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The Effect of Physical and Emotional Well-Being on the Quality of Life for Elderly People Living in Nursing Homes

Objective: This study aimed to examine the effects of physical and emotional well-being on the quality of life for elderly individuals living in nursing homes.

Materials and Methods: The study was conducted using a descriptive and correlational design. The population consisted of 104 individuals residing in a nursing home in a province of Türkiye. Data were collected using the Demographic Information Form and the Quality of Life Scale in Older People, and analyzed using SPSS version 23 statistical software.

Results: Among the participants, 26.0% were aged 65–69, 51.9% were male, 81.7% were residing in the nursing home for 0–5 years, 32.7% reported feeling lonely or without family, 64.4% were staying in the nursing home voluntarily, and 51.0% had occasional visitors. Additionally, quality-of-life scores were significantly higher among those who did not experience bodily pain/sensitivity (20.96±6.88) and those who did not feel lonely (20.21±7.90).

Conclusion: The findings indicate that the quality of life for elderly individuals in nursing homes is significantly influenced by physical discomfort (pain) and emotional factors (loneliness). Enhancing physical comfort and strengthening emotional support may improve life satisfaction and overall well-being in institutional care settings.

Key Words: Elderly, nursing home, quality of life, nursing

Huzurevinde Kalan Yaşlıların Yaşam Kalitesi Üzerinde Fiziksel ve Duygusal İyilik Halinin Etkisi

Amaç: Bu çalışma, huzurevinde yaşayan yaşlı bireylerin yaşam kalitesi üzerinde fiziksel ve duygusal iyilik halinin etkisini araştırmayı amaçlamıştır.

Gereç ve Yöntem: Tanımlayıcı ve ilişki arayıcı tipte yürütülen araştırmanın evrenini, Türkiye'nin bir ilinde bulunan huzurevinde yaşayan 104 birey oluşturdu. Veriler; Tanıtıcı Özellikler Formu ve Yaşlılarda Yaşam Kalitesi Ölçeği kullanılarak toplandı. Araştırmadan elde edilen veriler SPSS 23 paket programıyla değerlendirildi.

Bulgular: Çalışmaya katılan yaşlı bireylerin; %26' sı 65-69 yaş aralığında, %51.9'u erkek, %81.7'si 0-5 yıldır huzurevinde yaşamakta, %32.7'si kendisini kimsesiz/yalnız hissetmekte, %64.4'ü huzurevinde kendi isteğiyle bulunmakta, %51'si ise ziyaretçisinin ara sıra gelmekte olduğunu belirtmektedir. Ayrıca yaşlılarda yaşam kalitesi ölçeği; vücudunda ağrı/hassasiyet hissetmeyen (20.96±6.88) ve kendisini kimsesiz/yalnız hissetmeyen (20.21±7.90) katılımcılarda anlamlı derecede daha yüksek bulunmuştur.

Sonuç: Bulgular, huzurevlerinde yaşayan yaşlı bireylerin yaşam kalitesinin fiziksel rahatsızlıklar (ağrı) ve duygusal faktörler (yalnızlık) tarafından anlamlı şekilde etkilendiğini göstermektedir. Fiziksel konforun artırılması ve duygusal desteğin güçlendirilmesi, kurumsal bakım ortamlarında yaşam memnuniyetini ve genel iyilik halini artırabilir.

Anahtar Kelimeler: Yaşlı, huzurevi, yaşam kalitesi, hemşirelik

Introduction

As the elderly population is increasing in the world, it is also rising in Turkey. According to TUIK 2023 data, the proportion of elderly population is estimated to reach 11.0% in 2025, 12.9% in 2030, 16.3% in 2040, 22.6% in 2060 and 25.6% in 2080 (1). Aging is a process in which biological, psychological, and social changes occur in the later stages of an individual's life. The changes that emerge during this process restrict or prevent older individuals from performing all their physical and social activities. These limitations, which cause negative emotions in the elderly, adversely affect their quality of life (2, 3). During the aging process, factors such as an individual's health status, social support, economic conditions, physical activity, mental health, environmental conditions, and personal life satisfaction are critically important in determining the general happiness and life satisfaction of older individuals. Understanding these factors that affect the quality of life in old age is essential for protecting and improving the health of the elderly.

Quality of life is a condition that reflects the balance between an individual's expectations and actual life experiences (4). Functional capacity, health status, psychological condition, personal beliefs, life goals, expectations, norms, and concerns affect an individual's quality of life (5). In older individuals, in addition to chronic, physical, and mental illnesses, factors such as gender, age, low economic status, irregular medication use, low education level, pain, physical disabilities, lack of social security, inability to access healthcare services, and social isolation negatively impact both their health and quality of life (6-8).

Nursing is a health discipline that aims to protect and improve the health of individuals, families and society; to improve and support life functions when there is a physical, mental or social deterioration in health status (9). Nurses support elderly individuals to meet their physical care needs, cope with emotional difficulties, maintain their self-sufficiency, adapt to the limitations they experience and maintain their sense of self-worth. The aim of services for elderly individuals is to support their quality of life and to contribute to their independent and active life as much as possible (10). The aim of this study is to investigate the effect of physical and emotional well-being on the quality of life of elderly individuals living in nursing homes. Additional objectives include to increase the awareness of health professionals providing services to the elderly living in nursing homes, to guide nursing home staff in services to improve the quality of life for the elderly and to provide an up-to-date contribution to the literature. The study aims to address the following research questions regarding older individuals residing in nursing homes:

1. What are their sociodemographic characteristics?
2. Is there a difference between their sociodemographic characteristics and quality of life?
3. What is the level of their quality of life?

Materials and Methods

Research and Publication Ethics: Approval (Session No: 2022/26, Decision No: 02 Protocol No: 195) was obtained from the Kahramanmaraş Sütçü İmam University Medical Research Ethics Committee to conduct the study and official permission was obtained from the Ministry of Family Social Policies and Provincial Directorate. Elderly individuals were informed about the purpose of the study, assured that their data would remain confidential, and reminded that they could withdraw from the study at any time. Additionally, the study was conducted in accordance with the Principles of the Declaration of Helsinki, and written consent was obtained from the participants using an Informed Voluntary Consent Form.

Study Design: This study was conducted using a descriptive and correlational design.

Place and Duration of the Study: The study was initially planned to include a total of 188 older individuals

residing in the Kahramanmaraş Nursing Home for Elderly Care and Rehabilitation Center and the Şehit Hakan Duygal Nursing Home for Elderly Care and Rehabilitation Center in the central district of Onikişubat between July 10, 2022, and December 30, 2022. However, due to delays in obtaining institutional permissions, the study could not be conducted within the specified period. By the time the necessary institutional approvals were obtained, the Kahramanmaraş earthquakes occurred on February 6, leading to the closure of the elderly care and rehabilitation center. After the disaster, 188 elderly individuals returned to the facility in June 2024. Ethics committee approval for the study was updated accordingly.

Population and Sample of the Study: The study population consists of elderly individuals (188 elderly individuals) residing in nursing homes between July and October 2024. The sample includes elderly individuals who resided in the nursing home during this period and met the inclusion criteria. The inclusion criteria are as follows: volunteered to participate, spoke Turkish, resided in a nursing home, and had no communication or cognitive impairment. No specific sampling method was used; instead, all elderly individuals who met the inclusion criteria were included. A total of 188 elderly individuals resided in the nursing home during the two-month study period. However, following the Kahramanmaraş earthquake on February 6, 76 elderly individuals were diagnosed with dementia or Alzheimer's disease by a physician and 8 elderly individuals refused to participate in the study and were excluded. Among the remaining residents, those who did not have visual, auditory, or psychological impairment and agreed to participate were included. The total number of individuals included in the study became 104. A demographic information form and the Quality of Life in the Elderly Scale were used to collect data. Both instruments were administered through face-to-face interviews conducted by the researcher. The completion of the forms took approximately 15-20 minutes.

Data Collection Tools

Demographic information form: The demographic information form prepared by the researchers consisted of 20 questions aimed at identifying participants' socio-demographic characteristics, chronic diseases, length of stay in the nursing home, medication use, friendships, visitor status, and level of dependence in daily activities.

Quality of Life Scale in Older People: The CASP-19 scale was developed by Hyde et al. to measure the quality of life of older adults. The scale consists of 19 items, four sub-dimensions (control, autonomy, pleasure, and self-realization), and follows a four-point Likert type (11). The Turkish validity and reliability study, conducted by Türkoğlu and Adıbelli (2014), led to the removal of six items, refining the scale into a 13-item, two-sub-dimension measure with a four-point Likert format (Never: 0 – Always: 3). The Autonomy and Satisfaction Perception sub-dimension consists of items 3, 5, 6, 7, 8,

9, 10, 11, 12, and 13, while the Perceived Constraint sub-dimension consists of items 1, 2, and 4. The items in the perceived constraint sub-dimension are reverse coded. The total score obtained from the scale ranges between 0 and 39, with higher scores indicating better quality of life. The Cronbach's alpha coefficients for the sub-dimensions and the total scale were found to be 0.93, 0.75, and 0.91, respectively (4). In this study, the Cronbach's alpha coefficients were found to be 0.85, 0.70, and 0.80, respectively."

Data collection: The study data were collected by the researchers by face-to-face interviews in a separate room using the form and scale. The completion time was approximately 15–20 minutes. The purpose of the study was explained to the participants in detail, and it was stated that the study was conducted with institutional permission and ethical committee approval. Additionally, the data were collected after obtaining informed voluntary consent forms and verbal consent from the participants.

Data Analysis: The data obtained from the study were analyzed using the Statistical Package for the Social Sciences (SPSS) version 23.0 (IBM Corp., Armonk, NY, USA). Descriptive statistical methods, including mean, standard deviation, frequency, and percentage calculations, were used. Normality was assessed using Skewness and Kurtosis tests. In the present study, Skewness values ranged from -1.69 to 1.89, while Kurtosis values ranged from -1.09 to 1.43. According to the literature, if Skewness and Kurtosis values fall within the range of -2 to +2, the data are considered normally distributed (12). For the comparison of two independent groups, the t-test was used, while analysis of variance (ANOVA) was applied to compare more than two groups. Pearson correlation analysis was conducted to examine relationships between variables. A p -value of <0.05 was considered statistically significant.

Limitations and Strengths of the Study: A limitation of the study was that the data were collected from a single nursing home in one province, which may restrict the generalizability of the findings. However, a strength of the study was that the researchers collected the data in the elderly individuals' natural environment, allowing for a more immersive and contextualized research process.

Results

Among the elderly individuals who participated in the study, 26.0% were aged 65-69 years, 51.9% were male, and 76.0% were widowed. Half of the participants (50.0%) had 1 to 4 children, while 53.8% were illiterate. Additionally, 52.9% had low income and no social security, and 81.7% were residing in the nursing home for 0–5 years. More than half (55.8%) had a chronic illness, and 72.1% reported taking their medication regularly. 43.3% experienced pain or sensitivity in their body, while 32.7% reported feeling lonely or without social support. Regarding health concerns, 44.2% stated that they had no worries about their health, and 88.5% reported following a regular diet. Furthermore, 73.1% indicated that there was a regular exercise program in the institution, and 64.4% stated that they were living in the nursing home voluntarily. Overall, 88.5% expressed satisfaction with staying in the facility. Regarding social interactions, 51.0% had occasional visitors, 86.5% had friends in the nursing home, and 60.6% reported having a good relationship with their friends (Table I).

The mean score of the Autonomy and Satisfaction Perception sub-dimension was significantly higher among the participants who had friends in the nursing home (14.36 ± 6.73 , $p < 0.05$) (Table 1). The mean score of the Perceived Constraint sub-dimension was significantly higher among the participants who were 85 years or older (5.75 ± 2.28) and male (5.35 ± 2.11), had no social security (5.45 ± 2.21), had a chronic illness (5.60 ± 1.85), experienced bodily pain or sensitivity (6.57 ± 1.59), were concerned about their health (5.76 ± 2.01), or believed that there was no regular exercise program in the institution (6.07 ± 2.03), ($p < 0.05$) (Table I).

The Quality of Life Scale score was significantly higher among the participants who did not experience bodily pain or sensitivity (20.96 ± 6.88) and did not feel lonely or without social support (20.21 ± 7.90), ($p < 0.05$) (Table 1).

The overall mean scores of the participants were 13.64 ± 7.26 for the Autonomy and Satisfaction Perception sub-dimension, 4.86 ± 2.34 for the Perceived Constraint sub-dimension, and 18.50 ± 7.36 for the total Quality of Life Scale ($p < 0.05$) (Table 1).

There is a highly significant positive correlation ($r = 0.949$) between the Quality of Life Scale in Older Adults and the Autonomy and Satisfaction Perception sub-dimension (Table 2).

Table 1. Comparison of Demographic Characteristics and Quality of Life Scale Scores in Older Adults

| Demographic Information (n=104) | N (%) | Quality of Life Scale in Older People | | | |
|-----------------------------------|------------------------|--|---|---------------------|-------------------|
| | | Autonomy and Satisfaction Perception Sub-Dimension (0-30 points) | Perceived Constraint Sub-Dimension (0-9 points) | Total (0-39 points) | |
| Age | 65-69 | 27(26.0) | 14.74±7.25 | 4.92±2.49 | 19.66±7.53 |
| | 70-74 | 13(12.5) | 14.30±7.07 | 4.00±2.44 | 18.30±6.66 |
| | 75-79 | 20(19.2) | 12.55±7.79 | 5.10±2.51 | 17.65±8.57 |
| | 80-84 | 21(20.2) | 13.09±7.02 | 5.00±1.87 | 18.09±6.49 |
| | 85 ve ↑ | 23(22.1) | 13.43±7.57 | 4.95±2.43 | 18.39±7.64 |
| Statistical Analysis (F/p) | | | 0.32/0.86 | 0.51/0.72 | 0.24/0.91 |
| Gender | Male | 54(51.9) | 13.38±6.56 | 5.35±2.11 | 18.74±6.93 |
| | Female | 50(48.1) | 13.92±8.01 | 4.34±2.48 | 18.26±7.87 |
| Statistical Analysis (t/p) | | | -0.37/0.71 | 2.24/0.02 | 0.33/0.74 |
| Marital Status | Married | 11(10.6) | 15.00±8.22 | 5.63±2.83 | 20.63±7.18 |
| | Single | 14(13.5) | 13.14±6.43 | 5.50±2.47 | 18.64±6.84 |
| | Widowed | 79(76.0) | 13.54±7.34 | 4.64±2.23 | 18.18±7.51 |
| Statistical Analysis (F/p) | | | 0.22/0.79 | 1.46/0.23 | 0.53/0.59 |
| Number of Children | 0 | 27(26.0) | 11.44±7.52 | 5.03±2.26 | 16.48±7.72 |
| | 1-4 | 52(50.0) | 14.36±6.52 | 4.98±2.42 | 19.34±6.67 |
| | 5 and ↑ | 25(24.0) | 14.52±8.22 | 4.44±2.31 | 18.96±8.20 |
| Statistical Analysis (F/p) | | | 1.69/0.18 | 0.54/0.58 | 1.41/0.24 |
| Education Level | Illiterate | 56(53.8) | 13.26±7.84 | 4.51±2.44 | 17.78±7.85 |
| | Literate | 12(11.5) | 13.16±6.96 | 4.58±2.06 | 17.75±6.94 |
| | Primary Education | 27(26.0) | 13.25±6.27 | 5.70±2.28 | 18.96±6.50 |
| | High School and above | 9(8.7) | 17.77±6.43 | 4.88±1.90 | 22.66±6.83 |
| Statistical Analysis (F/p) | | | 1.06/0.36 | 1.65/0.18 | 1.21/0.30 |
| Income Level | Low Income | 55(52.9) | 12.70±7.85 | 5.10±2.48 | 17.81±7.64 |
| | Income Equals Expenses | 43(41.3) | 14.72±6.34 | 4.72±2.21 | 19.44±7.01 |
| | High Income | 6(5.8) | 14.50±8.04 | 3.66±1.63 | 18.16±7.88 |
| Statistical Analysis (F/p) | | | 0.96/0.38 | 1.16/0.31 | 0.58/0.55 |
| Social Security | Yes | 49(47.1) | 14.93±7.07 | 4.20±2.32 | 19.14±7.60 |
| | No | 55(52.9) | 12.49±7.30 | 5.45±2.21 | 17.94±7.17 |
| Statistical Analysis (t/p) | | | 1.73/0.08 | -2.80/0.00 | 0.82/0.41 |
| Nursing Home Duration | 0-5 years | 85(81.7) | 13.68±7.59 | 4.74±2.37 | 18.42±7.82 |
| | 6-10 years | 13(12.5) | 14.30±6.53 | 5.61±2.36 | 19.92±5.70 |
| | 10 years and above | 6(5.8) | 11.66±3.38 | 5.00±1.78 | 16.66±1.63 |
| Statistical Analysis (F/p) | | | 0.27/0.76 | 0.79/0.45 | 0.42/0.65 |
| Chronic Illness | Yes | 58(55.8) | 13.12±7.57 | 5.60±1.85 | 17.39±7.77 |
| | No | 46(44.2) | 14.30±6.88 | 4.27±2.53 | 19.91±6.64 |
| Statistical Analysis (t/p) | | | -0.82/0.41 | -3.09/0.00 | -1.74/0.08 |
| Regular Medication Use | Yes | 75(72.1) | 14.05±7.16 | 4.60±2.41 | 18.65±7.61 |
| | No | 29(27.9) | 12.58±7.55 | 5.55±2.02 | 18.13±6.80 |
| Statistical Analysis (t/p) | | | 0.92/0.35 | -1.87/0.06 | 0.31/0.75 |

Continuation of Table 1

| | | | | | |
|--|-------------------------|----------|-------------------|-------------------|------------------|
| Pain/Sensitivity in Body | Yes | 45(43.3) | 12.11±7.35 | 6.57±1.59 | 15.80±7.06 |
| | No | 28(26.9) | 13.57±7.21 | 3.68±2.42 | 20.96±6.88 |
| | Sometimes | 31(29.8) | 15.93±6.80 | 5.03±1.76 | 20.14±7.15 |
| Statistical Analysis (F/p) | | | 2.62/0.07 | 17.33/0.00 | 5.98/0.00 |
| Feeling Lonely | Yes | 34(32.7) | 11.38±6.51 | 4.61±2.61 | 16.00±7.13 |
| | No | 42(40.4) | 15.30±8.27 | 4.90±2.42 | 20.21±7.90 |
| | Sometimes | 28(26.9) | 13.89±5.90 | 5.10±1.87 | 19.00±6.10 |
| Statistical Analysis (F/p) | | | 2.86/0.06 | 0.34/0.71 | 3.29/0.04 |
| Concern About Health | Yes | 23(22.1) | 12.17±6.75 | 5.76±2.01 | 16.21±6.67 |
| | No | 46(44.2) | 13.91±7.08 | 4.04±2.82 | 19.67±7.21 |
| | Sometimes | 35(33.7) | 14.25±7.89 | 4.22±2.04 | 18.48±7.84 |
| Statistical Analysis (F/p) | | | 0.62/0.53 | 6.73/0.00 | 1.71/0.18 |
| Regular Diet | Yes | 92(88.5) | 14.25±7.10 | 4.81±2.33 | 19.06±7.16 |
| | No | 5(4.8) | 8.40±8.32 | 3.40±2.30 | 11.80±9.12 |
| | Sometimes | 7(6.7) | 9.42±6.75 | 6.57±1.61 | 16.00±6.95 |
| Statistical Analysis (F/p) | | | 2.90/0.06 | 2.96/0.05 | 2.83/0.06 |
| Regular Exercise Program in Institution | Yes | 76(73.1) | 13.94±7.38 | 4.42±2.30 | 18.36±7.26 |
| | No | 28(26.9) | 12.82±7.02 | 6.07±2.03 | 18.89±7.77 |
| Statistical Analysis (t/p) | | | 0.69/0.48 | -3.33/0.00 | -0.32/0.74 |
| Reason for Residing in Nursing Home | Own Will | 67(64.4) | 13.31±7.69 | 5.08±2.24 | 18.40±7.69 |
| | Family's Request | 27(26.0) | 13.33±6.29 | 4.55±2.51 | 17.88±6.29 |
| | No One to Care for Them | 10(9.5) | 16.70±6.66 | 4.20±2.57 | 20.90±8.06 |
| Statistical Analysis (F/p) | | | 0.97/0.38 | 0.94/0.39 | 0.62/0.53 |
| Satisfaction with Residing in Nursing Home | Yes | 92(88.5) | 13.53±7.30 | 4.90±2.28 | 18.43±7.29 |
| | No | 12(11.5) | 14.18±7.54 | 4.36±2.90 | 18.54±8.38 |
| Statistical Analysis (t/p) | | | -0.27/0.78 | 0.71/0.47 | -0.04/0.96 |
| Visitor Frequency | Frequent | 12(11.5) | 15.83±8.56 | 4.41±2.06 | 20.25±8.17 |
| | Occasional | 53(51.0) | 14.03±6.67 | 5.00±2.48 | 19.03±6.61 |
| | No Visitors | 39(37.5) | 12.43±7.60 | 4.82±2.26 | 17.25±8.06 |
| Statistical Analysis (F/p) | | | 1.16/0.31 | 0.31/0.73 | 1.03/0.35 |
| Having Friends in Nursing Home | Yes | 90(86.5) | 14.36±6.73 | 4.88±2.24 | 19.25±6.57 |
| | No | 14(13.5) | 9.00±9.01 | 4.71±2.99 | 13.71±10.27 |
| Statistical Analysis (t/p) | | | 2.64/0.01 | 0.20/0.83 | 1.95/0.07 |
| Quality of Relationship with Friends | Good | 63(60.6) | 14.73±7.00 | 4.76±2.24 | 19.49±6.81 |
| | Moderate | 30(28.8) | 12.93±6.96 | 4.73±2.31 | 17.66±7.21 |
| | Poor | 11(10.6) | 9.36±8.39 | 5.81±2.92 | 15.18±9.97 |
| Statistical Analysis (F/p) | | | 2.85/0.06 | 1.01/0.36 | 1.91/0.15 |
| X±SD | | | 13.64±7.26 | 4.86±2.34 | 18.50±7.36 |
| (Min-Max) | | | (0-29) | (0-9) | (3-36) |

Table 2. Examination of the Relationship Between the Quality of Life Scale in Older Adults and its Sub-Dimensions

| Scale and Sub-Dimensions | 1 | 2 | 3 |
|--|---------|--------|---|
| Autonomy and Satisfaction Perception Sub-Dimension | 1 | | |
| Perceived Constraint Sub-Dimension | -0.118 | 1 | |
| Quality of Life Scale in Older Adults | 0.949** | 0.201* | 1 |

** p < 0.01 (2-tailed) * p < 0.05 (2-tailed)

Discussion

Data on the aging world population points to an increasing focus on improving the quality of life of the elderly and building a dynamic society. Psychological, physiological, economic and social changes that occur during aging may differ depending on individual perceptions (13). Considering the physical and mental problems that elderly individuals may experience, health professionals have important duties in ensuring their well-being (14); therefore, determining the factors affecting the quality of life of elderly individuals living in nursing homes is of great importance. This study aimed to investigate the effect of physical and emotional well-being on the quality of life in elderly individuals living in nursing homes. When the scores of the quality of life scale in the elderly according to the socio-demographic characteristics of the elderly were evaluated; it was found that the gender of the elderly individuals in the study did not affect their quality of life levels. In other words, the quality of life levels of the elderly with different genders are similar. In the study conducted by Alaçayır in 2024, it was seen that the gender of elderly individuals did not affect their quality of life levels (15). When other studies in the literature are examined, it is seen that the quality of life of male elderly is higher than that of female elderly (16-18). This finding of our study is not similar to the results of the studies in the literature.

While some studies in the literature reveal that the quality of life of elderly individuals with high income levels is higher than those with low income levels (19, 20), our study and other studies conducted especially in the nursing home environment (21, 22), show that income level has no significant effect on quality of life in this environment. This contradiction can be explained by the fact that the basic needs of elderly individuals in nursing homes are met by the state or the institution, thus reducing the impact of personal financial resources. Therefore, it can be concluded that the effect of income level on quality of life may vary according to the living environment of the elderly and this effect is more limited in institutionalised care settings.

In the study, those aged 85 and above, the male participants, those without social security, those with chronic illnesses, those experiencing bodily pain/sensitivity, those concerned about their health, and those without access to a regular exercise program in the institution reported higher levels of perceived constraints. Niederstrasser & Attridge (2022) conducted a study in older adults and found that older adults with high pain levels had significantly lower physical activity levels, which led to a restriction in exercise perception (23). These findings show a strong similarity with the results of our study, supporting that lack of access to exercise, pain, social security and psychological barriers systematically limit the perception of exercise in older adults.

In our study, it was found that the educational level of elderly individuals did not have a significant effect on quality of life. This finding is similar to the results of a study conducted in French nursing homes showing that

sociodemographic variables, including educational level, do not affect quality of life (24). A study evaluating elderly individuals under institutional care in Guangzhou concluded that level of education has no impact on quality of life (25). Although these data strongly support the result of our study, it shows that education level is not a determining factor of quality of life in care centres such as nursing homes. When the literature is analysed, there are opposite findings. When most of the studies in the literature were analysed, it was found that high level of education positively affected the quality of life of the elderly in the opposite direction to our findings (15, 19, 20, 25-28).

This study found that autonomy/satisfaction perception and overall quality of life among older adults residing in nursing homes were moderate, while perceived constraints were high. Another significant finding was that the mean scores of autonomy and satisfaction perception of the participants who had friends in the nursing home were significantly higher is a result parallel to the effect of social support on the feeling of autonomy in the literature. In the Marmara University study, a statistically significant relationship was found between friend support and self-confidence of nursing home residents (29). In addition, in a study conducted in Australia, autonomy-supported approaches that provide individuals with choice in a nursing home significantly increased life satisfaction by explaining 25% of the difference in quality of life (especially with the effect of choice in social activities and staff-resident interaction) (30). These findings strongly support that increased perceptions of autonomy and satisfaction in our study are associated with nursing home companionship. The presence of social support and friendships plays a vital role in enhancing quality of life in older adults. We can say that strong and qualified social ties increase quality of life in older ages. It has been observed that the CASP-19 scores of elderly individuals who have established intensive social relationships are higher (31). In addition, a high level of social support is considered to be an effective factor on quality of life (32). In the study conducted by Aydın Boylu and Günay, it was revealed that increasing the social support relationships of the elderly had a positive contribution to life satisfaction (33). Although it is known that social support has a great impact on the economic, psychological, and physical life satisfaction of the elderly, it protects them from the negative effects of life crises and improves their quality of life (34, 35).

In addition, among the older adults in our study, those who did not experience physical pain, used their medications regularly, did not feel lonely, and ate regularly had higher total quality of life scores. Various studies have shown that the ability to fulfill activities of daily living increases life satisfaction and quality of life (36, 37). In this context, the ability of elderly individuals to meet their own needs, to fulfill their daily activities independently and to avoid the feeling of loneliness can be considered as important factors contributing to increased quality of life. Professionals providing care in nursing homes can improve the quality of life of elderly

individuals by focusing on areas such as pain management, supporting medication compliance, reducing social isolation and balanced nutrition.

Several factors were found to positively influence quality of life in nursing home residents, including satisfaction with living in the nursing home, having friends in the institution, receiving visitors, participating in physical exercise, the absence of chronic illness, and not having health concerns. Similarly, previous research showed that older adults who engage in physical activity reported higher life satisfaction and better quality of life (38). Furthermore, marital status, socioeconomic status, and age, along with employment status, cognitive impairments, and social isolation, were identified as factors associated with quality of life in older adults (13). These factors should be taken into account when evaluating quality of life in old age, as understanding them plays a crucial role in protecting and improving older adults' health and ensuring their overall well-being and happiness (4). In our study, age, gender, and number of children did not significantly affect quality of life. However, not feeling lonely and being married positively influenced autonomy and satisfaction perception. Moreover, a strong positive correlation was found between the Quality of Life Scale and the Autonomy and Satisfaction Perception sub-dimension.

Our study on older adults living in nursing homes indicates that social support is weakly associated with quality of life. Additionally, the results show that the participants who reported having a chronic illness had lower total quality of life scores. As aging progresses, the prevalence and number of chronic diseases increase, which can lead to greater dependence, reduced life satisfaction, and a more negative attitude toward life (39).

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