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Effect of Mobility on the Quality of Life among Older Adults in Geriatric Home at Makkah Al-Mukarramah

Hanan I. Ahmed [1*] Esraa E. Mohamed [2] Sahar M. Aly [3]

1. Community Health Nursing, Faculty of Nursing, Ain Shams University(Egypt).

2 . Fellow at Geriatric Medicine & Gerontology Department, Ain Shams University(Egypt)

. 3. Nursing Administration, Faculty of Nursing, Port Said University (Egypt).
* E-mail of the corresponding author: drhnan21@yahoo.com

1,2 and 3 Faculty of Nursing, Umm Al Qura University, Makkah Al-Mukaramah, KSA.

Abstract

Background: Mobility limitations are common in older adults, affecting the physical, psychological, and social aspects of an older adult's life. The term quality of life (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Quality of life should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of the quality of life include not only wealth and employment but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging Quality of life (QOL) is aboard concept affected in a complex way by the person's physical health, psychological state, social relationship, and the relationship to salient feature of the environment. **Aim:** This study aimed to assess the nature of relationship between mobility on QOL in older adults through assessing the older adults' mobility, Activity of daily living (ADL) and QOL. **Subjects and methods:** A descriptive study was conducted on a convenient sample of 75 older adults in Social Care Home at Makkah AL-Mukarramah. Tools of data collection were an interview questionnaire form to collect socio-demographic characteristics, Elderly Mobility Scale (EMS), WHOQOL-BREF, and ADL. **Results:** The current study revealed that nearly half of older adults their ages ranged from (>75- 85 years) and more than two thirds of them had osteoarthritis, hypertension, diabetes mellitus, and urinary incontinence, more than half of the study sample were received assistance in bathing, dressing, and continence and more than half of subjects feeds themselves without assistance. **Conclusion:** There is a strong positively relationship between QOL, ADL, and elderly mobility (EM). Most of the older adults at geriatric home are completely dependent in ADL and mobility. Also there was highly statistically significant difference between QOL and EM. **Recommendation:** Training exercise must be provided upon initial range of motion of older adult, and encourage the older adult to applied ADLs.

Key words: Mobility, Quality of Life, Older Adult and Geriatric Home.

1 . Introduction

Sarcopenia, the age-associated loss of skeletal muscle mass and function, has considerable societal consequences for the development of frailty, disability, and health care planning. A group of geriatricians and scientists from academia and industry met in Rome, Italy, on November 18, 2009, to arrive at a consensus definition of sarcopenia. The current consensus definition was approved unanimously by the meeting participants and is as follows: Sarcopenia is defined as the age-associated loss of skeletal muscle mass and function.(Fielding, and Roger, 2011).

Spontaneous self-definition was investigated in a heterogeneous sample of N = 516 participants of the Berlin Aging Study, aged between 70 and 103 years. The content of the self-definition revealed that old and very old persons view themselves as active and present-oriented. The self-definition also reflected an inward orientation, and central themes of life-review, health, and family. (Freund, Alexandra M., et al, 2009).

This age group is further classified into the so-called early old, who are aged 64–75 years, and the so-called older elderly, aged 75 years or older. The definition of an older or elderly adult can be considered from chronological, biological, or socio-cultural perspectives. Chronological age is generally used as a default, and older age is typically defined as the age at which a person becomes eligible for statutory and occupational retirement pensions.(Gibson, et al.2010). Aging is often accompanied by a decline in functional performance and disability as described in the disablement process model.(Tak, et al. 2012).

Mobility is fundamental to active aging and is intimately linked to health status and quality of life. Although

there is widespread acceptance regarding the importance of mobility in older adults, there have been few attempts to comprehensively portray mobility, and research has to a large extent been discipline specific. (Anstey, et al. 2006).

Mobility is broadly defined as the ability to move oneself (e.g., by walking, by using assistive devices, or by using transportation) within community environments that expand from one's home, to the neighborhood, and to regions beyond. The concept of mobility is portrayed through 5 fundamental categories of determinants (cognitive, psychosocial, physical, environmental, and financial), with gender, culture, and biography (personal life history) conceptualized as critical crosscutting influences. Each category of determinants consists of an increasing number of factors, demonstrating greater complexity, as the mobility environment expands farther from the home. (Anstey, et al. 2006).

The world health organization (WHO) defines Quality of life as "an individual's perception of their position in life in the contest of culture and value system in which they live and relation of their goals, expectation, standers and concerns". It is broad ranging concept affected in a complex way by the person's physical health, psychological status, person's beliefs, social relationship and their relationship to silent features of their environment(. Abdel Alkadr.A.2012).

A positive approach to health encompasses physical, mental, emotional and social wellbeing. Stress management, meditation and visualization, brain fitness, laughter therapy, healthy lifestyles, self-motivation and improvement, happiness, attitudes and prevention, as well as a number of other approaches, can make a huge impact on one's quality of life, health, and happiness. Motivated and informed readers can enjoy the resources here to discover approaches to healthier living as they explore the links between mind, body and brain.(Fowler and Angela, 2013)

The nurse who work with healthy older adult persons in their communities, acutely ill elders requiring hospitalization and treatment, and chronically ill or disabled elders in long term care facilities, skilled care, home care and hospice. The scope of practice for gerontological nursing includes all older adults from the time of old age until death. Roles of the gerontological nurse are care giver or provider of care, teacher, advocate, manager, and research consumer.(Mauk . 2010).

2 . Significance of the problem:

In recent years, there has been a sharp increase in the number of older persons worldwide and more old people are alive nowadays than at any time in history, the proportion of the population aged 60 and over, is also growing each year. By the year 2025, the world will host 1.2 billion people aged 60 and over and rising to 1.9 billion in 2050. The proportion of the elderly population to total population was 5.8% in 2000 it expected to reach 8.7% by year 2025 and 15.0% by 2050. (National Center For Chronic Disease Prevention And Health Promotion 2010).

The mobility has direct effect on quality of life for older adult. There are some changes on older adult that affect their mobility on quality of life. Changes that occur with older adult fall into four categories: physical, psychological, emotional, and social. (National Association of Chronic Disease Director 2008).

Physical changes, decrease in physical strength, endurance, and flexibility and the second are decline in efficiency of body organs. In psychological changes, there are decrease the ability in learn, decrease in acquire new skills and information, and decrease recording the information. In emotional changes older adults are often perceived as lonely, hopeless, and sad. Even older adults who report high levels of satisfaction frequently express beliefs that most other older adult are not faring well. **(**Eliopoulos, 2005),(Reker, 2006) (and Anstey, 2009):

Social changes, later life of older adult begin to experience many different types of losses, such as health, job, money, home, and death of friends and family. This changes that effect on older adult's mobility such as injuries due to a fall are the commonest cause of decrease of there mobility, there are some important factors that effect on quality of life's older adult such as falling and poor eyesight, disruption of balance sense, muscle weakness or limited core stability, inadequate nutrition (vitamin D deficiency), and poor nervous system control leads to downward of immobility and then disturbance in there quality of life.(Anstey, 2009).

3 . Aim of the Study

This study was carried out to assessthe nature of relationship between mobility on QOL in older adults through:

3.1. Assessing older adults' mobility condition/state.
3.2. Assessing older adults' activity of daily living (ADL).
3.3. Assessing older adults' Quality of life.

4. Research Question

Are there relationship (correlated) between mobility and quality of life among older adults in the geriatric home (Social Care Home at Makkah AL-Mukarramah)?

5. Subjects and methods

5.1. Technical design:

5.1.1. Research design:

The study design is a descriptive study.

5.1.2. Setting:

The study was conducted at geriatric home for male and female (Social Care Home at Makkah AL-Mukarramah).

5.1.3. Sampling:

A convenient sample of all available older adults males and females was taken from Social Care Home at Makkah Al-Mukarramah included (65 older adults female – 10 older adults male) they were chosen according to the inclusion criteria for older adult who able to communicate.

5.1.4. Tools of data collection:

- **Tools of data collection:**

1-The first tool: (An interviewing assessment form):

A- Part 1: (social demographic data) which included the following: (age, gender, marital status, occupation and income).

B- Part 2: (health assessment) which included the following: (activity, habits, chronic disease according body system problem and mobility).

2-The second tool:(Older adult Mobility Scale Score)-(EMS):

Scale of assessment of mobility of older people in Geriatric Home setting, good things about it are Functional, clinically significant, minimal training needed, can be used as an assessment tool and an outcome measure. And it is limitations are difficult to use in community environments, not sensitive for patients with issues of poor confidence. The purpose is to provide a scale for assessment of mobility, considering locomotion, balance and key position changes. Modified by the researchers to suit the nature of the current study and have validity from 2 academic staff from nursing college in Umm Al-Qura University. It was used and filled by the researchers individually to assess older Adult **(49)**.

It include the following items:

First Item: Lying to Sitting (independence - needs help of 1 person –and needs help of >2 people).

Second Item: Sitting to Lying (independent- needs help of 1 person – and needs help of >2 people).

Third Item: Sitting to Standing (independent in under 3 seconds- independent in over 3 seconds- needs help of 1 person - needs help of >2 people).

Fourth Item: Standing (Stands without support and able to reach- Stands without support but needs support to reach- Stands but needs support- Stands only with physical support of another person)

Fifth Item: Gait (Independent - Independent with frame- Mobile with walking aid but erratic/unsafe- Needs physical help to walk or constant supervision)

Sixth Item: Timed Walk 6 meters (under 15 seconds- 16-30 seconds- over 30 seconds- unable to cover 6 meters)

Scoring system:the total scores are 18 points divided into:

Scores under 8 – generally these clients are dependent in mobility maneuvers; require help with basic ADL, such as transfers, toileting and dressing.

Scores between 8 – 12– generally these clients are borderline in terms of safe mobility and independence in ADL i.e. they require some help with some mobility maneuvers.

Scores over 12 – Generally these clients are able to perform mobility maneuvers alone and safely and are independent in basic ADL.

3- the third tool: (Activity of daily living)-(ADL):

Are an important component in determining the level of care needed during a nursing home stay. ADLs are the necessary activities many of us take for granted, such as feeding and bathing ourselves, dressing and grooming, and generally doing the things needed to get through each day. It is critical that nursing home and medical facilities use tools that measure and track ADLs in their care and treatment of the physically and mentally challenged **(50).**

It include the following items:

First item: Bathing- sponge bath, tube bath, or shower (Receives no assistance gets by self- receives assistance

in bathing only one part of the body- receives assistance in bathing more than one part of the body)

Second item: Dressing- get clothes from closets and drawers , including underclothes and outer garments; uses fasteners (without assistance- without assistance except tying shoes- receives assistance or stay partly or completely undressed)

Third item: Toileting- going to the toilet room for bowel and urine elimination; cleans self after elimination and arranges clothes (without assistance- receives assistance- doesn't go to toilet room)

Fourth item: Transfer- (moves without assistance- moves with assistance- doesn't get out of bed)

Fifth item: continence- (controls urination and bowel movements completely by self- has occasional "accidents"- supervisions helps keep urine or bowel control; catheter is used, or is incontinence)

Sixth item: feeding- (without assistance- feed self except for getting assistance in cutting meat or buttering bread- receives assistance)

Scoring system:total scores are 12 points divided into :

Scores from 0 to 5 –these patients are completely dependent inall activities; require help with basic ADL, such as transfers, toileting and dressing.

Scores from 6 to 9 – these patients are partially dependent in some of activities; they require some help with basic ADL.

Scores from 10 to 12 –these patients are independent and able to perform mobility maneuvers alone and safely and are independent in basic ADL.

4- The fourth tool: (Quality of life)-(WHOQOL)-BREF:

The WHOQOL-BREF instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment. The WHOQOL-BREF is a shorter version of the original instrument that may be more convenient for use in large research studies or clinical trials.Modified by the researchers to suit the nature of the current study and have validity from 2 academic staff from nursing college in Umm Al-Qura University. It was used and filled by the researchers individually or in group to assess the QOL of the Older Adult **(51)**.

Scoring Domains of the WHOQOL-BREF:

The WHOQOL-Bref produces a profile with four domain scores and two individually scored items about an individual's overall perception of quality of life and health. The four domain scores are scaled in a positive direction with higher scores indicating a higher quality of life.

The Questions score level of questions (3-4-26) changed to little =1, Moderate =2, Very much =3. It include the following domains:

Domain 1 (overall and physical ability) = Q2+Q15+Q3+Q4+Q10+Q1+Q16+Q17+Q18 **(52)**.

Domain 2(psychological)= Q5+Q6+Q7+Q11+Q19+Q26 **(52).**

Domain 3 (social relationships)=Q20+Q21 +Q22 **(52)** .

Domain 4 (the environment)=Q8+Q9+Q12+Q13+Q14+Q23+Q24+Q25 **(52)**.

Note: In World Health Organization of Quality Of Life (WHOQOL-Bref) the higher score indicates better health.**(53)**

Find total score for QOL tool:

1-Overall and physical domain: total scores are 21 points divided into: 14 to 21 as highQOL, <14 to 7 as moderate as moderate QOL, and <7 as low QOL.

2-Psychological:total scores are 18 points divided into :12 to 18 as high QOL, < 12 to 6 as moderate QOL, and < 6 as low QOL.

3-Social Relationship:total scores are 9 points divided into: 9 to 6 as high QOL, < 6 to 3 as moderate QOL , and < 3 as low QOL.

4-Environment:total scores are 24 points divided into: 24 to 16 as high QOL, < 16 to 8 as moderate QOL, and < 8 as low QOL**.**

5.2. Operational design:

5.2.1. Preparatory phase:

A review of the past, current related literature covering all aspects of the problem using available book, journals, articles, and magazines was done to be a quantized with the various aspect of research problem. The tool of data collection was adopted and modified by the researchers under supervision of experts in the field of nursing.

5.2.2. Exploratory phase:

1. Pilot study:

A pilot study was carried out on 10% of older adult to test the study tools for it's simplicity, reliability, clarity, validity, and the time required to fill the tools, because any changes of the tools construction the pilot studied sample were included in the study sample results.

2. Field work:

The actual field work was carried out from 28-10-1434H to 18-12-1434H for data collection. The researchers were available 1 day/ week at Social Care Home for 3 weeks from 8 a.m. to 12 p.m. The nature and purpose of the study were explained to the studied older adult. The assessment sheet was filled out by the researchers individually or in group. The average time needed for completion of each form was around (15-20 minutes).

5.3. Administrative design:

An official permission to conduct the current study was obtained from the dean of faculty of nursing in Umm AL-Qura University and manager of Social Care Home at Makkah AL-Mukarramah.

5.3.1. Statistical design:

The collected data were coded and analyzed using the number and percentage distribution, using $\mathbf{X^2}$ test ($p>0.05$= not significance, $P<0.05$= significance, and $P<0.001$= high significance.

5.3.2. Limitation of the study:

1- There were some difficulties during data collection because the presence of older adults with cognitive (mental) impairment as dementia and Alzheimer disease.

2- Most of the elderly males not participate in the study because of culture barriers at Makkah AL-Mukarramah.

5.3.3. Ethical consideration:

Permission for data collection at the previously mentioned study sitting was obtained from manager of Social Care Home at Makkah AL-Mukarramah. Meeting and discussions were held between the researchers and the physicien of the Social Care Home and she organized with the administrative personnel. Aims, objectives, and expected outcomes were explained and they get better cooperation. A clear and simple clarification was given to each study subject. They were secured that all the gathered information will be confidential and used for research purpose only and they were allowed to withdraw from the study at any phase and an oral consent was obtained prior to their inclusion in the study.

6. Results

Table (1): Distribution of the older adults regarding to their socio demographic characteristics (No=75).

Items		No.	%
Age	Young old (65-75 yrs)	30	40%
	Old-old (>75-85 yrs)	33	**44%**
	Oldest old (>85-100 yrs)	12	16%
Gender	Male	10	13.3%
	Female	65	**86.7%**
Marital status	Married	23	30.7%
	Widowed	34	**45.3%**
	Divorced	14	18.7%
	Single	4	5.3%
Occupation	Unable to work	35	**46.7%**
	Unemployed	5	6.7%
	Retired	10	13.3%
	Home wife	25	33.3%
Income	1000 to 2000	58	**77.3%**
	>2000-3000	7	9.3%
	>3000-4000	4	5.3%
	>4000	6	8.1%

(Table 1). *The results obtained from this study are categorized as the following:*

The characteristics of the study subjects, It included 75 older adults, (44%) of the studied subjects' age ranged between >75-85 years, while (16%) of them ages ranged between >85 to 100 years. Also (86.7%) of subjects

were female, (45.3%) of subjects are widowed, and (18.7%) of subjects were divorced. As for occupation (46.7%) of them were unable to work, meanwhile (77.3%) of the studied subjects their income ranged between 1000 to 2000 SR/month.

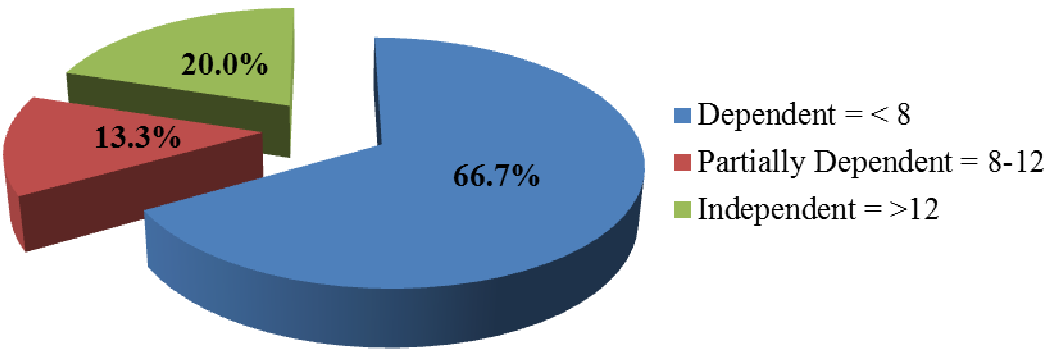

Figure (1): ***Total score number and percentage distribution of the older adults according to their Elderly Mobility Scale (No. =75)***

(Figure 1) 66.7% of subjects were dependent on others for mobility, while 20% of subjects were independent for mobility.

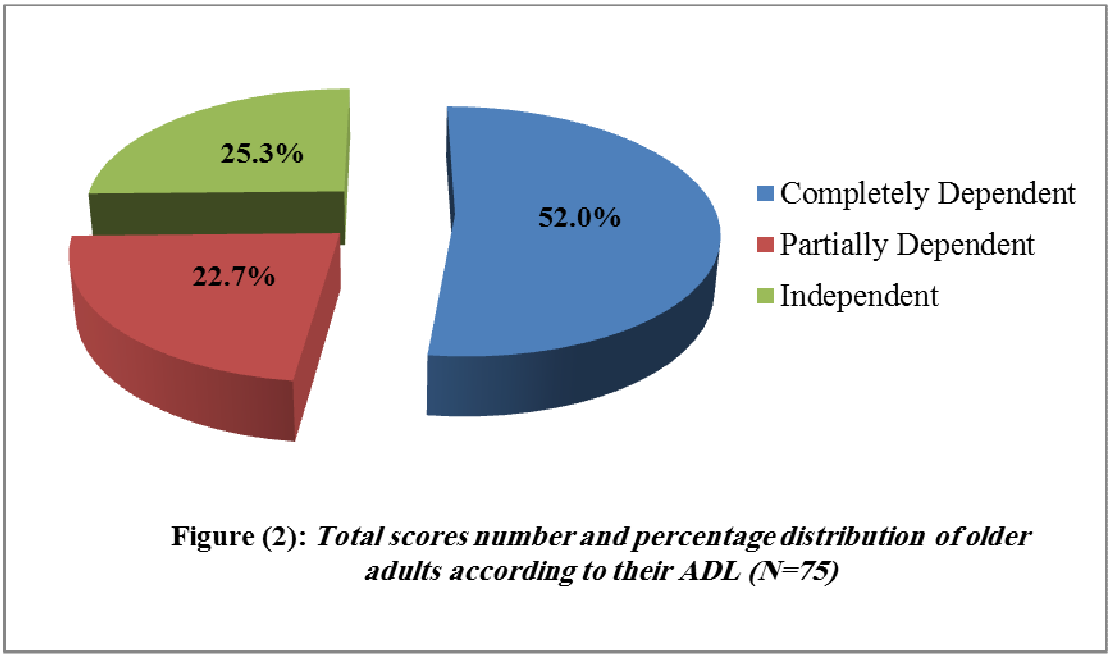

Figure (2): ***Total scores number and percentage distribution of older adults according to their ADL (N=75)***

(Figure 2) 52% of the subjects were completely dependent on others to perform ADL, and 22.7% of them were partially dependent.

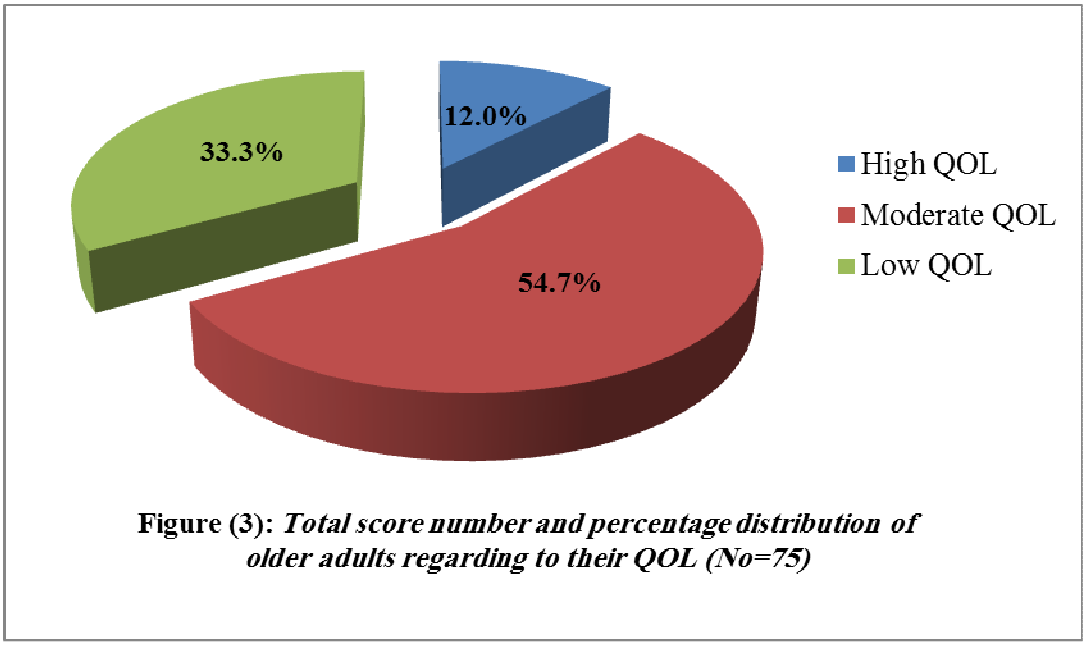

Figure (3): ***Total score number and percentage distribution of older adults regarding to their QOL (No=75)***

(Figure 3)54.7% of current study subjects were moderate QOL, and 12.0% of them were high QOL.

Table (2): ***Relationship between Older Adults Socio demographic characteristics (age & occupation) and total mobility (No.=75)***

Items	Completely dependent No.=50		Partially Dependent No.=10		Independent No.=15		X^2	P-value	Sig.
	No.	%	No.	%	No.	%			
Age (years):							3.44	0.025	**(HS)**
65-75	30	60.0	6	60.0	4	26.7			
>75-85	12	24.0	3	30.0	9	60.0			
>85-100	8	16.0	1	10.0	2	13.3			
Occupation:							0.883	0.013	**(HS)**
Unable to work	23	76.7	4	13.3	8	53.3			
Unemployed	3	10.0	1	3.3	1	6.7			
Retired	7	23.3	1	3.3	2	13.3			
Home wife	17	56.7	4	13.3	4	26.7			

(Table 2).There was highly statistically significant between the age and mobility**, also there was** highly statistically **significant relationship between studied** subjects **occupation and their mobility**

Table (3): ***Relationship between Older Adults Socio demographic characteristics (age & occupation) and their Total ADL (No.=75)***

Items	Completely dependent No.=39		Partially Dependent No.=17		Independent No.=19		X^2	P-value	Sig
	No.	%	No.	%	No.	%			
Age (years):							2.74	0.014	**(HS)**
65-75	15	38.5	7	41.2	8	42.1			
>75-85	20	51.3	6	35.3	7	36.8			
>85-100	4	10.3	4	23.5	4	21.1			
Occupation:							6.201	0.003	**(HS)**
Unable to work	21	53.8	8	47.1	6	31.6			
Unemployed	3	7.7	0	0.0	2	10.5			
Retired	4	10.3	4	23.5	2	10.5			
Home wife	11	28.2	5	29.4	9	47.4			

(Table 3).There was a highly statistically significant relationship between the age of the studied subjects and their ADL**; also there was** a highly statistically **significant relationship between studied** subjects **occupation and their ADL**

Table (4): Relationship between Older Adults Socio demographic characteristics (age & occupation) and their Total QOL (No.=75)

Items	Low QOL No.=25		Moderate QOL No.=41		High QOL No.=9		X^2	P-value	Sig
	No.	%	No.	%	No.	%			
Age (years):							3.741	0.025	**(HS)**
65-75	11	44.0	23	56.2	6	66.7			
>75-85	9	36.0	14	34.1	3	33.3			
>85-100	5	20.0	4	9.7	0	0.0			
Occupation:							6.201	0.001	**(HS)**
Unable to work	16	64.0	26	63.5	6	66.7			
Unemployed	2	8.0	0	0.0	0	0.0			
Retired	3	12.0	6	14.6	2	22.2			
Home wife	4	16.0	9	21.9	1	11.1			

(Table 4).There was a highly statistically significant relationship between the age of the studied subjects and their QOL**; also there was** highly statistically **significant relationship between studied** subjects **occupation and their QOL**

Table (5): Relationship between Older Adults mobility and their QOL (No.=75).

Items	Completely dependent No.=39		Partially Dependent No.=17		Independent No.=19		X^2	P-value	Sig
	No.	%	No.	%	No.	%			
QOL:							4.38	0.001	**(HS)**
High QOL =25	13	20.5	6	14.2	6	13.6			
Moderate QOL =41	21	51.2	9	21.9	11	26.8			
Low QOL =9	5	55.5	2	10.0	2	13.3			

(Table 5).There was a highly statistically significant relationship between the mobility and QOL **of the studied** subjects

7. Discussion

Old age or elderly is defined as persons 65 years of age and older. There are some changes on Older Adult that effect their mobility on QOL. The mobility has direct effect on QOL for older adult. Changes that occur with Older Adult fall into four categories: physical, psychological, emotional, and social. There are some important factors that effect on Older Adult's QOL such as falling and poor eyesight, disruption of balance sense, muscle weakness or limited core stability, inadequate nutrition, and poor nervous system control leads to downward of immobility and then disturbance in there QOL.

As regards the socio demographic study characteristics of older adults' the result of this study revealed that approximately half of older adults *(Kim, et al. 2013).* Ageing and adult health status in eight lower-income countries, and found that 15% of older adult aged 50 and over. Regarding to gender of older adults the result of this study clarified more than two third of subjects study were female, and a little of study subjects were male because the culture barriers in Makkah AL-Mukarramah.

Concerning with the older adults' marital status, the finding of the present study showed that nearly half of study subjects were widowed which disagreement with (Marj , et al, 2010). Those findings is never married and divorced had significantly higher odds ratios of poor self-rated health than their respective reference group. Low trust was significantly higher among the divorced and unmarried compared to the married/cohabitating, also those findings disagreement with(Lindström,and Martin 2009). Those findings is marital separation or divorce in a sample of more than 1,300 adults assessed on several occasions between 1960 and 2000.

As regard older adults' physical domain in assessing QOL the finding of the study subjects showed the result is more than three quarters of studied subjects were not satisfied with their sleeping. This finding was agreement with (Sbarra, et al. 2009) who assess several changes that occur with ageing, changes in sleep quality and quantity can be the most difficult for many older adults and to be satisfied with ageing, older adults experience normal changes in sleep architecture and sleep-wake cycles.

As regard older adults' psychological domain in assessing QOL the finding of the study subjects showed that more than half of subjects think that they feel their meaning of life to be moderate. This findings are agreement with(Hawkins and Kevin, 2011) who found that the older adult generally reported a greater presence of meaning in their lives than those in early or meddle adulthood also.

The finding of this study showed that less than quadrant of the sample think they cannot concentrate very much, this findings are agreement with(Hawkins and Kevin, 2011) who assess the cognitive performance different between college first year student and older adult, the result was calculating for each age group separately. They did not find any significant overall effect of condition on cognitive performance for the first year college student P<.95 however, they did find significant effect of conduction on cognitive performance for older adults P<.03.

As regarding to older adults' social relationship domain in assessing QOL, the finding of the present study

showed that less than quadrant of the subjects satisfied with sexual life very much. This finding are observed because all of the older adults in this geriatric home living without husbands\wife also less than half of studied subjects dissatisfied with their personal relationship.

This findings are agreement with(Steger,et al. 2009) who assess the prevalence of social engagement of the disabled elderly was 23 people (26.7% of the participants) also the finding of the study subjects showed the result is less than half of the sample satisfied with support they get from their friends is a little. This finding are agreement (Steger,et al. 2009) who assess Social Support and Self-Reported Health Status of older adults they needed more support also reported having poorer health compared with better health 2 times more often than did older persons who were satisfied with the support available to them.

As regard older adults' environment domain in assessing QOL the finding of the study showed that less than quadrant of the sample think that there environment not physically healthy. This findings are agreement of (Gackowski,et al. (2011) who did a multinomial logistic regression analysis demonstrated a significantly lower rate of medical procedures among the residents in special nursing homes compared with those in care medical facilities, geriatric intermediate care facilities and group homes because it is more prepared and healthier physically .

Concerning to mobility of older adult at geriatric home the needs for help of one person in sitting to standing was more than one quarter. The finding of (Ann Marie,et al. 2009) who reported that the older adult needs help of one person was 10%, which disagreement with the finding of current study. As regard to mobility, the result was two fifths of older adult needs physical help to walk or constant supervision, and agreed with(Nakanishi, et al. 2013) who showed that 32.2% of participants presented with impaired gait and need for help of assistance.

As regard to mobility, the result of the current study reported that three fifth of older adult completely dependent on assistance to mobile. This result was contradicted with (Okochi, et. al.,2013) who studied that low mobility was observed in 16% of older adults and dependent on assistance. Concerning to mobility of older adults, the finding reported that less than one fifths of older adults were partially dependent on assistance to mobile. This was contradicting with (Mahlknecht, et. al., 2013) who reported that moderate levels of mobility were found in 32% of older adults.

Also, the finding of the current study presented that one fifth of older adult independent and can mobile without assistance. But (Hudakova, et al. 2011) who were contradict that high level of mobility up to 52% in older adult.

As regard older adults' ADLs the finding of the study sample showed the result is nearly half of the study subjects were completely dependent. This finding was agreement with the study of basic ADL disability and functional limitation rates among older Americans [(31)] (Wufan F., 2013) who reported that the rates of basic ADL disabilities among community-dwelling adults aged 65 and older increased 9% between 2000 and 2005. When institutionalized elders were included, basic ADL disability rates were stable among men but increased among women. Also this findings are agreement with(Fuller, et. al., 2009) who assess progressive resistance strength training for improving physical function in older adults are review assessed physical function in older adults at the level of impairment, functional limitation and disability.

Also this finding are agreement(Liu, et al. 2009) who assess the mediating effect of chronic pain on the relationship between obesity and physical function and disability in older adults and reported that older obese adults had greater ADL disability.

Regarding the relationship between the assessment of QOL and elderly mobility (EM), this study revealed that there were statistically significant relationships between the decreases of QOL and decreases the independency between QOL and older adult mobility. [(28)](Okochi, et al. 2013).

8. Conclusion

There is a strong positively relationship between QOL, ADL, and EM. Most of the older adults at geriatric home are completely dependent in basic of activities of daily living and mobility. Also there was highly statistically significant difference between QOL and EM, older adults who completely dependent have low QOL.

9. Recommendations

Based on the current study findings, the following recommendations can be suggested:

9.1. Training exercise must be provided upon initial range of motion of older adults.

9.2. Encourage exercise of (home and Geriatric home) care for older adults.

9.3. For the future study plan to apply training exercise program for older adults at geriatric home through care-givers.

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