Quality of Life of Older Adults with Mobility Impairment

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Abstract: Mobility impairment is a potential or actual limitation of independent physical movement within the environment. **The aim** of this study to assess the quality of life of older adult with mobility impairment. **Design** this study was descriptive research design**. Setting** it was conducted at clinics and homes of older adults who are attending the outpatient clinics in Ain Shames Center for geriatric medicine. **Sample** the study involved all mobility impairment of older adults / (n=199). **Tools** Three tools were used for data collection, **First tool,** an interviewing questionnaire was used to assess socio-demographic characteristic and three aspects of quality of life. **Second tool**, an observation check list to assess home environment. **Third tool,** collected data from medical record about client's history. **Results** the most important findings was the mean age of elderly was 71.3±9.1, 29.2% of older adults with mobility impairment had arthralgia,, 66.8%of them had continuous pain, 58.2% of older adults with mobility impairment having houses with poor kitchens and toilets in safety measures, 80.9% of older adults with mobility impairment were unable to prepare their food, 54.3% of them had feeling of hopelessness and 61.8%of study sample cannot able to participate in social activities. **Conclusion** based on results of the current study, showed that mobility impairment of elderly were greatly affected by joints diseases rather than muscles and other disorders and more than three quarters of them were unable to perform physical activities of daily living as food preparation, while in psycho-social status more than half had feeling of hopelessness and suffered financial burden . **Recommendations** suggested that health education program about prevention of joint and muscles diseases, coping with physical daily living activities and socio- psychological needs.

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Key words: Quality of life, Mobility impairment, Activities of daily living

1. Introduction

Older adults as a diverse group of individuals with various socio-cultural backgrounds who are more heterogeneous than homogeneous. The later years of life will come to be more widely regarded as years of opportunity for older people and for society, in addition to prevention, care, and various health related activities direct attention is devoted to the promotion of high-level wellness ***(Miller, 2009)***.

Mobility impairment is defined as disabilities that affect the ability to move, manipulate objects, and interact with the physical world. Mobility impaired users include the users who are confined to wheelchair or bed or the people with incapacitated hand movement. Total lack of muscular control in the part or most of the body; include weakness, such as lack of muscle strength. Interference with control, where muscles are tense and controlled are having problems in accuracy of motor coordination and joint movement, involuntary, uncontrolled and purposeless motion and joint movement limitation, small limbs, missing limbs or abnormal trunk size ***Guralnik et al., (2010).***

Lin et al., (2009) categorized mobility impaired users into three kinds: Users with slightly impaired mobility, such as users with trembling hand can be caused by aging and repetitive strain injuries, users with intermediate impaired mobility may include weakness spasticity, ataxia and skeletal impairment and users with severe impaired mobility, such as users with locked – in syndrome who are prisoners in their own bodies, users mainly suffer with paralysis, which mean total lack of muscular control in the part or most of the body.

The concept of quality of life has regarded the outcome of advantages and disadvantages experienced cover the course of life, which in turn are shaped by the large social, cultural, legal, economic, and historical context. It should not come as surprise that there is little consensus about how to conceptualize and measure quality of life and there is no comprehensive theoretical model, ***(Skevington et al., 2008).***

According to **Calandra (2008);** assessment of psychological status older adults with mobility impairment ,revealed a large number of older suffer from symptoms of depression, older adults may also worried about change of life style, treatment regimen and badly affect the normal activities of life.

The term "activities of daily living" or ADLs, refers to the basic of tasks of everyday life and the skills that a person must be able to perform in order to live independently. The basic activity of daily living consists of self-care tasks, dressing and undressing, eating, transferring from bed to chair ,and back,

voluntarily control urinary and fecal discharge, using toilet and walking(not bedridden).While instrumental activities of daily living (IADLs) are not necessary for fundamental function, but enable the individual to live independently within a community. IADLs are important but not essential skills for someone living independently since services such as home care can provide the required support, food preparation, taking medications, shopping, using telephone, and managing money **Kouppi and Hartikainen (2008).**

When people are unable to perform these activities, they need help in order to cope, either from human being or mechanical devices or both. Although persons of all ages may have problems performing the ADLs, prevalence rate are much higher for the elderly than for nonelderly. Within the elderly population, ADL prevalence rates rise steeply with advancing age and are especially high for persons aged 85 and over ***(Rivlin & Wiener, 2007).***

Activities of daily living (ADL) include **basic ADL (BADL)**, which explore the basic capacity of persons to care for themselves, and **instrumental ADL (IADL)**, which refer to higher level of performance. Both BADL and IADL should be evaluated to capture the full spectrum of disability ***Thomas et al., (2009).***

Significance of the study:

According to the 2005 Census, 6.2% or over 11 million people between the age of 61 and 64 reported a physical disability, which can affect mobility. Using a broader definition of disability, the National Center for Medical Rehabilitation Research has estimated as many as 25 million people has mobility impairments in Egypt (**Arthritis Foundation, 2008).**

The primary objective for nursing management is to promote the older adult's ability to manage daily living, both functionally and psychosocially. The most effective treatment empowers the older adult to be an effective arthritis self care manger. To effectively manage daily living with arthritis, the older person needs knowledge, attitudes resources and psychosocial coping skill. He/ she needs to mange pain, movement, exercise, self care, home maintenance, fatigue and depression ***(Allender & Spradley; 2007; and National Institutes of Health, 2007).***

Aim of the study:

The aim of the study is to assess the quality of life of older adults with mobility impairment

Through:

1- Identifying the physical activity of daily living among older adults.
2- Determining the psychosocial status of older adults.
3- Assessing the safety of older adult's home environment.

Research questions

-1-Is the mobility impairment affect the physical activity of daily living among older adults?

2-Is the mobility impairment affect the psychosocial status of older adults?

2. Subjects and Methods

Research design:

A descriptive exploratory design was used in carrying out this study.

Setting:

The present study was conducted in two areas: Ain Shames center for geriatric medicine and client's home.

Sample:-

The sample, It is a purposive sample, the sample were chosen from all attendants' clients to the orthopedic clinics of Ain Shames center of geriatric medicine, total sample include 199 clients. They were chosen according to inclusive criteria; older adults (Age 60 years or above), diagnosed mobility impairment and their agreement to participate in the study by written consent.

Tools of the study:

Three tools were used for data collection

Tool-I: Interviewing questionnaire: This tool was prepared to assess the following items:

a) **Socio-demographic characteristic for older adults with mobility impairment**. It included questions about age, Gender, marital status, occupational, smoking, monthly income, and level of education.

b) **Measuring different aspects of quality of life** was done using a scale developed by **Kouppi and Hartikainen (2008),** and modified by the researcher it included three aspects

1-Physical

Activity of daily living and instrumental activities of daily living: it was based on Scales of Barthel index and Cleveland and was modified by the researcher The questionnaire was written in a simple Arabic language it consisted of 12 items to assess physical activities of daily livings as personal hygiene, using toilet, bathing, shopping, food preparation, travel, dressing, taking medications, ascending and descending stairs, laundry, using telephone, and managing money.

Scoring system:

Each question had 3 levels of answers: "unable to perform the task", need some help", "and "fully independent". These were scored 1, 2, and 3 respectively. Scoring less than 12 means unable to perform the task, scores 13-24means needed some help. On the other hand, more than 24 score means fully independent.

2-Psychological well-being:

It consisted of 10 questions about problems in mental concentration, listening to health educational programs, taking regular self medication, feeling of hopelessness, taking tonics without prescription, suffering from side effects of treatment, following the doctor's order, difficulty to cope with disease, caring

toward general health, and feeling of self- interest. The questionnaire was written in a simple Arabic language.

Scoring system:

Each question had 3 levels of answers: "Never ", "sometimes ", and "Always ". These were scored 1, 2, and 3 respectively. Scoring less than 10 means "Never ", scores 11-20 means "sometimes ", On the other hand, more than 20 score means "Always ".

3-Social concern:

It consisted of 10 questions such as, presence of enough number of friends, good social relationship with the family, share with others, feeling the burden on others, difficulty to communicating with others, help and participation of friends, disease causing financial burden, treatment affect the sexual relationship, treatment affect daily living activities, ability to participate in social activity . The questionnaire was written in a simple Arabic language.

Scoring system:

Each question had 3 levels of answers: "Never ", "sometimes ", and "Always ". These were scored 1, 2, and 3 respectively. Scoring less than 10 means "Never ", scores 11-20 means "sometimes ", and more than 20 score means "Always ".

Tool-II: An observation check list modified from: **Abdel-Aziz (2008).** This tool was prepared to assess the safety home environment of older adult. The researcher filled it during home visits.

Scoring system: score was assigned 1 if the home condition is poor, 2 if moderate and 3 if good.

Tool-III: A medical record from the outpatient clinics was used to collect data about the clients' diagnosis such as: causes of disability, occurrence, site and characteristic of pain.

Validity test was done through 5 experts from the Staff Faculty of Nursing, Community Health Nursing.

Fieldwork:

- To carry out the study, an approval was obtained from the outpatient director of Ain Shames center for geriatric medicine. A letter was issued to them from the Faculty of Nursing Ain Shams University explaining the aim of the study in order to obtain permission and co-operation.
- Data were collected in six months; from beginning of November 2010 till the end of April 2011.
- Three clients were interviewed each day. The researcher was present at the outpatient clinic three days/week from 9.00 am to 1.00 pm, each interview was done individually.
- Home visits for 67clients who agreed to be visited at home and their houses were in the area of Ain Shams University each client was carried out in 15 – 20 minutes.
- According to the pilot study finding, the questionnaire forms achieved in 30 – 40 minutes for every client.

Pilot study:

The aim of the pilot study was to test the practicability of the data collection tools and to estimate needs to fill in each tool. The total number of the pilot sample was 20 clients from the outpatient clinics. They were not included in the main study sample. The tools were modified. Modification included rephrasing of some questions, rearrangement of the questions sequences, and omission of some questions such as (female smoking and walking by using wheel chair,). After refinement and modifications, the final form of the tool was developed and the time of each home visit, was carried out in 15-20 minutes.

Ethical consideration:

Permission has been obtained from each elderly before conducting the interview and given a brief orientation to the purpose of the study. They were also reassured that all information gathered would be confidential and used only for the purpose of the study. No names were required on the forms to ensure anonymity and confidentiality.

Statistical analysis:

The obtained data were analyzed and tabulated, descriptive statistics as frequencies, percentages, means and standard deviations were calculated using computer SPSS for windows ver. 11.0.

3. Results

Table (1) shows that 63.3 % of older adults with mobility impairment were females mean age was 71.3±9.1 years and 58.8 % of them were illiterate, 53.3 % was single, 78.4% was not working, 76.4% of the sample had insufficient income and 74.9% were non-smokers.

Table (2) regarding to joints disease, it reveals that 29.2% of the sample of older adults with mobility impairment had arthralgia, 26.1% had osteoarthritis, 7.5% had rheumatic arthritis and according to muscles diseases, 4.6% of the sample of older adults with mobility impairment had poly-myalgia rheumatica and 2.0%of them had fibro-myalgia as well as17.6%of older adults with mobility impairment had foot problems and 6.0%of them had fracture in hip joint.

Table (3) shows that 66.8% of older adults with mobility impairment had continuous pain, and 24.6% of them had pain when pressure on the joint. As regards site of pain, 49.7%of sample had knee pain; while the hip and knee together it was 38.2 % and according to characteristics of pain 83.9% of the studied sample had pain and discomfort with range of motion.

Table (1): Distribution of mobility impairment of the older adults regarding to socio-demographic characteristic no=199.

Items	NO	%
Gender :		
Male	73	36.7
Female	126	63.3
Age group:		
65-	131	65.8
75-	56	28.1
85	12	6.1
Mean ±SD	71.3±9.1	
Level of education:		
illiterate	117	58.8
intermediate	69	34.7
Higher education	13	6.5
Marital status:		
Single	106	53.3
Married	93	46.7
Occupation:		
Working	43	21.6
Not working	156	78.4
Monthly income(LE):		
Sufficient	152	23.6
Insufficient	47	76.4
Mean ±SD	462.8±176.8	
Smoking:		
yes	50	25.1
No	149	74.9

Table (2): Distribution of older adults with mobility impairment according to the Cause of disability (n=199)

Items	NO	%
Cause of disability :		
1-Joints diseases		
Arthralgia	58	29.2
Osteoarthritis	52	26.1
Rheumatic arthritis	15	7.5
Gouty arthritis	14	7.0
2-Muscles diseases		
Poly-myalgia rheumatica	9	4.6
Fibro- myalgia	4	2.0
4- Foot problems	35	17.6
3- Fracture in hip joint	12	6.0

Table (4) shows that the safety measures of home environment for older adults with mobility impairment were poor in kitchen and toilet in 58.2% of houses. . In addition, sleep room and stairs and corridors in 70.1% and 79.1%of houses respectively. Concerning illumination of rooms, and corridors / toilet, it was moderate in 55.2% and49.3%of houses respectively, while it was a good in 14.9% and 13.4%of houses respectively.

Table (5) shows that 80.9% of older adults with mobility impairment were unable to perform physical activities of daily living as food preparation, while during ascending and descending stairs were 80.4%. Older adults who unable to perform managing money were represented by 62.3% of them. While 90.4% of older adults with mobility impairment were need some help for using toilet, 80.4%for bathing and 57.2%for dressing. However, 50.3% and 37.7% of older adults with mobility impairment were fully independent in shopping and personal hygiene respectively. While 4.5% of them were fully independent in laundry and food preparation.

Table (6) shows that 54.3% of the studied sample always had feeling of hopelessness, 37.7 % had problems in mental concentration and 37.2% had feeling of self interest. While 56.3% of the studied sample never suffers from side effects of treatment, 53.8% had no difficulty with coping with disease, 52.3% never care toward general health, and 50.7% never listen to health education programs, and also 29.1% of older adults with mobility impairment sometimes taking tonics without prescription, 26.6% of the studied sample sometimes difficulty with coping with disease and 26.1%of them sometimes following doctor's orders.

Table (3): Distribution of older adults with mobility impairment according to their pain (n=199):

Items	NO	%
Occurrence of pain:		
Continuous pain	133	66.8
Pain when pressure on the joint	49	24.6
Pain with muscle cramps	15	7.5
Pain with movement and weight bearing	2	1.1
Site of pain :		
Knee	99	49.7
Hip and knee together	76	38.2
Elbow	24	12.1
Pain can be characterized:		
Pain and discomfort with rang e of motion	167	83.9
Muscle resistance pain	24	12.1
Up cramps	8	4

Table (7) shows that 58.7% of the older adults with mobility impairment always suffer financial burden from the disease, 53.8% of the studied sample always Share with others, 48.7%of them had good social relationship with the family, and 47.7% had enough number of friends. While 61.8%of the study sample cannot be able to participate in social activities, 51.8%of them never give help and participate with friends, while 47.7% of the older adults with mobility impairment had no difficulty to communicating with others and 45.2% of them had no feeling the burden on

others. However, 37.7% and 31.2% of study sample sometimes the treatment had affected their daily living activities and sexual relationship respectively.

Table (4): Distribution of older adults with mobility impairment according to their safety homes environment (n=67):

Items	***Good***		***Moderate***		***Poor***	
Safety measure	No	%	No	%	No	%
o Illumination of room	10	14.9	37	55.2	20	29.9
o Corridors & toilet illumination	9	13.4	33	49.3	25	37.3
o Kitchen	8	11.9	20	29.9	39	58.2
o Toilet	8	11.9	20	29.9	39	58.2
o Sleep room	5	7.5	15	22.4	47	70.1
o Stairs and corridor	4	6	10	14.9	53	79.1

*The number is not exclusive

According to research question No1: Is the mobility impairment affect the physical activity of daily living among older adults?

Table (5): Distribution of mobility impairment of the older adults regarding to their physical daily living activities (n=199):

Items	Unable to perform task		Need some help		Fully independent	
	No	%	No	%	No	%
Personal hygiene	92	46.2	32	16.1	75	37.7
Using toilet	4	2.0	180	90.4	15	7.5
Bathing	4	2.0	160	80.4	35	17.6
Shopping	9	4.5	90	45.2	100	50.3
Food preparation	161	80.9	29	14.5	9	4.5
Travel	90	45.2	35	17.6	74	37.2
Dressing	12	6.0	114	57.2	73	36.6
Taking medications	6	3.0	169	84.9	24	12.1
Ascending and descending stair	160	80.4	28	14.1	11	5.5
Laundry	**7**	3.5	183	92	9	4.5
Using telephone	15	7.5	86	43.2	98	49.2
Managing money	124	62.3	58	29.1	17	8.5

*The number is not exclusive

According to research question No. 2: Is the mobility impairment affect the psychosocial status of older adults? **Table (6&7)**

Table (6): Distribution of the mobility impairment of the older adults according to their psychological status

Items	Never		Sometimes		Always	
	No	%	No	%	No	%
Problems in mental concentration	72	36.2	52	26.1	75	37.7
Listening to health education programs	101	50.7	35	17.6	63	31.7
Taking regular self medication	72	36.2	38	19.1	89	44.7
Feeling of hopelessness	66	33.2	25	12.5	108	54.3
Taking tonics without prescription	100	50.3	58	29.1	41	20.6
Suffering from side effects of treatment	112	56.3	44	22.1	43	21.6
Following the doctor's orders	91	45.8	52	26.1	56	28.1
Difficult to cope with the disease	107	53.8	53	26.6	39	19.6
Caring toward general health.	104	52.3	44	22.1	51	25.6
Feeling of self-interest	90	45.2	35	17.6	74	37.2

*The number is not exclusive

Table (7): Distribution of the mobility impairment of the older adults according to their social status of their quality of life

Items	Never		Sometimes		Always	
	No	%	No	%	No	%
Presence of enough number of friends	65	32.7	39	19.6	95	47.7
Good social relationship with the family	73	36.7	29	14.6	97	48.7
Share with others	66	33.1	26	13.1	107	53.8
Feeling the burden on others	90	45.2	29	14.6	80	40.2
Difficulty to communicating with others	95	47.7	41	20.6	63	31.7
Help and Participate of friends	103	51.8	37	18.6	59	29.6
Disease causing financial burden	21	10.6	61	30.7	117	58.7
The treatment affect the sexual relationship	89	44.7	62	31.2	48	24.1
The treatment affect the daily living activities	89	44.7	75	37.7	35	17.6
Ability to participate in social activities	123	61.8	51	25.6	25	12.5

*The number is not exclusive

4. Discussion

Community – dwelling older people at risk for losing independence, establishing guidelines and identifying intervention to alter or to provide public health services to mange increasing dependence .Mobility is related to body changes from aging. Loss of muscles mass, reduction in muscles strength and function, stiffer and less mobile joints affecting balance can significantly compromises the mobility of older people ***(World Health Organization, (2010).***

Regarding socio-demographic characteristics of mobility impairment of the older adults, this study showed that less than two-third of mobility impairment of the older adults was females. While more than one third were males ***(Table1)***. The finding in line with those of the study carried out on elderly "the relationship between the perceived stressors among arthritis patient" in Egypt ***Masbah (2007),*** indicated that, slightly more than two third of the arthritis or impaired patient were female while less than one third were male. Also, ***Guralnik, et al. ;(2010)*** reported that mobility impairment of the older adults with arthritis is more common among females than males.

The present study has revealed that more than half of older adults were single, more than half of them were illiterate, and more than one third of them were intermediate school ***(Table1)***. These finding are in agreement with ***Mohamed (2008),*** who clarified in the study about" effect of balance disorders on activities of daily living and mood state in the elderly" in Egypt, as it was found that more than half of the sample were illiterate and single. This could be attributed to difficulties experienced in education and marriage by low socio-economic class.

Also, the result of present study had revealed that, more than three quarter of mobility impairment of the older adults was not working and their income was insufficient for their needs ***(Table 1)***, The finding is congruent with the study carried out on elderly "assessed perceived stressors among arthritis patients in Egypt by ***Masbah (2007),*** it was reported that the majority of those patients had low income and reported that the income should be studied as a vital part of the elderly needs especially when inflation exists and health problems are pressing without intimate supports from relatives or any friends .

Furthermore, concerning the smoking as an indicator of the socio demographic status in the present study, the nearly three quarter of mobility impairment of the older adults were non smoker, about one quarter of mobility impairment of the older adults only were smokers ***(Table 1)***. These finding are in agreement with ***Mohamed (2008),*** who found that about two-third were non smokers, about one third were current smoker. These finding disagreements with ***Mauk (2008),*** who mentioned that cigarette smoking over a period of years is the risk factors for rheumatoid arthritis. According to ***Hirsch (2007),*** who suggested that smoking is recently found to be associated with risk of osteoporosis condition that causes old people to become bent over, and their bones to break more easily.

Regarding the causes of disability and mobility impairment of the older adults, the results of the present study revealed that, about more than one quarter of the studied mobility impairment of the older adults was diagnosed arthralgia, followed by osteoarthritis and rheumatic arthritis less than one quarter and less than one tenth respectively ***(table 2).*** This finding were supported by ***Bill*** **(2009),** who found in the study about arthritis in the elderly in Florida that about two thirds of cases was arthritis followed by osteoarthritis and rheumatic arthritis . This might be due to the fact that osteoarthritis could cause severe joint deformities and mobility impairment of the older adults affecting activities of daily living.

Regarding occurrence of pain this study revealed that two third of older adults with mobility impairment were in pain all time(**Table3)** According to **Quan *et al*. (2007)**, it was mentioned that pain is the most prominent symptoms in most elderly people with arthritis and is the most important determinant of disability in patients with osteoarthritis .The finding is in line with that of the study carried out on elderly knee pain and osteoarthritis in older adults in the United Kingdom by **Peat (2008),** who found that one quarter of studied group was in pain all time. This might be a cause of mobility impairment in half of elderly having knee osteoarthritis.

The present study revealed that more than half of older adults with mobility impairment having houses with poor kitchens and toilets in safety measures items (**Table4**). This finding was supported by a study done by **Abu Aisha (2008),** who found in the study about the effect of an educational program regarding prevention of accidents among older adults in Egypt, that the half of studied sample homes was poor in kitchen and toilets.

The current study finding indicated that less than three quarters of older adults with mobility impairment houses were poor in sleep room and more than three quarters of them were poor as well in relation to stairs and corridor safety. These finding were in agreement with **Abd Elaziz (2008),** who reported the accidents inside the house are one of the common causes for mobility impairment among the elderly. The injuries due to accidents are a serious public health problem in the world.

The present study has illustrated that, more than three quarters of older adults with mobility impairment were need some help to perform bathing as regarded laundry required some help to complete task which observed from the majority of mobility impairment of the elderly regarding activities of daily living (**Table5**). This parallel to the study done by ***Lin et al., (2009),*** who found that in the study more than half of studied sample were moderate help required to complete bathing and laundry tasks. It may be because this task need move the fingers joint and severity of fingers pain followed practice this task.

Regarding to physical activities of daily living, the current study revealed that nearly half of older adults with mobility impairment was fully independent using telephone regarding activities of daily living (**Table5**) .This study is congruent with ***Soliman (2008)*** who found in the study that more the two third of studied group were fully independent in telephone using.

Also, the current study revealed that less than half of older adults with mobility impairment was unable to perform travelling takes **(Table 5).** This study is in line with ***Soliman (2008),*** who reported that less than one-third of studied group was dependent in travel. This might be due to sitting for long hours will aggravate joint stiffness, difficulty when standing up and also might be due to more effort needed from older adults during travelling.

Regarding to psychological aspect of the quality of life of mobility impairment of the older adults the result showed that (**Table 6**) about more than half of the studied sample always feeling of hopelessness, more than one-third of them had problems in mental concentration and feeling of self interest. While more than half of the studied sample never suffered from side effects of treatment and difficult to cope with disease, more than half caring toward general health, and more than half listening to health education programs. This result is consistent with ***Burckhard et al. (2009), who*** found in the study about quality of life of adults with chronic illness; about more than half of the studied sample always feeling of hopelessness one-third had problems in mental concentration and one-third feeling of self interest. While two-third of the studied sample never suffered from side effects of treatment. This might be explained by the fact that elderly with joint diseases taking medical treatment for long time and also seeking medical advice several times without improvement of pain and movement.

Regarding to social aspect of the quality of life of mobility impairment of the older adults, it shows that (**Table 7**) about less than half of the studied sample had always-good social relationship with family, share with others and also less than half of them have enough number of friends. More than half of the studied sample never gives help and participation to friends. While more than one third of them, the treatment had sometimes affected the daily living activities .This result is consistent with ***Han (2008),*** who found in the study about quality of life of persons with spinal cord injury living in Taipei, more than half of the studied sample always good social relationship with family. While one third of them, the disease and treatment had some effect on the activities of daily living.

The current study revealed that more than half of mobility impairment always suffer financial burden from the disease. This result is consistent with ***Neumann (2009),*** who found in the study about ‘‘measuring quality of life of women with fibro myalgia’’ that more than half of the study sample revealed deterioration in economic condition caused by the disease. This finding were supported by ***Diener (2010)***, who reported in the study about ‘‘measuring quality of life: economic, social, and subjective indicators’’ that more than two thirds of study sample had bad economic status from the disease. This might be attributed to inadequate monthly income of elderly, costly treatment and lack of medical insurance.

Conclusion

The findings of the present study and research questions shed light on some of the important features of the aging stage of life regarding their diseases which cause mobility impairment and effects on quality of life. The findings of the present study revealed that mobility impairment of elderly were greatly affected by joints diseases rather than muscles and other disorders and more than three quarters of them were unable to perform physical activities of daily living as food preparation, while in psychological aspect more than half had feeling of hopelessness. Concerning the social aspect more than half of older adults with mobility impairment suffered financial burden and less than three quarters of them could not participate in social activities.

Recommendations

In the light of finding of the present study the following recommendation can be suggested:

Health education programs to improve the quality of life of the older adults about: prevention of joint and muscles disease, coping with daily living activities, physical mobility maintenance and socio-psychological needs. .

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