home is 2.87. The t-test value of $p<0.05$ proves that this difference is significant, and H_{0J} can be rejected. We accept the alternate hypothesis that there is a significant difference between the quality of life in the physical capacity domain of the residents of the experimental home and the comparison home after the intervention.

Here again, there is a significant increase in the physical capacity domain for the experimental home after the intervention, while during the same period, in the absence of intervention, the comparison home has shown a decrease in this domain.

From these data, it can be inferred that the intervention helped to increase the physical capacity of the participants.

Psychological Domain

Figure 6.26: QoL Score before and After - Psychological



The mean value of the psychological index for the experimental home before the intervention was 3.32, and for the comparison home it was 3.31. The t- test gives p >0.05, and the null hypothesis H_{0C} can be accepted. There is no significant difference between the quality of life in the psychological domain of the residents of the experimental home and the comparison home before the intervention.

The mean values of the psychological index for the experimental and control homes after the intervention are 4.32 and 2.93 respectively.

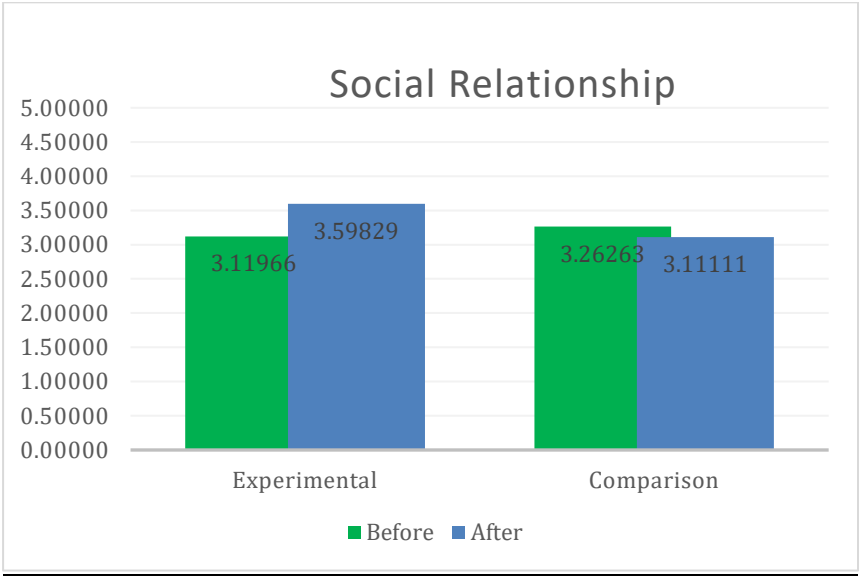
The t-test gives p<0.05. H_{0K} is rejected and we accept the alternate hypothesis that there is a significant difference between the quality of life in the psychological domain of the residents of the experimental home and the comparison home after the intervention.

Here again, we see the trend of the index value having increased for the experimental home, while there is a decrease in the case of comparison home.

Hence it is inferred that the intervention was effective in enhancing the quality of life of the participants in the psychological domain.

Social Relationships Domain

Figure 6.27: QoL Score before and After - Social Relationships



The mean value of social index for the experimental home before the intervention was 3.11, and that of the comparison home was 3.26. In the t-test before the intervention, p >0.05. So, the null hypothesis H_{0D} can be accepted, that there is no significant difference between the quality of life in the 'level of independence' domain of the residents of the experimental home and the comparison home before the intervention.

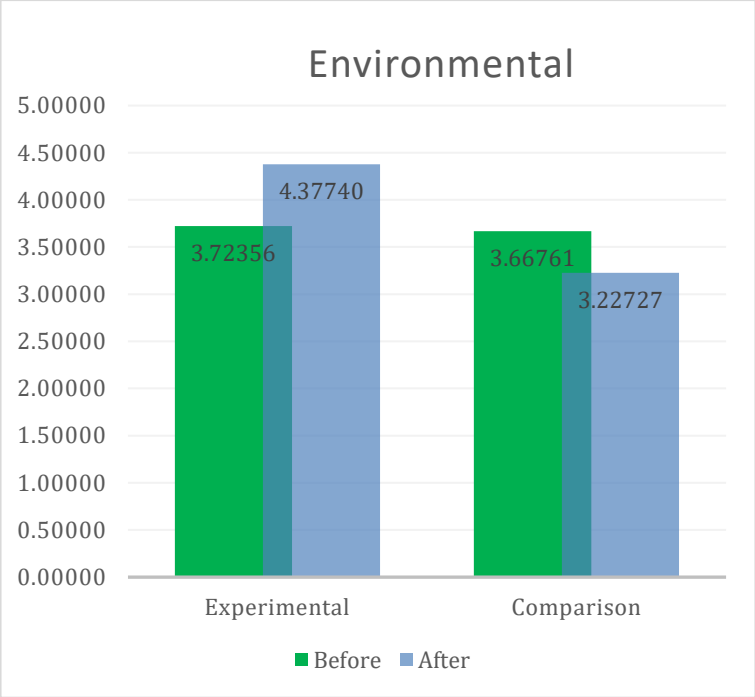
After the intervention, the mean value of social index for the experimental home increased to 3.59, while that for comparison home decreased to 3.1.

The t-test gives p<0.05. So, the null hypothesis H_{0L} is rejected. We accept the alternate hypothesis that there is a significant difference between the quality of life in the 'level of independence' domain of the residents of the experimental home and the comparison home after the intervention.

Thereby the researcher infers that the quality of life of the participants in the social relationships domain has been positively enhanced by the intervention.

Environmental Domain

Figure 6.28: QoL Score before and After -Environmental



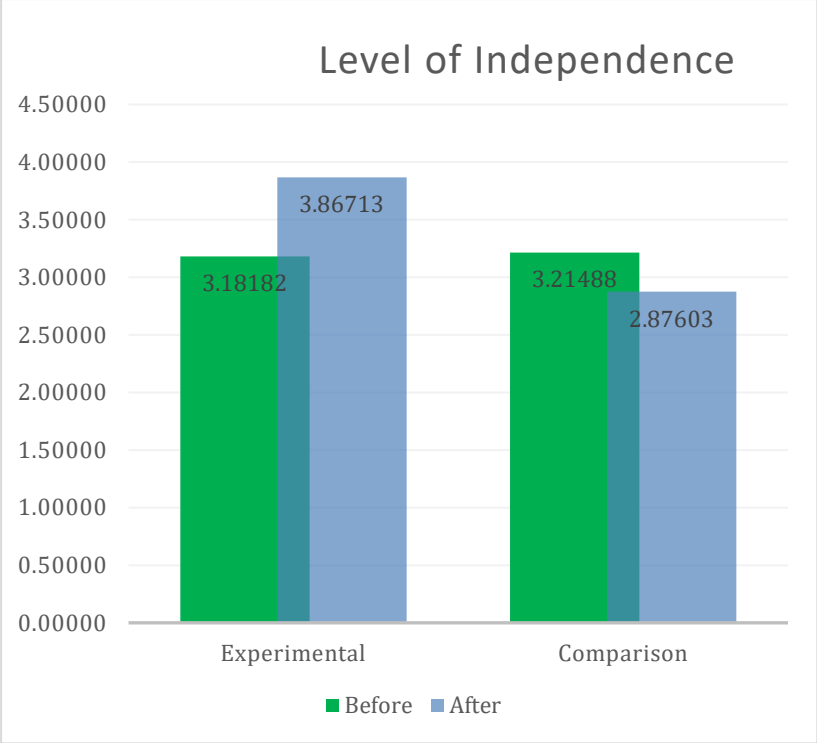
Before the intervention, for the experimental home, the mean value of the environmental index was 3.72 and for the comparison home, it was 3.66. The difference is insignificant, as the t-test gives $p>0.05$. So, H_{0E} can be accepted, that there is no significant difference between the quality of life in the 'environmental' domain of the residents of the experimental home and the comparison home before the intervention.

After the intervention, the environmental index for the experimental home rose to 4.37, while that for comparison home became 3.22. The t-test shows $p<0.05$. So, the null hypothesis H_{0M} is rejected. We accept the alternate hypothesis that there is a significant difference between the quality of life in the 'environmental' domain of the residents of the experimental home and the comparison home after the intervention.

It can be inferred from these findings, that the quality of life of the participants in the environmental domain has been increased by the intervention.

Level of Independence Domain

Figure 6.29: QoL Score before and After - Level of Independence



The mean value of the Independence Index before the intervention was 3.18 for the experimental home and 3.21 for the comparison home. From the t test it is seen that before the intervention, for the Independence Index, p >0.05. So, H_{0F} can be accepted, that there is no significant difference between the quality of life in the 'level of independence' domain of the residents of the experimental home and the comparison home before the intervention.

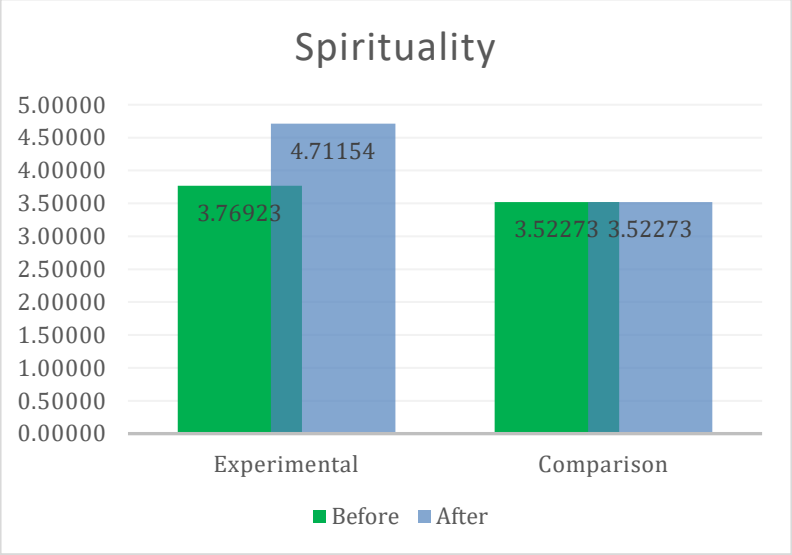
After the intervention, the mean values of Independence index for the experimental and control homes were 3.86 and 2.87 respectively. That is, the value for the experimental home has increased, while that of comparison home has decreased.

The t-test for after the intervention shows p<0.05. So, the null hypothesis H_{0N} is rejected. We accept the alternate hypothesis that there is a significant difference between the quality of life in the 'level of independence' domain of the residents of the experimental home and the comparison home after the intervention.

It is inferred that the intervention had a positive effect in enhancing the quality of life of the participants with respect to their level of independence.

Spirituality Domain

Figure 6.30: QoL Score before and After - Spirituality



For the spirituality index before the intervention, the mean value for the experimental home was 3.76 and that for the comparison home was 3.52. From the t test it is seen that before the intervention for the Spiritual Index, p >0.05. So, H_{0G} can be accepted, that there is no significant difference between the quality of life in the 'spirituality' domain of the residents of the experimental home and the comparison home before the intervention.

After the intervention, the mean value for the experimental home increased to 4.71 while that for the comparison home remained the same at 3.52. The t-test for after the intervention shows p<0.05. So, the null hypothesis H_{0O} is rejected. We accept the alternate hypothesis that there is a significant difference between the quality of life in the 'spirituality' domain of the residents of the experimental home and the comparison home after the intervention.

Hence it is inferred that the intervention helped to increase the quality of life of the participants in the spiritual domain.

Overall quality of life

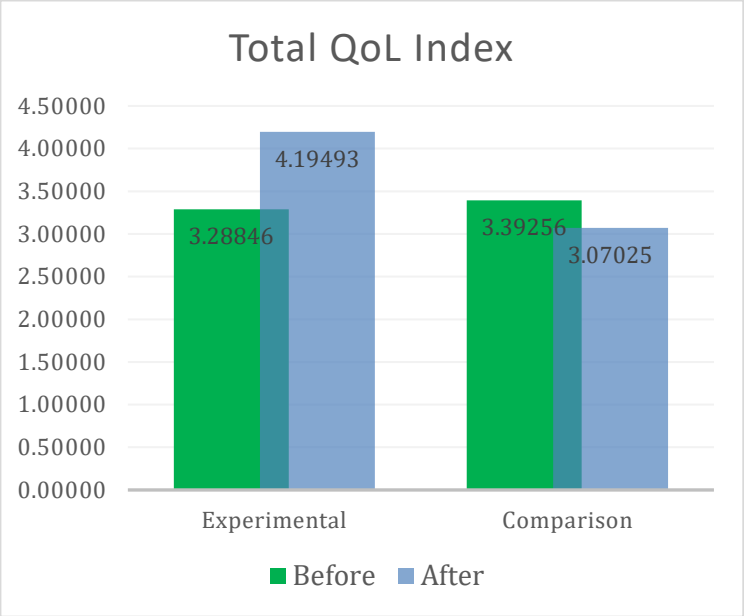
Before the intervention, the mean value of Overall QoL Index for the experimental home was 3.67 and for the comparison home, it was 3.50. From the t test it is seen that before the intervention for the overall QoL Index, p >0.05. So, the null hypothesis H_{0A} can be accepted. There is no significant difference between the overall quality of life of the residents of the experimental home and the comparison home before the intervention.

After the intervention, the mean value of overall QoL Index for the experimental home went up to 4.75, while for the comparison home, it actually went down to 2.84. The t-test gives p<0.05. So, the null hypothesis H_{0I} is rejected in this case. We accept the alternate hypothesis that there is a significant difference between the overall quality of life of the residents of the experimental home and the comparison home after the intervention.

From these data, it can be inferred that the intervention had a positive effect on the overall quality of life of the participants.

Total QoL Index

Figure 6.31: QoL Score before and After -Total QoL



The mean value for Total Quality of Life Index for the experimental home before the intervention was 3.28, and for the comparison home was 3.39. The T test for the total Quality of Life before the intervention shows a p value greater than 0.05, indicating that the null hypothesis H_{0H} can be accepted. There is no significant difference between the total quality of life of the residents of the experimental home and the comparison home before the intervention.

After the intervention, the mean value for Total QoL Index for the experimental home increased to 4.19, while that for the comparison home decreased to 3.07. The T test post intervention shows $p<0.05$, H_{0P} is rejected and the alternate hypothesis is accepted. That is, post intervention, there is a significant difference between the total quality of life of the residents of the experimental home and the comparison home before the intervention.

This gives rise to the inference that the intervention has been effective in improving the total quality of life of the participants.

6.4 Conclusion

The analysis of the data in Phase 1 of the study gives an understanding of the adequacy of risk management facilities in the Elderly Care homes in Thrissur District which came under the purview of this study. Pie charts, frequency tables, spider diagrams and bar graphs have been used to visualise the data, and statistical tools like Mann Whitney U Test and One Way ANOVA have been used to understand the significant differences among the different categories of homes. From the data interpretation, it is seen that 81% of the 62 homes studied have scored between 70 to 90% in the adequacy index.

Phase 2 of the study is a Quasi-experimental design. The data was collected using WHOQOL100 questionnaire before and after the intervention in the experimental home. This was compared with data collected from the comparison home within the same time frame, but without the intervention being done there. The pre-intervention data analysis showed that the two homes were comparable with regard to Quality of Life. After the intervention, there is a significant improvement in the Quality of Life of the participants of the experimental home. The changes were visualised using spider diagrams. The t-test was used for hypothesis testing, to prove that the intervention was effective.

The findings are discussed in detail in the next chapter.

CHAPTER 7

FINDINGS & DISCUSSION

7.1 Introduction

Statistical tools and visual representations help to organise the raw data and make them meaningful. However, these results need to be interpreted in context to arrive at relevant conclusions, about the research objectives and questions. This chapter contains a detailed discussion of the results obtained from the data analysis, and the findings therein.

The results of Phase 1 are descriptive, and are used to gain a comprehensive summary of the risk situations in different Elderly care homes in Thrissur chosen for this study. This section discusses whether factors like location and type affect the risk situation. Factors like ownership and occupancy are also discussed.

The risk assessment of each subdomain is discussed in detail, and key risk factors are identified. General trends and learnings emerging from these discussions have been pointed out.

Findings in Phase 2 involve measurements of the effectiveness of the intervention, by collating the results for the experimental home and the comparison home. The results have been analysed with respect to the 6 domains specified in the WHOQOL100 tool. This section also discusses how the interventions are aimed at addressing specific aspects of each domain.

The results in both phases have been discussed in the light of the researcher's own observations, interactions and extensive review of literature, to arrive at meaningful insights.

7.2 FINDINGS FROM PHASE 1: RISK ASSESSMENT

In the first phase, a risk assessment was conducted in 62 Elderly care homes in Thrissur District. The data was analysed in three levels.

In the first level, frequency tables and pie diagrams were used to get a general understanding about the location, type and capacity utilisation of the homes.

In the second level, the risk factors in the homes were studied using a tool containing 129 questions. The risk factors were grouped into 11 subdomains - namely Location, Exterior, Interior, Bathroom Facilities, Cleanliness, Hygiene, Food, Health, General environment factors & Relationships, Safety and Activities. The homes were also given scores based on their safety with respect to these risk factors. Here, a higher score means that the home is relatively risk- free. Frequency tables, spider webs and graphs were used to visualise and interpret the data.

In the third level, the 11 subdomains were again grouped into four major indices, and the performance of the homes on each of these indices were compared based on their location and type. Here, spider webs and graphs were used to visualise the data, and statistical tools were used to ascertain the significance of the variations.

7.2.1 Location

The number of elderly care homes located in rural and urban areas was found to be 74% and 26% respectively, clearly indicating that there are 3 times more elderly care homes in rural locations than in urban areas.

When the performance of the elderly care homes in the risk assessment survey was compared based on differences in location using the Mann Whitney U test, it showed that there is no significant difference.

Hence, we can conclude that the risk factor is Elderly care homes in Thrissur are not dependent on their location.

7.2.2 Ownership

Of the 62 unpaid elderly care homes in Thrissur District, only one is Government owned. The rest are owned and run by Non-Governmental Organisations (NGO). That is, 98% of the elderly care homes are privately-owned.

In Kerala, there are 623 Elderly care homes under NGO ownership and 13 which are run by the Government, that is 98% of elderly care homes in the entire state are privately owned.

We can see that the situation in Thrissur district is exactly identical to the situation in the State.

However, it is key to note that, in spite of the ownership, the Government through the Social Justice Department, exerts control over the functioning of these homes, and the home managements are accountable to the Government. Funding support is also given to these privately owned homes.

7.2.3 Type

It is seen that 70%of the elderly care homes are exclusively for women, while only 19% are exclusively for men. 11% cater to both.

The Economic Review 2017 by the Kerala State Planning Board cites some findings which may have a bearing on this trend.

Table 7.1: Marital Status of Kerala's Senior Citizens

	Total	**Men**	**Women**
Never Married	2.6	1.8	3.3
Currently married	60.8	88.9	37.8
Widowed	35.7	8.8	57.0
others	0.9	0.5	1.9
Without Partner	39.2	11.1	62.2

Source: The Economic Review 2017

From this table, it is clear that while 88.9% of men are currently married, only 37.8% women are. The percentage of widowed women is 57% while that of

widowed men is only 8.8%. Percentage of women who never married, at 3.3%, is nearly double that for men, which is 1.8%. On the whole, while 11.1% of men are without a partner, this number is at 62.2% for women.

One reason could be that men marry women who are much younger than them, so that most men in their late 70s or 80s have their wives still living with them, while most women in this age group are already widowed. Other socio-cultural reasons would need to be looked into.

When the risk factors in elderly care homes were compared based on the type of home, the One-way Anova showed that across all 4 major indices, male and female homes had almost equal level of performance, which was greater than that of mixed homes.

7.2.4 Occupancy

A comparison was done between the sanctioned strength and the current strength of the elderly care homes. It is seen that only 7 of the 62 homes have an occupancy greater than 80% of the sanctioned strength. 14 homes have occupancy between 60 to 80%, 15 between 40 - 60%, 15 between 20- 40% and 6 below 20%. In total, the Elderly care homes in Thrissur have 52% occupancy. This is lower than the average occupancy for Kerala, which is 67% as per SJD records.

The primary inference from this result would be that the requirements for elderly care homes in Kerala, and specifically Thrissur, is being more than amply met, with enough sanctioned strength to meet current and future demands.

6.2.4 Risk Assessment

The risk factors in elderly care homes were classified into 11 sub domains. The results for each subdomain are discussed in this section.

1. Location Score

58 of the 62 homes have a location score greater than 80%, and the other 4 also have scored more than 60%. This indicates that risks due to location and access issues are very less.

It is interesting to see that 59 of the 62 homes are located on property owned by the management. Clause 33 of the Guidelines issued by the Social Justice Department, Government of Kerala, allows Elderly care homes to function in rented or leased building, provided there is a five-year rent/lease agreement. Within these 5 years, the Elderly care home is directed to endeavour to acquire its own building and premises. According to this clause, even though a home can be started in rented/ leased premises, it has to be shifted to its own premises within a few years. This clearly indicates that it is imperative for the home managements to have their own property to continue running the home with licence.

With regard to risks from natural calamities, 10 homes have reported a possibility. All 10 had been affected by the Kerala Floods of 2018. However, the floods on that occasion were a very rare occurrence which affected almost the entire state. Flooding is not a recurring issue, and these homes have not been affected since. This relative safety could be due to the topographical features of the district, which is usually unaffected by natural calamities in general.

Even though most of the homes are located in rural areas, they still have access to health services and markets. Kerala's health care system has been upheld as one of the most developed in the world, and this could be a reason for this unfettered access across rural locations also. There are well functioning Primary Health Centres and Community Health Centres in all Panchayats, Corporations and Municipalities.

2. Exterior Score

This aspect consisted of 8 questions related to the compound of the home.

Here, 48 of the 62 homes have scored above 80%, and 13 have scored in the 60-80 range. Only one home has scored below the 40% marks.

The basic safety aspects like having a compound wall, prevention of waterlogging, no sharp stones or hazardous trees etc are taken care of in all except one or two homes. The two questions where more number of homes have responded in the negative are with regard to having a garden and having provisions for wheelchairs in the compound. The two questions pertaining to whether the compound is fit for a walk, also have some negative responses.

This points out that the focus of the home is more on basic safety. Factors which are not compulsory to safety, but still have a positive effect on physical and mental wellbeing seem to have very little priority.

Having a garden, and being able to take a stroll in it, have proven advantages. 'Green care', or therapy by exposure to plants and gardening is actively being researched. Simply being in the garden has been shown to have therapeutic benefits for the elderly. It gives them a place to reminisce, and it also helps improve physical and mental conditions (Scott et al, 2020; Thompson R, 2018). In spite of these advantages, many Elderly Care Homes are not seen to have a garden, or if they do, there is no wheelchair provision to enable the elderly to move through the garden.

3. Interior Score

The interior aspect consists of 36 factors related to the infrastructure and furniture inside the care home building. The questions in this section are more probing, and we find that the scores have come down in general, with only 18 homes scoring above the 80% mark.

The factors which have received maximum negative responses are: provision for alarm bells in the rooms, handrails, sturdy furniture, wheelchair access to washbasin and scientifically built ramps.

It is seen that the furniture is usually made of plastic, which may tend to slip or break easily, causing accidents. As older adults tend to put their whole weight on the chair or table when they change their position, this danger is very pronounced in Elderly Care Homes. Cost could be a deterrent in obtaining more sturdy furniture of steel or wood.

One factor which affects the interior facilities is the age and original purpose of the building. For the homes which have scored highly, the buildings have been recently built, and exclusively for the purpose of running an elderly care home. But some are old buildings donated to the management, and were originally regular homes, with modifications added later. In these buildings, it is difficult to make all the required architectural modifications.

Another factor is the lack of vision of the architects or builders, where the buildings are constructed or modifications made without giving proper notice to the special needs of older adults. For example, in some homes, it was found that the floor is tiled with polished tiles. This gives a neat and fresh appearance to the floor, and makes it easy to clean - which are definitely positive factors to consider. However, these tiles are often slippery, which constitutes a huge safety hazard to the elderly.

It is also interesting to note that, once again, the factors which are given least priority, pertain to the general wellness and independence of the inmates - for example, having a wash basin which has wheelchair access and having suitable ramps and handrails which facilitate easy personal mobility to the inmates.

In designing the interiors, we can also see that the homes have met the compulsory criteria envisaged by the Orphanage control board, and a few of the criteria given in an elaborate study by Dr P K B Nayar for the Social Justice Department, Govt of Kerala. Here again, these criteria ensure basic safety and protection mechanisms. However, the more subtle aspects of Dr Nayar's guidelines have not been prioritised.

4. Bathroom Facilities Score

The bathroom is the riskiest place within the home, with high possibilities for falls and accidents. (Carter et al, 1997). This Score includes 21 questions related to safety in the bathrooms and toilets in care homes.

49 homes have scored above 80% in this aspect, and 12 have scored between 60 - 80. No homes have fallen below the 40% mark.

It is seen that all homes have enough bathrooms and toilets according to the ratio specified in the OCB guidelines. All the homes are also seen to have proper drainage, enough lighting, well placed bath accessories, non-slippery floors and non-slippery mats. For all except two homes, the bathrooms and toilets are inside the building itself. There are facilities to take bath in the sitting position too.

However, more than 50% of the homes do not have grab bars in the toilet and bathrooms. This is a concern, as the absence of grab bars is found to be one of the most common reasons for major fall-related injuries in old age (Carter et al, 1997).

None of the homes have the provision for a wheel-chair friendly toilet or bathroom, which again raises questions of independent mobility for invalid older adults.

5. Cleanliness Score

The Cleanliness aspect consisted of 8 questions related to the cleanliness of the interior of the building. Only 8 homes have scored more than 80% and 13 homes have scored less than 40% in this aspect. Though the rooms themselves are generally clean, there seem to be issues with cluttering and dust. A majority of the homes have a lack of proper light and ventilation in the storeroom. There are some homes where there is an issue of foul smell from the bathrooms and toilets.

This is an area of concern, as cleanliness of living spaces is a prerequisite for physical and mental health.

One reason could be the lack of human resources. In many homes, the same person serves the multiple roles of caretaker, cook and cleaning staff. Deep cleaning is not a priority. There is also a lack of knowledge about the need for ample sunlight and ventilation in the storeroom, especially when food materials are stored there. Cluttering could be a result of improper space planning, and too little shelf space given to the inmates to store their daily necessities.

6. Hygiene Score

The hygiene aspect has 7 questions related to personal hygiene of the inmates. In contrast to the cleanliness score, the hygiene score is very high for all homes. 61 out of 62 homes have scored more than 80%.

While all homes have enough facilities, 53 homes also have a system in place to ensure that the inmates' personal hygiene is taken care of.

This is a very positive trend, as maintaining personal hygiene helps prevent communicable diseases, especially in a setting like a Elderly Care Home where many physically vulnerable people are living together in close contact.

7. Food

The food aspect pertains to 6 factors related to the diet of the inmates.

Clause 42 of the OCB Guidelines lays down that the inmates should have a balanced diet prepared by a nutrition expert. Tasty food and pure drinking water is available in all homes, and 59 homes have a diet plan. 45 homes have special diet plans according to the health needs of different inmates. However, none of the homes have taken the support of a nutrition expert in preparing this plan.

13 homes have scored more than 80% in the food aspect, and only one home has scored below 40%. 48 homes have scored between 40 and 80%.

8. Health Score

The health aspect contains 19 questions related to provisions for ensuring physical and mental health of the inmates and medical facilities available to them.

While 22 homes have scored more than 80%, 34 have scored between 60 - 80%. Only 6 homes have scored below 60%.

All homes provide clean clothes and beddings, maintain medical records of inmates, and ensure that inmates take their medicines on time. 61 homes provide regular

health check-ups and palliative care either within the campus or have referral provisions. Psychiatric treatment is also provided as needed.

This could be due to the impact of the *Vayomitram* project of the Government. The care homes are utilising the benefits of medical check-up and free medicines provided as part of this project.

However, 39 homes are reporting some difficulty in having emergency access to an ambulance, though other vehicles may be available.

Only 31 homes have a regular exercise routine for the inmates and only 27 have all inmates participating regularly.

None of the homes have health insurance for the inmates. There could be different reasons for this. Firstly, most treatments would be done at Government facilities, which is very inexpensive or even free. Secondly, many of the inmates do not have proper documents required to enrol in insurance schemes of Government or private agencies.

9. General environment factors & Relationships Score

There are 8 factors in this aspect, pertaining to the general atmosphere in the home, and the relationships among inmates and caretakers. 48 homes have scored over 80% and 13 have scored between 60 and 80%.

In most homes, staff members have a basic training in psychology, and a support system to ventilate their feelings. This ensures a precaution against compassion fatigue and stress among caretakers. As a direct consequence, the staff members have a cordial relationship with the inmates. The researcher has also observed that for the inmates, the predominant feeling towards the staff is that of gratitude. The inmates feel relieved that they have someone to take care of them in their old age. However, there seems to be some friction among the inmates themselves. The researcher is aware that there could have been some subjective bias in answering these questions, as the respondents feel inclined to give the ‘polite and right’ answer. Most homes report that the complaints of the inmates are satisfactorily

attended to. All 62 homes have a provision to take care of the money and belongings of inmates, and to return them when needed.

10. Safety Score

This is a set of 3 questions based on safety measures for fire and electric hazards. While 59 homes have an electrician on call to take care of any potential electric hazards at the earliest, 57 homes report that their staff are trained in basic first aid. However, only 13 homes have their staff trained in basic fire and safety measures. On the whole, 43 homes have a score of over 80% in the safety aspect.

11. Activity Score

The activity aspect includes 10 questions to check whether the homes have activities to engage the inmates and the nature of these activities. 60 homes have said that they have regular activities to engage the inmates all day, and 57 of them give priority to the inmates' preference in selecting these activities, and 59 say that their activities have social impact. However, only 5 homes have activities that are income generating.

In 61 homes, the inmates have opportunities to interact with outsiders regularly, and in 35 homes they are taken for regular outings. However, in 61 of the 62 homes, the inmates are not allowed to go outside on their own even if they wish to.

In all 62 homes, there are celebrations involving the inmates, but only in 19 homes, the birthdays or special days of the inmates themselves are celebrated.

Overall, in the activity aspect, while 16 homes have scored over 80% and 40 homes have scored between 60- 80%, 4 have scored between 40- 60% and 2 below 40%.

7.3 A caretaker approach to Old Age care?

Analysing the 11 sub dimensions, it is seen that the Elderly Care Homes in Thrissur have scored satisfactorily in all aspects. 52 of the 62 homes have put up a score exceeding 70%. From this it can be inferred that the Elderly care homes in Thrissur meet the basic risk management needs specific to old age care.

Based on the questions which got most negative responses, the following were identified as major risks.

1. The rooms have no alarm bells for the residents to call for help
2. There are no ramps in the entry/exit areas
3. The slope of the ramp is not convenient for easy passage
4. There are no handrails in the corridors
5. There are no handrails in the rooms
6. The furniture is not sturdy
7. The washbasin cannot be used while sitting in a wheelchair
8. There are no grab bars in the bathrooms and toilets
9. The grab bars are not well fixed
10. The grab bars are not of suitable height
11. The furniture is not of the right texture
12. There is no provision to take bath in a wheelchair
13. The services of a dietician/ health professional are not utilised in preparing the diet plan
14. Exercise is not part of the daily routine
15. Inmates do not participate in the exercises
16. Inmates have no health insurance
17. There are no income generating activities
18. The inmates do not have the freedom to go out on their own
19. Inmates' birthdays or special days are not celebrated

These factors have one thing in common - all of them relate to the independence and individuality of the inmate in some way. Having facilities like grab bars, ramps, handrails and wheelchair friendly spaces ensure safe and easy mobility for the older people. Wheelchair- friendly bathrooms and washbasins help them to take care of their personal needs themselves. Having alarm bells increases their confidence. Having a diet chart planned by an expert, and regular exercise ensures better health and disease prevention. Since the health needs differ from person to person, having a personalised diet plan will be very effective in ensuring the health and wellbeing of the residents. Taking part in income generating activities gives them a sense of usefulness. Allowing them to go out on their own gives them a sense of freedom, and increases self-esteem. Celebrating their special days makes them feel special and significant.

A lack in these aspects points to the fact that Elderly Care Homes are mostly run with a caretaker approach. The management and the staff are sincere in their efforts to make life easy and safe for the older adults. That needs to be definitely appreciated.

However, with changes in the perspectives of social work, it is now widely accepted that the elderly are not simply takers of care and support. The new approach focuses on tapping their inherent strengths and resources to help them help themselves. This is the strengths-based approach to Elderly care. The Strengths-based approach does more than ensuring safety and care for the older adults. It increases their quality of life.

It is this approach that is dealt with in Phase 2 of this study, where a strengths-based intervention is given to the inmates of a chosen home, and the change in their quality of life as a result of the intervention is studied.

7.4 FINDINGS FROM PHASE 2

Risk Management and Strengths-Based Intervention

The findings of phase 1 formed the foundation for preparing the intervention package of phase 2.

The homes were organised based on their total scores from Phase 1, in ascending order. The bottom 25% and top 25% were excluded from consideration in the subsequent phase. Two homes were then chosen from the remaining middle 50% for the intervention phase of the study.

Based on discussions with the management and the researcher's observations, the *Sandeepany Mathrusadanam*, Guruvayur was chosen as the experimental home to deliver the intervention, while *Saketham Sevanilayam* Mapranam was chosen as the comparison home.

The quality of life of the residents of the experimental home and comparison home were measured using the WHOQOL100 tool prior to the intervention. The measurements were done across 6 domains - Physical Capacity, Psychological, Social Relationships, Level of Independence, Environmental and Spiritual, along with the Overall quality of life and health perceptions. The total QoL was also measured.

A strengths-based intervention was designed and implemented in the experimental home over a period of six months. The intervention was of two types - Strengths-based protective and strengths-based engagement. The first type of interventions are designed to conserve and augment the existing strengths and resources within the individual. The second type helps to engage the participants with the resources around them. The intervention module was designed to cover all aspects of the quality of life as specified in the WHOQOL100 tool. Each intervention session however, may not be unique to one particular domain, but may be intended to influence multiple domains. In this discussion, each session is included under the domain which it predominantly influences.

After the intervention was completed in the experimental home, the same WHOQOL100 questionnaire was once again administered in both homes.

The data was visualised and analysed using statistical tools. The findings in each domain are discussed here.

<u>Physical Capacity Domain</u>

The facets which come under the Physical Capacity Domain include pain and discomfort, energy and fatigue as well as sleep and rest.

The pre-intervention assessment gave a mean value of 2.12 for the experimental home and 3 for the comparison group. The t-test shows that the experimental home has a significantly lower value than the comparison group in this domain.

The SB-P interventions done to address the physical capacity domain included Yoga sessions, guided chair-based exercises, a general ayurvedic health check-up, and eye check-up, health education sessions, nutritional counselling, session on strength training,

The SB-E interventions included simple games that the participants can engage in on a daily basis.

The post-intervention assessment showed that the mean value of Physical Capacity Score had increased to 4.06 for the experimental home.

Here, the researcher has directed the intervention into 3 major areas -

- Addressing existing health issues - From the personal interactions with the participants, the researcher had identified that they had various physical discomforts like pain, sleeplessness, fatigue, eye problems, etc. The researcher felt that it was important to address these needs urgently. This was achieved through the ayurvedic medical camp and eye check-up.

- Increasing physical activity - The researcher had observed that the participants were leading more or less a sedentary lifestyle. Since physical activity is directly related to physical capacity and health, the researcher included Yoga, Guided Chair Based Exercises and Simple games in the intervention.

- Taking responsibility - The researcher realised that to sustain any changes, the participants need to take responsibility themselves. This was achieved through interventions like health education sessions and nutritional counselling.

From the results of Phase 2 study for the physical capacity domain, it is clear that this approach focusing on these three areas, has helped to increase the Quality of Life of the participants in this domain.

Psychological Domain

The psychological domain includes the following facets - positive feelings, thinking, learning, memory and concentration, self-esteem, body image and appearance as well as negative feelings.

The mean value for QoL in this domain before the intervention was 3.32 for the experimental home and 3.31 for the comparison home. The t-test indicated that the difference between the two values was not significant, and the situation in the two homes can be treated as similar. After the intervention, the mean value for the experimental group increased to 4.32, while that for the comparison group reduced to 2.93. The t-test also indicates that this is a significant difference, hence proving the effectiveness of the intervention.

The predominant SB-P interventions pertaining to the psychological domain included counselling, reminiscence, an expert interactive session on Living in Harmony and spiritual retreat, and predominant SB-E interventions include mindfulness, group support & group discussion, creating programmes for YouTube broadcast, a wall painting demonstration, screening of film and celebration of Mothers' Day.

These interventions addressed the following broad areas -

- Addressing immediate psychological needs and concerns - The immediate needs of the participants were addressed through counselling, group support & group discussion.

- Building resilience- It is important that the older adults develop the psychological & cognitive strength to maintain their emotional and mental health. This was done through sessions like mindfulness, reminiscence intervention, spiritual retreat and an interactive discussion on harmonious living.

- Promoting positive feelings- Creative engagements and celebrations help to sustain positive feelings. The participants were encouraged and supported to create programmes to be broadcast on their YouTube channel. Demonstration of wall painting, and celebration of Mothers' Day were also part of promoting positive feelings.

Physical activities like Yoga, chair-based exercises and games are also supportive in the psychological domain. The ayurvedic health check-up helped to address psychosomatic illnesses.

Health education and nutritional counselling sessions helped provide new learning and promote cognitive abilities.

From the results, it is evident that these interventions have been effective in addressing the challenges of the older adults in the psychological domain and have helped to improve their QoL.

Social Relationships Domain

The Social Relationships domain considers the personal relationships and social support facets.

Before the intervention, the mean QoL score in this domain was 3.11 for the experimental home and 3.26 for the comparison home. The t-test showed that the difference between these two values was not statistically significant, suggesting a similar situation in both homes. Following the intervention, the mean QoL for the experimental group rose to 3.59, whereas it decreased to 3.1 for the comparison group. The t-test revealed a significant difference, providing evidence for the intervention's effectiveness.

The predominant SB-P intervention in this domain included a talk on Living in Harmony, which focussed on strengthening relationships. SB-E interventions included interacting with the community through a zumba demonstration session, temple visits with agemates from other homes, interactions with artists and authors, intergenerational interactions with children having special needs and with regular children.

The social interactions were designed in three levels -

- Interactions with experts - These interactions involved discussions on various topics like relationships, art, literature etc. This helps cognitive stimulation, cultural enrichment and learning, along with increased confidence in social interaction.

- Interaction with agemates - Temple visits with agemates from other homes was an opportunity for the older adults to make new friends, mingle with persons who will understand and empathise with their own situations and experiences.

- Intergenerational interaction - Interaction with children gave the older adults an opportunity to share their wisdom and experiences. It helped them express their suppressed feelings of love and affection, which they wished to bestow on their own grandchildren. Of all the intervention activities, this was the one the participants enjoyed the most.

Activities like celebration of mothers' day, group support & group discussion also helped address the quality of life in the social relationships domain.

The results of statistical analysis prove that the intervention was effective in increasing the quality of life in this domain.

Environmental Domain

The Environmental domain includes the following facets - physical safety and security, home environment, financial resources, health and social care, accessibility and quality, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment and transport.

Prior to the intervention, the average quality of life (QoL) in this domain stood at 3.72 for the experimental home and 3.66 for the comparison home. The t-test revealed a nonsignificant difference, suggesting a comparable situation in both homes. Following the intervention, the mean QoL for the experimental group saw

an increase to 4.37, whereas it decreased to 3.22 for the comparison group. The t-test confirmed a significant difference, providing evidence of the intervention's effectiveness.

The SB-P interventions include physical risk management tips, environmental modifications, and health education. The SB-E interventions done were leisure activities like zumba and games, and sessions for caretakers and management.

The environment domain was addressed in three levels.

- The internal environment of the participants was addressed through leisure activities like zumba dance, simple games etc.
- The physical environment around them was made more supportive through environment modifications as well as by training them in physical risk management.
- The caretakers and the management also form an important part of the participants' environment. They were given sessions to educate and support them to incorporate more effective ways to manage the home.

These interventions, as the results indicate, have helped to improve the quality of life in the environmental domain.

Level of Independence Domain

The Level of Independence domain includes the following facets - mobility, activities of daily living, dependence on medication or treatments

Before the intervention, the average quality of life in this domain was 3.18 for the experimental home and 3.21 for the comparison home. The t-test suggested a nonsignificant difference, implying a comparable situation in both homes. Following the intervention, the mean QoL for the experimental group rose to 3.86, whereas it dropped to 2.87 for the comparison group. The t-test confirmed a significant difference, thereby demonstrating the effectiveness of the intervention.

The SB- P intervention in this domain consisted of strength training to conserve and develop muscle strength, flexibility and mobility and to improve independent physical activity.

The SB-E intervention was a group session for the participants and the caretakers, engaging them in a discussion on the importance of retaining the level of independence in old age and how this can be achieved. The session also addressed their concerns and fears in this matter.

The level of independence is very closely related to physical capacity. So, the interventions targeting improvement in physical capacity will also enhance the level of independence of the older adults.

The results of statistical analysis prove that, along with physical capacity, the quality of life in the level of independence domain has also shown significant improvement.

Spirituality Domain

The mean value for QoL in this domain before the intervention was 3.76 for the experimental home and 3.52 for the comparison home. The t-test indicated that the difference between the two values was not significant, and the situation in the two homes can be treated as similar. After the intervention, the mean value for the experimental group increased to 4.71, while that for the comparison group remained the same at 3.52. The t-test indicates that this is a significant difference, hence proving the effectiveness of the intervention.

The SB-P intervention included a spiritual retreat and *satsang*, to strengthen their spiritual beliefs and value systems.

The SB-E intervention included engaging their peer group and local networks, by organising a visit to temples with their peers in other homes, and conducting group bhajans.

Interventions in this domain addressed two aspects.

- The participants were given an opportunity to explore the spiritual aspects of life, through a full day spiritual retreat, where they could engage in study and meditation.

- The participants had mentioned during interactions that their religious beliefs were their greatest strength. This strength was reinforced by enabling visits to temples which they considered sacred, during a time period which they considered auspicious.

The results prove that the spiritual dimension also shows a significant improvement in quality.

Overall quality of life

The WHOQOL100 includes four questions related to general quality of life and health perceptions. Prior to the intervention, the mean quality of life in this domain was 3.67 for the experimental home and 3.50 for the comparison home. According to the t-test, the difference between these values was not significant, suggesting a similar situation in both homes. Following the intervention, the mean QoL for the experimental group increased to 4.75, while it decreased to 2.84 for the comparison group. The t-test showed a significant difference.

These findings indicate that the interventions targeting various domains have had a positive impact on the overall quality of life, as evidenced by the analysis of the WHOQOL100. The improvement in QoL for the experimental group, coupled with the decrease in QoL for the comparison group, underscores the effectiveness of the interventions across multiple facets of wellbeing.

Total QoL Score

The total QoL Score indicates a summary of the results from the different domains. Since the experimental group has shown an increase in quality of life across all the domains, the Total QoL Score invariably shows an increase.

Before the intervention, the mean Total Quality of Life was 3.28 for the experimental home and 3.39 for the comparison home. The t-test results suggested a

nonsignificant difference, indicating that the two homes had a similar situation to start with. Following the intervention, the mean QoL for the experimental group rose to 4.19, while it decreased to 3.07 for the comparison group. The t-test showed a significant difference, providing evidence for the effectiveness of the intervention in positively impacting the overall quality of life.

Risk Management

In the risk assessment of the first phase, 31 risk factors had been identified in the experimental home. With the support of the home management, and through the intervention, 17 of these factors could be resolved. Suggestions made by the researcher regarding another 3, were not accepted by the residents, as they were comfortable with the current situation, and were not yet ready to change. The management has accepted the suggestions of the researcher regarding the remaining 11 factors, which require some infrastructural changes. Regular follow ups by the researcher have shown that the management has started acting upon these recommendations.

The importance of Relationship

The principles of social work highlight the importance of building a good relationship between the client and the social worker. During the course of the study, the researcher had regular interactions with the stakeholders of the experimental home, for nearly a year. Over this time, the researcher developed a good rapport with the study participants, which was reciprocated. Their cooperation and involvement with the activities of the intervention could have been motivated by this relationship. It also helped the participants to feel involved in the activities that were being newly introduced. This may have also helped in overcoming their resistance to change.

The researcher values the positive relationship that she has developed with the participants and appreciates their kindness and love. She considers them not just as the ‘subjects’ of a study, but as strong and compassionate individuals. She keeps the relationship alive by continuing to support them in whatever way she can.

Conclusion

The results obtained through descriptive and statistical analyses have been discussed in detail in this chapter. The contextual interpretation of the results and their significance have been analysed in the light of the research questions of the study.

The results of Phase 1 of the study on deeper discussion, have clearly brought out the need for adopting a strengths-based perspective to the institutionalised care of the elderly. The findings from the scoping review also reveal the complex relationship between risk factors and quality of life. This supports the choice of a strengths-based approach for developing the intervention module.

The results of Phase 2 study have given evidentiary support for the effectiveness of the intervention. Thus, it can be concluded that the risk management and strengths-based intervention implemented in this study has without doubt increased the quality of life of the elderly in institutionalised care.

The discussions in this chapter also lead to certain insights, which can be adopted in a more general manner. These insights are discussed in the next chapter, and formulated into workable recommendations.

CHAPTER 8

RECOMMENDATIONS

8.1 Introduction

Social work research becomes meaningful when it can translate into practical solutions for the community to overcome present challenges and move towards a better future.

The present study, titled "Enhancing the Quality of Life of the Elderly in Residential Care - Feasibility of a Risk Management & Strengths-Based Intervention", has explored the application of the concepts of risk management & strengths-based approach in the field of elderly-care. Through this study, the researcher has come up with an overview of the existing ground situation in Elderly Care Homes with regard to risks and risk management. A scoping review as part of the study has indicated how various risk factors can affect the Quality of Life of the elderly. The intervention phase has amply demonstrated that a risk-management & strengths-based intervention is feasible in the institutional setting, and can significantly enhance the Quality of Life of the elderly in residential care.

Based on the learnings of this study, this chapter puts forth recommendations for policy, practice and research. The findings from all phases of the study have been combined together to come up with suggestions on how the strengths-based approach can be applied in the current context. The chapter concludes by exploring the potential for collaboration between academia, practitioners and policymakers.

8.2 Recommendations for Policy

Risk Management Protocols in Elderly Care Homes:

While going through policy documents and during the visit to Elderly Care Homes, the researcher observed that Risk management as such is not a policy priority. The guidelines for Care Homes include the basic safety measures, but have not considered all bio-psycho-social risk factors comprehensively. Prevention of risks is not only the humane thing to do, but it is also cost saving in the long run.

Considering that the care homes included in the study are all run on a not-for-profit basis, financial prudence is much needed. It is better to invest in risk -management measures than to incur huge hospital expenses or disability-care expenses later on. Hence the policy framework should be re-worked to include detailed risk assessment & risk reduction protocols in the guidelines for Elderly Care Homes. Along with regular inspections to ensure compliances the government should also provide financial support to implement these protocols.

Policy Framework to include Psycho-Social factors

In the current guidelines, more thrust is given on environmental and infrastructural factors. The psycho-social needs of the residents of the care homes are not considered. Policy frameworks should include detailed guidelines on how these needs can be met. This could include activities for improving self-esteem, encouraging socialisation, promoting community interaction, regular counsellor visits, and so on. This would also lead to reduction of psycho-social risks in the older adults, and ensure better emotional health, and a more pleasant psycho-social environment in the home.

Strengths-based approach in Policy Making

The policymakers should adopt a strengths-based approach to the care of older adults. Such an approach would consider the residents of care homes as partners in their own care. There can be provisions for a managing committee that includes representatives from the residents as well. Instead of just giving them a forum to express their grievances, it would enable them to actively participate in decision making. They will also have a sense of ownership towards their own care, reducing the burden on caretakers.

Broader Evaluation Criteria

To ensure compliance of the care homes to the risk management provisions, there should be periodic inspections by competent professionals. The evaluation criteria should be clearly defined and should be broad enough to assess all the recommended bio-psycho-social and environmental components in the guidelines.

There should also be a provision to document qualitative aspects like best practices, challenges, etc. Inspections by authorities should not be limited to checking the books. They should interact with the residents. Technology- assisted surveys will ensure that the inspection staff on the ground adhere to the evaluation requirements.

Training & Awareness

Implementing the policy decisions should not be an additional burden to the management of the care homes, nor should it be something that needs to be enforced with punitive actions. The policy makers should feature in provisions for training programmes for the personnel at all levels of the Elderly Care Homes. Certificate programmes can be introduced for existing staff, which will not only increase their competence, but also make them more professional in their approach and attitude. Training should also be given to the government officials who are in charge of the respective departments. They should be made aware of the challenges involved in running a care home, and be compassionate to the residents, caretakers and managers. There should be a sense of camaraderie at all levels - from the resident to the highest government official - a feeling that we are all working together for a social cause.

Provision to recognise Best Practices

Based on periodic evaluations, best practices in care homes can be publicly applauded and rewarded. There can be an annual ‘Best Care Home’ Award. This concept can be expanded to include awards like ‘Best Caretaker’, ‘Best Inmate’ etc. This will motivate the care homes to follow better care practices. It will also be a source of excitement for the residents as well as the caretakers. It will promote a sense of healthy competition among the homes too.

Sensitising Children & Youth

Children and youth should be aware of the problems faced by the elderly. This will enable and empower them to support the older adults in both community and institutional settings. A sensitisation component should be included in the regular

curriculum for all age groups. Even short-term certificate programmes can be created for this purpose, including theoretical and practical components.

8.3 Recommendations for Practice

Need for a Strengths-Based Approach

The first phase of this study has explored the actual scenario of Elderly Care Homes in Thrissur. The homes are generally well-managed and the basic needs of the elderly are being satisfactorily met. The NGOs who are running such homes are doing a commendable service, with the good intention of supporting the elderly.

Looking for possibilities of improvement, the study identified major risk factors in each domain of the risk assessment. While remedies can be suggested for each of these factors separately, it is also seen that a shift in the approach to old age care is a common foundation to prevent all these deficits.

What is urgently needed here is to inculcate a strengths-based approach to the institutionalised care of older adults. The elderly who come to these homes are usually forced to make that choice due to social and economic compulsions, and not because they are bedridden (Homes for the infirm were not a part of this study). They still have strengths and resources, and are capable of actively participating in their own care regime.

Unfortunately, the caretakers' noble urge to help usually leads to the caretaker completely taking over the life of the older adult. Respecting the independence and individuality of the older adult is the foundation of the strengths-based approach. The elderly have the resources and the strengths to become active partners in the functioning of the care home. Involving them in this role will reduce the burden of the caregivers and home management, engage the elderly purposefully, and improve the effective functioning of the home.

This is where the strengths-based approach plays a key role.

The recommendations in this regard are shared in the following sections.

Strengths-based training to stakeholders

It will be beneficial to give practical strengths-based training to all stakeholders including the caretakers, management personnel, and authorities of the homes. The purpose of the training should be to create an attitude shift, and also to enable them to incorporate these tenets in their daily routines and decisions. The training can also be given to the older adults, so that they also know what to expect and how they can participate in their own care regime.

The training should enable the stakeholders to assess the extent of risks involved in every situation. For example, they should be able to know how much physical activity is suitable, and how much may cause injury to the older adult. A strength-based approach does not exclude being sensitive to the risk factors. It advocates a sensible approach to risk, wherein the strengths are utilised and the risks are minimised.

Involving experts from suitable fields – Multidisciplinary Approach

Institutional care of older adults is a specialised arena by itself. Even though care homes are started and managed out of compassion and a service attitude, to ensure their effectiveness, a professional approach is required. It is beneficial to involve professionals from relevant fields in preparing the care plan and planning the facilities. However, there should be someone responsible, who can translate the recommendations of the experts into workable solutions. This key person should also listen to the needs and wishes of the older adults, and ensure buy-in from the other staff.

This study recommends involving professionals in the following areas:

1. Taking the suggestions of a nutrition expert in preparing the general diet plan and special diets according to health needs.

The diet plan should particularly consider the needs and characteristics of older adults. Older adults will have specific needs and tastes as far as food is concerned. A healthy diet should not feel like a punishment, as this will demoralise them. It should be seen that this plan is translated into a tasty menu which the older adults

enjoy. This requires the understanding and cooperation of other employees too, especially the cook, purchase manager etc.

2. Taking the suggestions of an architect in planning or modifying the infrastructure

Some care homes function in buildings which are exclusively built for this purpose, while others function in remodelled buildings. Either way, it is important that there are elder-friendly arrangements in the building and the compound. While making such provisions, it is important to consult an expert architect to ensure that technical standards are adhered to. For example, ramps should be of proper slope, doorways and corridors should be wide enough to allow wheelchair movement, fire and safety standards should be met, etc. NGOs should take the lead in clearly communicating the specific needs of the elderly to the architect. For example, when fixing a grab bar, it should be noted that older adults may not have a firm grip. Once the needs are understood, the architect can suggest innovative methods and materials to meet these needs in a budget-friendly way. Adopting a strengths-based approach here means creating a physical space which is pleasing and comfortable, and where the older adults can move easily and freely. This promotes independence and increases their happiness.

Increased Participation

The elders living in care homes may have the physical and mental capacity to engage in purposeful activities. It would be good to involve them in the day to day management of the home, to whatever extent possible. For example, they can help with cooking, cleaning, purchase, accounts etc. Older adults with special skills can be trained in specific responsibilities. This will keep them physically and cognitively active. It will give them a sense of purpose and usefulness, which will increase their confidence. This will also help in creating a feeling of belongingness - the residents will truly start considering it as ‘their own home’, and the people there as their own family. It will reduce the burden on the caretakers. However, care should be taken to ensure that the responsibilities do not become a burden to the residents. They should be given proper encouragement and support.

Some areas where they can be involved, according to their interests and capacities, are as follows:

- Preparation of the diet plan
- Planning daily routines and activities
- Accounts & bookkeeping
- Purchases & procurements
- Taking care of medication & health needs
- Simple maintenance activities

Interaction with diverse generations

Out of all the intervention sessions conducted by the researcher, the participants found the interaction with children to be the most enjoyable. The researcher feels that this can be built upon further. Elderly Care Homes can make arrangements for the residents to interact with children more frequently. This can be done by inviting students from neighbouring schools or colleges to visit the home. These visits can be made purposeful also. Some suggestions in this regard are given below.

1. Students can be invited to conduct programs, give performances, and engage with the elderly through interactive sessions.
2. A tie-up with NCC/NSS units in nearby colleges can be planned to create and maintain a community garden in the home compound. This initiative is aimed at providing an opportunity for students and residents of the home to work together on a daily basis.
3. An activity related to children, such as a daycare facility or dance class, can be started with external staff. This step ensures a regular inflow of people into the compound, providing the elderly residents with opportunities to engage and socialise.

4. Internships and volunteering can be promoted, ensuring a regular stream of students visiting the care home. This initiative will also help sensitise the younger generation to the problems and challenges faced by the elderly.

5. Students can be encouraged to conduct research work in the elderly care home. Dissertations on topics relevant to the care of the elderly can be undertaken. The findings and recommendations of the research can be submitted to the institution itself and also to Local Self-Government Institutions for advocacy and policy-making purposes.

6. Visits by children from nearby Children's Homes can be organised. This interaction will be mutually beneficial as children will get to experience the love and care of a grandparent for some time.

Intergenerational interactions should be planned keeping in mind the required safety measures for all involved.

Regular Engagement

The homes should have a plan in place for regular engagement of the older adults in some kind of useful or purposeful activities. Exercise is a key element that should be included in the daily routine. The exercises should be carefully planned according to the physical capacity and health needs of the older adults. It would be good to involve experts in yoga, aerobics, zumba dance etc to prepare and conduct a suitable exercise regime. Depending on the interests of the participants, some classes can also be organised for them, like music, spiritual talks, etc.

Some activities can also be integrated into the daily routine, especially those which help in improving fine motor skills, gross motor skills, gait, balance, etc.

A few routine tasks which help in this regard include picking up the newspaper daily, plucking grass, folding clothes, hanging clothes to dry, etc.

Person-centred approach

It is important to sustain the individuality and self-concept of the older adult in a care home setting. Measures can be taken to promote this. For example, birthdays and special days of each person can be separately celebrated. These celebrations can be as simple as giving sweets or small gifts on that particular day. The spiritual beliefs and cultural traditions of the participants can also be considered, like going to the temple or church on one's birthday. Such small gestures go a long way in fostering the self-concept of the elderly. This also adds meaning and hope to their lives.

It is also important to create and maintain an updated Individual Care Plan (ICP) for each resident. This is a document that will contain all the relevant details of each resident, including their health status, medications, likes and dislikes, care needs, etc. Having an updated ICP ensures that the needs of the elderly residents are effectively met, even if there is a change in the staffing of the institution. The new professional who takes charge will have all the required data for a seamless transition.

Resource Mobilisation

It has been observed that care homes for the elderly are predominantly run by Non-Governmental Organisations (NGOs). Resource constraint is a major concern in implementing change initiatives, especially with regard to environmental modifications, staffing, etc. Identifying and accessing resources is a core characteristic of the strengths-based approach. Two major sources where the NGO can look for support are the Government and the Community. The community can provide support in the form of volunteers, cash donations, in kind donations and goodwill. The NGO can also seek pro-bono consultations from experts in different fields, to help in implementing the strengths-based approach, and also in other areas like management, fundraising, etc. Government support may be in the form of grants, social security, favourable policies, etc. The NGOs have to take the lead in accessing these resources. Collaborating with other NGOs may help not only in

sharing resources and learning, but also in collectively advocating and lobbying for policy-level changes.

Figure 8.1: Stakeholders in Social Change

8.4 Recommendations for Research

Studies on Risks & Risk Management

Risk management as a practical and essential concept is yet to take root in India. Given that the family system as it existed is changing in our country, older adults may increasingly find themselves alone in their old age - either living in the community on their own, or in an institution, paid or unpaid. This necessitates the need to be prepared. Preventing risk is the most important preparation that they need to make. Starting from home modification to bio-psycho-social health, people need to consciously minimise or eliminate potential risks. Extensive studies are required in this area, to explore and consolidate effective methods for assessing, preventing, eliminating and managing various bio-psycho-social and environmental risks.

Studies focussing on non-medical aspects of old age care

A large part of studies regarding older adults are seen to focus on the medical aspects of old age. While this is definitely an important and integral part of risk management, it is not the only aspect. There should be more studies on non-clinical aspects of ageing. Instead of focussing on labelled biological or psychological maladies, there should be studies on the common and general difficulties that older

people face in their day-to-day life. Some areas that could be explored in this regard are - intergenerational interactions, community interactions, challenges in household management, perceptions of self and others about ageing, etc.

Studies using strengths-based approach

The greatest advantage of the strengths-based approach is that it involves older adults as participants in their own care. It also helps bring out their strengths and capabilities to add purpose and utility to their life. There should be more studies on how such an approach can be implemented in day-to-day activities of older people in community and institutional settings. Strengths-based studies can also throw light on how older adults can be seen as contributing members of the society through planned community engagement. The effectiveness of strengths-based interventions in managing psycho-social risks can also be studied in community and institutional settings.

Studies specific to Institutionalised setting

There is a need for consistent research in the institutional setting, especially with regard to risks, risk management and a strengths-based approach. This is very relevant in the current scenario, when more older adults are opting for institutional care as a viable option. Within the institutional framework itself, the scenarios will be widely different in a paid home and unpaid home. Even among these, depending on the management, type of home, etc, there will be unique characteristics. Hence the scope of research in this area is wide and deep.

Qualitative studies on old age

Considering the changing social environments and perspectives with regard to old-age care, there needs to be a thrust on qualitative research. This will help identify the newly arising issues, challenges and opportunities in this field. It can help researchers to overcome limiting beliefs and assumptions and open up conversations into new and unexplored areas. Qualitative research can lead to new insights on tackling the problems that older adults face. It can also help to further strengthen quantitative and interventional studies on identified topics.

Social Work Perspective

Research from a social work perspective is essential to throw light on practice-level changes in aged-care. Social work research is not limited by the strict lines of medical or psychiatric disciplines, but can extend itself to include socio-economic, environmental or even spiritual dimensions of a person's life. It can look at aged care from a community perspective, and identify not only challenges and problems but also resources and possibilities from within the community. Social work research in old age care can help develop comprehensive care models that are suitable and essential in the changing scenario.

8.5 The Need for Academia-Practitioner-Policy Maker Interface

Social change is a complex process involving multiple stakeholders. For effective social change to take place, stakeholder interaction is a must. The same is the case with the care of older adults.

Academic research is needed to identify the problems and challenges in aged-care, and to explore innovative options for intervention and improvement. Practitioners can translate these findings into purposeful action in the field. When practice and research go hand in hand, it ensures that researchers get practical inputs to test their theories, and practitioners get academic guidance to solve problems as they arise. The effectiveness of interventions can also be evaluated with the involvement of academia. Policy makers can utilise the theoretical inputs of academia and the practical experiences of practitioners to make informed decisions that will bring about societal change. Through sound policy frameworks, they can institutionalise the change. Academia- practitioner inputs also enable policy makers to allocate resources effectively to sustain the change and to address emerging challenges.

Researchers should try to tie their findings to suggestions for practical implementation and policy recommendations. Disseminating research findings in the right fora is crucial to engage with the other two groups.

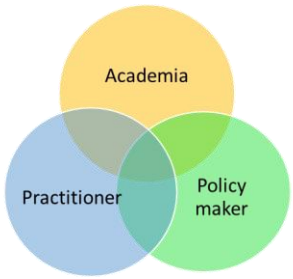
Practitioners should understand the value of the theoretical perspective in implementing care programmes. Instead of stubbornly relying on ‘tried and tested’

methods, they should be open to innovation, and sensitive to emerging care needs. On the other hand, they should not hesitate in bringing forth their experiential learnings and practical needs. They should influence the academia to engage meaningfully in relevant topics, and create the required body of evidence to convince policy makers. The practitioners should also be involved with lobbying and advocacy to influence policy makers to make the right decisions.

Policymakers should concur with experts from the academic and service fields while forming policy decisions. Their inputs would help frame functional policies with a sound practical base.

Each group has its own relevant function to perform, but should also recognise and appreciate the others' relevance. All three need to initiate empathetic conversations and explore ways and means to synthesise their functions, so that the best care practices and innovative problem solving can be implemented. Only by their concerted efforts in a collaborative environment, can the elderly be truly benefitted.

Figure 8.2: Academia-Practitioner-Policy Maker Interface



8.6 Conclusion

The recommendations given in this chapter focus on translating the learnings of this study to practical implementations in research, practice and policy.

Based on the gaps found in the existing literature and the felt needs on the ground, suggestions have been generated on potential areas for future research.

On the practice aspect, the recommendations focus on how the strengths-based approach can be applied in the day-to-day functioning of elderly care homes. These suggestions are not resource-intensive, and hence the only requirement is the will

and availability of the home management to implement them, and a paradigm shift in their perception of older adults. However, resource identification and utilisation being a key factor in strengths-based practice, the researcher has also mentioned the different resources available to the NGO. These can be harnessed by organisations to support their initiatives in improving the quality of life of the elderly in the care institutions.

Some policy-related recommendations have also been given to incorporate effective risk management and strengths-based practices in aged-care. Finally, the chapter touches on the necessity for collaboration among academia, practitioners, and policymakers in order to develop effective, evidence-based strategies that enhance the quality of care for the elderly.

CHAPTER 9

CONCLUSION

Risk assessment and management are key to ensure a safe, friendly and comfortable environment for the elderly. Given the large number of Elderly Care Homes in Kerala, it is imperative that these homes meet stringent criteria to enable a better quality of life for their residents. This study has been able to comprehensively cover the unpaid elderly care institutions sector in Thrissur District and come up with suggestions and recommendations with respect to risk management. The study has also validated the effectiveness of a strengths-based approach in improving the quality of life of the elderly in residential care. The intervention module created as part of the study can be implemented in other institutions too, with minor adjustments. The interventions are simple enough to be incorporated into the daily routines and management of the institutions, thereby setting a standard of quality living for the elderly residents.

This chapter concludes the report of the study, summarising the major findings, recommendations and potential impact.

9. 1 Key Findings

The Risk Assessment phase of the study has given some deep insights into the prevailing realities of Elderly Care Home. It was highly commendable that a large majority of the institutions meet basic safety and hygiene standards, and are doing well in providing food, shelter and safety to the residents. However, it was observed that identifying and managing risks was not a priority to the institutions. A scoping review of relevant literature revealed that various risk factors directly affected the Quality of Life of the elderly. Considering the complex interactions between risk and quality of life, the second phase of the study explored the feasibility of a risk management and strengths-based intervention to enhance the quality of life of the elderly in residential care. A Quasi-experimental research design was used for this, by selecting one residential care facility as the experimental group, and another similar one as the comparison group.

The researcher started the second phase of the study by identifying the internal and external resources available to the elderly residents of the experimental home. Their innate strengths consisted of their deep desire to be independent in activities of daily living, their sense of personal hygiene, interest in games, creativity and love for children. Acceptance, maturity, forgiveness, helping nature, socialising, sense of humour and wisdom were key learned strengths, and their supportive strengths consisted of the management of the institution, caretakers, the community, their leisure activities and their spirituality and faith in God. The risks and potential risks had already been identified in phase 1 of the study.

Based on the risks that needed to be reduced or eliminated, as well as the strengths identified, an intervention module consisting of 25 activities was developed. It had two focus areas- to conserve and develop the existing strengths, and to engage the participants with available resources around them.

The post-intervention scores on the WHOQOL100 showed a significant increase in all dimensions of QoL. This proves that risk management and strengths-based intervention is feasible in residential care homes for the elderly, and helps to enhance their Quality of Life.

9.2 Implications

The findings of this study have implications for policy, practice and research. At the policy level, it sheds light on the need to incorporate risk assessment and management protocols into the existing policy framework for Elderly care homes, and to develop effective monitoring and evaluation schemes. It also calls for broadening the scope of residential aged-care initiatives from a purely health and survival perspective to include psycho-social and environmental factors. Adopting a strengths-based approach in policy development will ensure that the diverse bio-psycho-social needs and quality of life of the elderly are given due consideration.

With regard to practice, the study challenges the commonly held perception that the elderly living in institutional care are necessarily consigned to a life of depression and social withdrawal. It proves that comprehensive interventions, if implemented in the right manner, can create a significant impact on the QoL. An interesting fact

here is the very significant increase in QoL score found in the physical capacity domain, even though the interventions provided were primarily non-medical in nature. Further exploration in this area could shed light on innovative and cost-effective methods of health-care management for the elderly - not only for those in institutional care, but also for those living in the community. This would be especially relevant, given the rocketing costs of medical care and hospitalisation in recent times.

The intervention module created by the researcher can be implemented in other institutions also. The researcher has come up with a set of long-term practical recommendations for practitioners, which will help in improving the Quality of Life of the elderly, and has also listed out methods of mobilising resources to support the implementation of these recommendations.

The study has also identified potential areas for further research, which can generate more evidence on the relevance of risk management and strength-based interventions to improve the quality of life and the quality of care available to the elderly.

The recommendations generated after this study basically focus on creating a perceptual shift in the approach to the care of the elderly. The researcher strongly believes that this study will be a valuable addition to the existing literature on social work practice in the care of the elderly. It can also serve as a practical manual for institutions and social work professionals who are engaged in working with elderly individuals.

9.3 Concluding Remarks

This study has shed light on the actual situations prevalent in Elderly Care Home in Thrissur District. Considering that this district is a miniature representation of the entire state with respect to its geography and other socio-economic and cultural factors, these findings can be safely generalised to the entire state of Kerala. The study brings to the forefront, the good practices in Elderly Care Homes and points out the areas where further development is necessary, especially in relation to the Quality of Life of the elderly residents. The study has also demonstrated the

effectiveness and practicability of adopting a strengths-based approach to elderly care. Adopting such an approach will go a long way in ensuring that the elderly enjoy a life of quality well into their years. Old age, then, can truly become a second childhood in a positive sense, where the elderly can be as carefree, creative and happy as children.

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APPENDIX -1

Risk Assessment Tool

Name of the Home:

Run by Govt\NGO\Pvt:

Current strength:

Home for Male/Female/Both:

Location

1. Is the location threatened by natural calamities? Yes No
2. Is Public transport easily available? Yes No
3. Does the OAH have easy access to health services? Yes No
4. Does the OAH have easy access to markets and shops? Yes No
5. Does the OAH have a vehicle for emergency situations? Yes No
6. Is the property owned by the organisation or Rented / Leased? Yes No

Exterior of the building

7. Is there a safe compound wall? Yes No
8. Is there space for walking in the compound? Yes No
9. Is there space for moving around in wheelchairs in the compound? Yes No
10. Is the ground slippery in the rainy season? Yes No
11. Are there sharp stones in the ground? Yes No
12. Is there water-logging? Yes No
13. Is there a garden? Yes No
14. Are the trees well maintained to ensure that there is no risk of loose branches, large coconut tree leaves, coconuts, etc falling when inmates are walking around? Yes No

Interior of Building

15. Are there provisions for changes/modifications in future? Yes No

16. Is there sufficient cross ventilation in the rooms? Yes No
17. Is there sufficient natural light coming in to the rooms? Yes No
18. Is there an emergency light/inverter/generator in case of power outage? Yes No
19. Are electric switches at the right position (placement, height, etc)? Yes No
20. Is there an alarm bell at the bedside? Yes No
21. Does the building have multiple exits? Yes No
22. Is there a ramp at all significant entry and exit points?
23. Is the slope of the ramp normal? Yes No
24. Is the floor even? Yes No
25. Is the floor non-slippery? Yes No
26. Do the floor colour and pattern support easy visibility? Yes No
27. Are there thresholds in between rooms? Yes No
28. Are there steps in between rooms? Yes No
29. Are the corridors wide? Yes No
30. Are the doorways between rooms wide? Yes No
31. Are the rooms arranged in a way that is easy to use? Yes No
32. Are there obstructions for easy movement in the room– pillars, furniture, unexpected steps, etc.? Yes No
33. Are there any obstructions in the corridors? Yes No
34. Are there handrails in corridors? Yes No
35. Are there handrails in the rooms? Yes No
36. Is the furniture sturdy? Yes No
37. Are the chairs or sofas of the right height? Yes No
38. Are chairs or sofas of the right texture - not too soft or not too hard? Yes No
39. Are there any sharp edges? Yes No
40. Are there any glass fixtures or furniture? Yes No
41. Are the floor mats or carpets slippery? Yes No
42. Is there provision for getting in and out of bed easily? Yes No
43. Is there enough spacing between beds in dormitories? Yes No

44. Are the beds adjustable? Yes No
45. Is the mattress of good quality? Yes No
46. Are the wash basins at the right height? Yes No
47. Can wash basins be used even when in a wheelchair? Yes No
48. Are the rooms clean? Yes No
49. Are the rooms cluttered? Yes No
50. Are the rooms dust – free? Yes No

Bathrooms & Toilets

51. Is there 1 of toilets for 6 inmates? Yes No
52. Is there 1 bathroom for 8 inmates? Yes No
53. Are the bathrooms inside the building? Yes No
54. Are the toilets inside the building? Yes No
55. Are the toilets and bathrooms easily accessible/ close to the bedroom? Yes No
56. Is the toilet/ toilet floor slippery? Yes No
57. Does the bathroom/ toilet floor pattern and colour support easy visibility? Yes No
58. Do bathrooms/toilets have grab bars? Yes No
59. Are the bathrooms and toilets separate?/ Are there separate dry and wet areas? Yes No
60. Are the grab bars sturdy and well-fixed? Yes No
61. Are the grab bars of the right height? Yes No
62. Is there sufficient light in the bathroom? Yes No
63. Are taps, showers etc of the right height? Yes No
64. Is there a proper drainage system? Yes No
65. Is there warm water for bathing? Yes No
66. Does the toilet have a European-style closet? Yes No
67. Does the toilet have a handshower? Yes No
68. Are buckets and mugs placed at the right height? yes No
69. Is there a facility to take a bath in the sitting position?
70. Is there a facility to sit in the wheelchair and take a bath? Yes No

71. Is the bathroom mat slippery? Yes No

Electrical & Fire Safety

72. Are the staff and inmates trained in fire safety measures? Yes No
73. Is there an electrician on call? Yes No
74. Are the staff trained in first aid? Yes No

Health, Hygiene & Sanitation

75. Is there a diet plan? Yes No
76. Is the diet plan prepared in consultation with a dietician or health professional? Yes No
77. Do the inmates feel that the food is tasty? Yes No
78. Is there a provision for a special diet according to health conditions? Yes No
79. Is pure drinking water available? Yes No
80. Is the store room cleaned daily? Yes No
81. Is the store room well ventilated? Yes No
82. Does the store room have sufficient sunlight? Yes No
83. Are there mosquito nets for all windows? Yes No
84. Is there provision for proper sewage treatment and disposal? Yes No
85. Is there a mechanism to ensure personal hygiene of inmates? Yes No
86. Is there a mechanism to ensure personal hygiene of staff? Yes No
87. Is sufficient water available for bathing and washing clothes in all seasons? Yes No
88. Is there a separate sick room? Yes No
89. Is there a proper facility for washing clothes for inmates who can do it on their own? Yes No
90. Are laundry facilities available to inmates who cannot do it on their own? Yes No
91. Is there a facility for proper drying of clothes? Yes No
92. Is there a foul smell in any of the living /sleeping areas? Yes No
93. Is there a foul smell in or near the bathrooms/toilet? Yes No

94. Are the pillows / bed sheets/ bath towels supplied adequately? Yes No
95. Are the pillows / bedsheets/ bath towels washed regularly? Yes No
96. Are enough clothes / under garments provided? Yes No
97. Is there a doctor on call? Yes No
98. Is there a nurse on call? Yes No
99. Are regular medical check-ups conducted? Yes No
100. Is there provision to check that all inmates take their medicines on time? Yes No
101. Is the ambulance readily available? Yes No
102. Is exercise part of the daily routine? Yes No
103. Do all inmates participate in the exercise routine? Yes No
104. Is there an individual history record? Yes No
105. Is cooked food accepted regularly from outside? Yes No
106. Is there provision for providing palliative care (either provided at the home or inmates transferred to any other suitable facility)? Yes No
107. Do all inmates have health insurance? Yes No

Emotional, Mental & Social Health

108. Is a counsellor available on call? Yes No
109. Are individual counselling sessions conducted regularly? Yes No
110. Are group counselling sessions conducted regularly? Yes No
111. Is psychiatric treatment provided to inmates when needed? Yes No
112. Do inmates have cordial relationships among themselves? Yes No
113. Do inmates have cordial relationships with staff? Yes No
114. Do the staff members have basic training in Psychology? Yes No
115. Are the staff members pleasant and friendly to the inmates? Yes No
116. Do the staff members have a support system to ventilate their feelings? Yes No
117. Are there activities to engage the inmates? Yes No
118. Are the activities chosen according to the inmates' interests? Yes No
119. Do the activities have a social impact? Yes No
120. Are the activities income-generating? Yes No

121. Are the inmates engaged throughout the day on all days? Yes No
122. Are there opportunities for inmates to interact with outsiders?Yes No
123. Are the inmates taken on outings regularly?Yes No
124. Are the inmates allowed to go out by themselves – caretakers will accompany them only when they request it? Yes No
125. Are there celebrations involving the inmates? Yes No
126. Are inmates' birthdays/ special days celebrated? Yes No
127. Is there a provision to attend to the complaints of inmates? Yes No
128. Are money and valuables of inmates safely stored? Yes No
129. Can inmates access money and valuables when they need it? Yes No

APPENDIX 2

WHOQOL 100

The following questions ask about how much you have experienced certain things in the last two weeks, for example, positive feelings such as happiness or contentment. If you have experienced these things an extreme amount circle the number next to “An extreme amount”. If you have not experienced these things at all, circle the number next to “Not at all”. You should circle one of the numbers in between if you wish to indicate your answer lies somewhere between “Not at all” and “Extremely”. Questions refer to the last two weeks.

1. Do you worry about your pain or discomfort?

   Not at all - 1

   A little - 2

   A moderate amount – 3

   Very much – 4

   An extreme amount - 5

2. How difficult is it for you to handle any pain or discomfort?

   Not at all - 1

   A little - 2

   A moderate amount – 3

   Very much – 4

   An extreme amount - 5

3.To what extent do you feel that (physical) pain prevents you from doing what you need to do?

   Not at all - 1

   A little - 2

   A moderate amount – 3

   Very much – 4

   An extreme amount - 5

4. How easily do you get tired?

Not at all - 1

Slightly - 2

Moderately – 3

Very much – 4

Extremely - 5

5. How much are you bothered by fatigue?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely - 5

6. Do you have any difficulties with sleeping?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount - 5

7. How much do any sleep problems worry you?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount - 5

8. How much do you enjoy life?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

9. How positive do you feel about the future?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely - 5

10. How much do you experience positive feelings in your life?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

11. How well are you able to concentrate?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

12.How much do you value yourself?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

13. How much confidence do you have in yourself?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

14. Do you feel inhibited by your looks?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

15. Is there any part of your appearance which makes you feel uncomfortable?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

16. How worried do you feel?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

17. How much do any feelings of sadness or depression interfere with your everyday?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

18. How much do any feelings of depression bother you?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

19. How well are your sexual needs fulfilled?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

20. Are you bothered by any difficulties in your sex life? To what extent do you have difficulty in performing your routine activities?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

21. How much are you bothered by any limitations in performing everyday living activities?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

22. How much do you need any medication to function in your daily life?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

23. How much do you need any medical treatment to function in your daily life?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

24.To what extent does your quality of life depend on the use of medical substance/medical aids

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

25. How alone do you feel in your life?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

26. How well are your sexual needs fulfilled?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

27. Are you bothered by any difficulties in your sex life?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

28. How safe do you feel in your daily life?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

29. Do you feel you are living in a safe and secure environment?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

30. How much do you worry about your safety and security?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

31. How comfortable is the place where you live?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

32. How much do you like it where you live?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

33. Do you have financial difficulties?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

34. How much do you worry about money?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

35. How easily are you able to get good medical care?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

36. How much do you enjoy your free time?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

37. How healthy is your physical environment?

Not at all - 1

Slightly - 2

Moderately - 3

Very much - 4

Extremely – 5

38. How concerned are you with the noise in the area you live in?

Not at all - 1

A little - 2

A moderate amount – 3

Very much – 4

An extreme amount – 5

39. To what extent do you have problems with transport?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

40. How much do difficulties with transport restrict your life?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

The following questions ask about how completely you experience or were able to do certain things in the last two weeks, for example activities of daily living such as washing, dressing or eating. If you have been able to do these things completely, circle the number next to “Completely”. If you have not been able to do these things at all, circle the number next to “Not at all”. You should circle one of the numbers in between if you wish to indicate your answer lies somewhere between “Not at all” and “Completely”. Questions refer to the last two weeks.

1.Do you have enough energy for everyday life?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

2. Are you able to accept your bodily appearance?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

3. To what extent are you able to carry out your daily activities?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

4. How dependent are you on medications?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

5. Do you get the kind of support from others that you need?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

6. To what extent can you count on your friends when you need them?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

7. To what degree does the quality of your home meet your needs?

Not at all - 1

A little - 2

A moderate amount - 3

Very much - 4

An extreme amount – 5

8. Have you enough money to meet your needs?

Not at all - 1

A little - 2

Moderately - 3

Mostly - 4

Completely – 5

9.To what extent do you have opportunities for acquiring the information that you feel you need?

Not at all - 1

A little - 2

Moderately - 3

Mostly - 4

Completely – 5

10. To what extent do you have the opportunity for leisure activities?

Not at all - 1

A little - 2

Moderately - 3

Mostly - 4

Completely – 5

The following questions ask you to say how satisfied, happy or good you have felt about various aspects of your life over the last two weeks . For example, about your family life or the energy that you have. Decide how satisfied or dissatisfied you are with each aspect of your life and circle the number that best fits how you feel about this. Questions refer to the last two weeks.

11. How satisfied are you with the quality of your life?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied - 5

12. In general, how satisfied are you with your life?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied - 5

13. How satisfied are you with your health?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied - 5

14. How satisfied are you with the energy that you have?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

15. How satisfied are you with your sleep?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

16. How satisfied are you with your ability to learn new information?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied - 5

17. How satisfied are you with your ability to make decisions?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

18. How satisfied are you with yourself?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

19. How satisfied are you with your abilities?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

20. How satisfied are you with the way your body looks?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

21. How satisfied are you with your ability to perform your daily living activities?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied - 5

22. How satisfied are you with your personal relationships?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

23. How satisfied are you with your sex life?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

24. How satisfied are you with the support you get from your family?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

25. How satisfied are you with the support you get from your friends?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied - 5

26. How satisfied are you with your ability to provide for or support others?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

27.How satisfied are you with your physical safety and security?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

28. How satisfied are you with the conditions of your living place?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

29. How satisfied are you with your financial situation?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied - 5

30. How satisfied are you with your access to health services?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

31. How satisfied are you with the social care services?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

32. How satisfied are you with your opportunities for acquiring new skills?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

33. How satisfied are you with your opportunities to learn new information?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

34. How satisfied are you with the way you spend your spare time?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

35. How satisfied are you with your physical environment (e.g. pollution, climate, noise, attractiveness)?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied - 5

36. How satisfied are you with the climate of the place where you live?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

37. How satisfied are you with your transport?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

38. Do you feel happy about your relationship with your family members?

Very unhappy - 1

Unhappy - 2

Neither happy nor unhappy - 3

Happy - 4

Very happy - 5

39. How would you rate your quality of life?

Very poor - 1

Poor - 2

Neither poor nor good - 3

Good - 4

Very good – 5

40. How would you rate your sex life?

Very poor - 1

Poor - 2

Neither poor nor good - 3

Good - 4

Very good - 5

41. How well do you sleep?

Very poor - 1

Poor - 2

Neither poor nor good - 3

Good - 4

Very good – 5

42. How would you rate your memory?

Very poor - 1

Poor - 2

Neither poor nor good - 3

Good - 4

Very good – 5

43. How would you rate the quality of social services available to you?

Very poor - 1

Poor - 2

Neither poor nor good - 3

Good - 4

Very good - 5

The following questions refer to how often you have felt or experienced certain things, for example the support of your family or friends or negative experiences such as feeling unsafe. If you have not experienced these things at all in the last two weeks, circle the number next to the response “never”. If you have experienced these things, decide how often and circle the appropriate number. So for example if you have experienced pain all the time in the last two weeks circle the number next to “Always”. Questions refer to the last two weeks.

1.How often do you suffer (physical) pain?

Never-1

Seldom-2

Quite often-3

Very often-4

Always-5

2. Do you generally feel content?

Never-1

Seldom-2

Quite often-3

Very often-4

Always-5

3. How often do you have negative feelings, such as blue mood, despair, anxiety, depression?

Never-1

Seldom-2

Quite often-3

Very often-4

Always-5

The following questions refer to any “work” that you do. Work here means any major activity that you do. This includes voluntary work, studying full-time, taking care of the home, taking care of children, paid work or unpaid work. So work, as it is used here, means the activities you feel take up a major part of your time and energy. Questions refer to the last two weeks.

1. Are you able to work?

   Not at all - 1

   A little - 2

   Moderately - 3

   Mostly - 4

   Completely – 5

2. Do you feel able to carry out your duties?

   Not at all - 1

   A little - 2

   Moderately - 3

   Mostly - 4

   Completely – 5

3. How satisfied are you with your capacity for work?

   Very dissatisfied - 1

   Dissatisfied - 2

   Neither satisfied nor dissatisfied - 3

   Satisfied - 4

   Very satisfied – 5

4. How would you rate your ability to work?

Very poor - 1

Poor - 2

Neither poor nor good - 3

Good - 4

Very good - 5

The next few questions ask about how well you were able to move around in the last two weeks. This refers to your physical ability to move your body in such a way as to allow you to move about and do the things you would like to do, as well as the things that you need to do. Once again these questions refer to the last two weeks.

1.How well are you able to get around?

Very poor - 1

Poor - 2

Neither poor nor good - 3

Good - 4

Very good – 5

2. How much do any difficulties in mobility bother you?

Not at all - 1

A little - 2

Moderately - 3

Mostly - 4

Completely – 5

3.To what extent do any difficulties in movement affect your way of life?

Not at all - 1

A little - 2

Moderately - 3

Mostly - 4

Completely – 5

4. How satisfied are you with your ability to move around?

Very dissatisfied - 1

Dissatisfied - 2

Neither satisfied nor dissatisfied - 3

Satisfied - 4

Very satisfied – 5

The following few questions are concerned with your personal beliefs, and how these affect your quality of life. These questions refer to religion, spirituality and any other beliefs you may hold. Once again these questions refer to the last two weeks.

1. Do your personal beliefs give meaning to your life?

Not at all-1

A little-2

A moderate amount-3

Very much-4

An extreme amount-5

2. To what extent do you feel your life to be meaningful?

Not at all-1

A little-2

A moderate amount-3

Very much-4

An extreme amount-5

3.To what extent do your personal beliefs give you the strength to face difficulties?

Not at all-1

A little-2

A moderate amount-3

Very much-4

An extreme amount-5

4.To what extent do your personal beliefs help you to understand difficulties in life?

Not at all-1

A little-2

A moderate amount-3

Very much-4

An extreme amount-5