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Analiza form spędzania wolnego czasu przez osoby niepełnosprawne w wieku ≥65 lat podstawą diagnozy w planowaniu edukacji zdrowotnej

Streszczenie

Wstęp. Edukacja zdrowotna jest procesem, w którym ludzie uczą się dbać o zdrowie własne i zdrowie społeczności, w której żyją. Szczególnie ważnymi odbiorcami edukacji zdrowotnej są osoby starsze z zaburzeniami zdrowia, w następstwie których doszło do trwałej niepełnosprawności.

Cel. Analiza czasu wolnego osób niepełnosprawnych w wieku ≥65 lat dla wykorzystania tego obszaru życia w edukacji zdrowotnej.

Materiał i metoda. Badaniami objęto 122 pacjentów po przebytym udarze mózgu lub protezoplastyce stawu biodrowego, kolanowego usprawnianych w oddziałach rehabilitacji. Populację do badań wyłoniono na zasadzie doboru celowego. Zastosowano metodę sondażu diagnostycznego, technikę wywiadu oraz autorski Kwestionariusz wywiadu dla osób niepełnosprawnych, w którym zawarto pytania związane z czasem wolnym tych osób. Uzyskany materiał poddano analizie statystycznej i opisowej.

Wyniki. Większość osób (89,4%) zmieniła sposoby spędzania wolnego czasu w następstwie choroby lub przebytej operacji. Badani w czasie wolnym najchętniej przebywali z rodziną (77,0%); samotność wybierało 12,3% seniorów, a 10,7% spędzało czas z przyjaciółmi, znajomymi. Wśród wszystkich zajęć w czasie wolnym przeważały bierne formy wypoczynku (81,2%), osoby najczęściej oglądały telewizję (27,2%), słuchały radia (19,2%), modliły się (17,5%) lub czytały prasę (17,2%). Czynne formy wypoczynku badanych seniorów stanowiły 18,8% wszystkich czynności i były to głownie spacery (44,8%) oraz spotkania towarzyskie, rodzinne (37,2%).

Wnioski. Istnieje możliwość wykorzystania części wolnego czasu starszych osób niepełnosprawnych dla potrzeb edukacji zdrowotnej. W planowaniu edukacji zdrowotnej należy uwzględnić odrębności wieku starszego, metodykę edukacji osób w późnej dorosłości, zalecenia WHO odnośnie promocji zdrowia seniorów oraz indywidualne potrzeby odbiorców.

Słowa kluczowe: osoba starsza, niepełnosprawność, edukacja zdrowotna, czas wolny.

Analysis of leisure activities for disabled people aged ≥65 as a basis for planning health education diagnosis

Abstract

Introduction. Health education is a process in which people learn to take care of their own health and the health of community in which they live. The elderly with health disorders with permanent disabilities are particularly important recipients of health education.

Aim. Analysis of free time for the disabled aged ≥ 65 with a purpose of using this area of life in health education.

Material and methods. The study included 122 patients treated in rehabilitation wards after brain stroke, hip joint or knee replacement. The research population was selected on the basis of deliberate selection. The method of diagnostic survey, interview technique and the author's interview questionnaire for disabled people were used, which included questions connected with leisure time. The resulting material was subjected to statistical and descriptive analysis.

Results. Most people (89.4%) changed leisure activities in the aftermath of illness or surgery. They mostly appreciated their free time spent with family (77.0%), 12.3% chose the moments of solitude, and 10.7% spent time with friends. Among all the activities during leisure time, passive forms of recreation were dominant (81.2%); watching TV (27.2%), listening to the radio (19.2%), praying (17.5%) or reading newspapers (17.2%). Active forms of recreation were accounting for 18.8% of all activities, mainly walking (44.8%), social and family meeting (37.2%).

Conclusion. There is a possibility of using free time of the disabled elderly for the purpose of health education. In planning this, distinction of the elderly age, methodology of persons' education in their late adulthood, WHO recommendations for promoting seniors' health education and individual needs of recipients should be considered

Key words: elder person, disability, health education, leisure.

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INTRODUCTION

Health education is a process in which people learn to take care of their own health and the health of the community in which they live [1]. Particularly important for health education are the elderly with disordered health condition, following which there was a permanent disability. Health education, geriatric prevention and health promotion are becoming essential due to the individual needs of seniors bound by the changes in health status, temporary or permanent disability, and psychological aspects of aging [2].

The health education of elderly, their families or carers, is the basic action in prevention of delaying the aging process. It focuses on: preparing an environment that supports health, shaping positive attitudes toward their own age, initiating pro-healthy lifestyle, helping in creating prevention habits in the anti-aging process, preventing deterioration of health condition, or the formation of secondary disability and social isolation.

The presented aims of health education can be realized in free time, which the elder people have. Seniors, especially the disabled or chronically ill, have free time to spare, which is used to promote well-being in old age and improve their quality of life by preparing for self-care.

AIM

The aim of this study was an analysis of leisure time of disabled people aged ≥65 (taking into account the change in the way of spending time as a result of disability, the people with whom most seniors are staying and the types of leisure time activities) for the planning of health education. The study included demographic and social characteristics of subjects and selected health indicators necessary for planning education.

MATERIAL AND METHODS

The research was conducted among patients recovering in rehabilitation wards in the city of Kielce. The research population was selected on the basis of deliberate selection. The study included individuals after brain stroke and hip joint or knee surgery. The research was voluntary and anonymous. The study excluded patients after brain stroke, which were unable to make logical verbal contact because of aphasia.

The method of diagnostic survey, interview technique and the author's interview questionnaire for disabled people hospitalized in rehabilitation wards were used, which included questions related to their leisure time.

The resulting material was subjected to statistical and descriptive analysis.

RESULTS

Demographic and social characteristics of the study population

The research included 122 disabled people aged 65-87. The average age was 71.18; while for women – 71.34; for men – 70.95.

There were 71 women (58.2%) and 51 men (41.8%). Most people lived in the city (54.6%).There were 43.4%of seniors living in rural areas.

More than half of the respondents (59.8%) were married; men were likely to dominate (84.3%) over women (42.3%). The category of marital status of widow or widower concerned 33.6%of seniors. As expected, nine times more frequently in this group were women (53.5%) than men (5.9%). The remaining patients were unmarried (6.5%) (Figure 1).

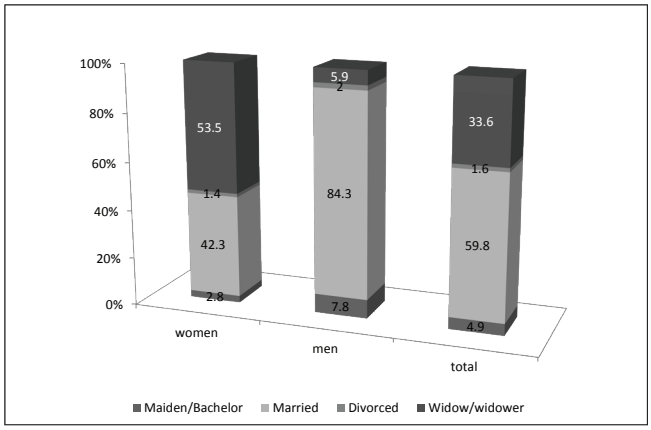


FIGURE 1. Marital status of the disabled people by sex and in total.

The largest subpopulation included people with the lowest education, i.e. incomplete primary or primary education (56.6%). In this category of education larger proportion was taken by women (63.4%) than men (47.1%). Secondary education was reported by 23.0%of seniors. Basic vocational education was mentioned by 11.5%of the disabled elderly, and higher education– by 9.0% (Figure 2).

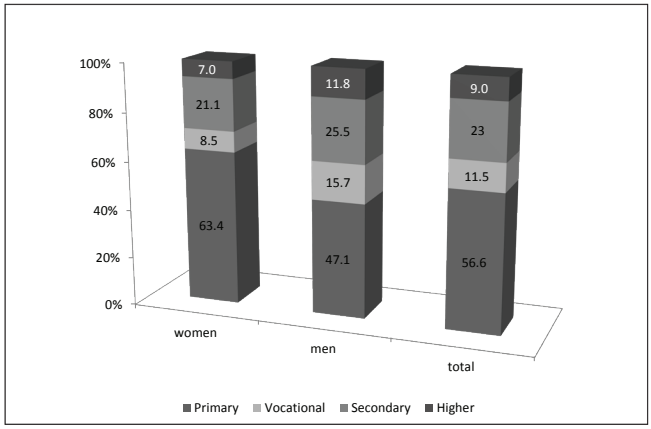


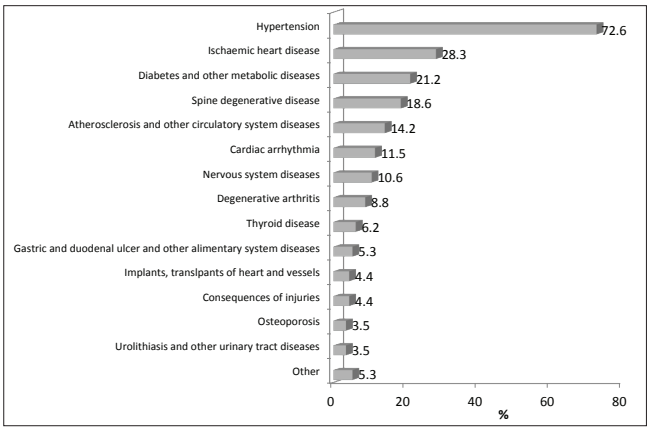
FIGURE 2. The disabled elderly education by sex and in total.

Health condition of the disabled people

The study population comprised 86 (70.5%) disabled people after brain stroke and 36 (29.5%) people after hip joint or knee surgery.

The 92.6% of patients apart from basic disease were having concomitant diseases. The most common health problem of the seniors was circulation system disorders. One fifth of the disabled (21.3%) suffered from diabetes and other metabolic diseases, and 18.6% suffered from degeneration of the spine. People with nervous system diseases accounted for 10.8%. Other health problems related to a smaller group of people, i.e. below 10% of the total.

The details are presented in Figure. 3.



* Percentage of data does not count to 100, because some of the patients had more than one concomitant disease.

FIGURE 3. Types of concomitant disease – the study group in total.

In other subpopulation of people (7.4%) concomitant diseases do not occur with the fundamental disease.

The leisure time of the disabled people aged 65+

Most disabled people (89.4%) changed the leisure activities after the illness or surgery, where it concerned most (61.5%) and only selected cases (27.9%). In the remaining group of seniors, changes in spending their free time were not noticed (10.7%). Taking into accounts ex and cause of disability, there were no statistically significant differences in this sphere (Table1).

TABLE 1. Change in spending free time activities as a result of reduced mobility – people according to sex, cause of disability and in total.

Change in spending free time activities	Sex				Disabilitycause				Total	
	Woman		Man		Prothesis-plasty		Brain stroke			
	n	%	n	%	n	%	n	%	n	%
Yes, strongly	45	63.4	30	58.8	21	58.3	54	62.8	75	61.5
Yes, in selectedcases	19	26.8	15	29.4	11	30.6	23	26.7	34	27.9
No, the same	7	9.9	6	11.8	4	11.1	9	10.5	13	10.7
Together	71	100	51	100	36	100	86	100	122	100

The elderly with disabilities mostly stayed in their free time with family (77.0%) – Table 2. Men were spending their free time with members of the family more than women (84.5% and 71.8% respectively). Also, more people after brain stroke (81.4%) than after hip joint surgery (66.7%) spent their free time with family.

Solitude was chosen by 12.3% people, with women (15.5%) spending their free time in loneliness twice more than men (7.8%).

Spending time with friends was reported by 10.7%, including 22.2% of people after hip joint surgery and 5.9% after brain stroke. (Table 2)

TABLE 2. People with whom respondents spent more time – people in the research according to sex, cause of disability and in total.

With whom they spent their free time	Sex				Disabilitycause				Total	
	Woman		Man		Prothesis-plasty		Brain stroke			
	n	%	n	%	n	%	n	%	n	%
With family	51	71.8	43	84.3	24	66.7	70	81.4	94	77.0
In solitude	11	15.5	4	7.8	4	11.1	11	12.8	15	12.3
With friends	9	12.7	4	7,8	8	22.2	5	5.9	13	10.7
Together	71	100	51	100	36	100	86	100.1	122	100

In the research the types of leisure activities were also identified. The questions were semi-open, contained a list of different activities performed during leisure time and gave the opportunity to free comments.

Among all exercises made in free time, passive form of recreation was dominating (81.2%). Watching TV was the most frequent activity (27.2%); listening to the radio (19.2%), praying (17.5%) or reading newspapers (17.2) - Figure 4. For almost 10% of people, passive form of leisure activities was in activity, which was defined by respondents as follows: ‘doing nothing’, ‘sitting’, ‘lying’. Two persons (0.6%) stated that ‘smoking’ and ‘drinking coffee’ are their free time activities. (Figure 4)

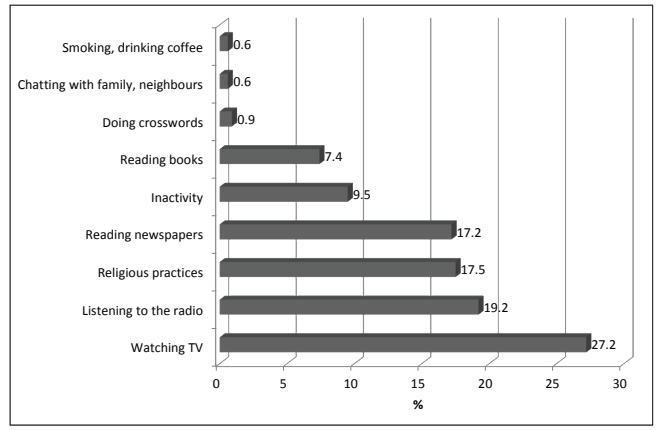


FIGURE. 4. Passive forms of relaxation for disabled people.

Active forms of relaxation in the researched group of seniors were reported within all activities - 18.8%: walking (44.8%) and family or social meeting (37.2%) – Figure 5.

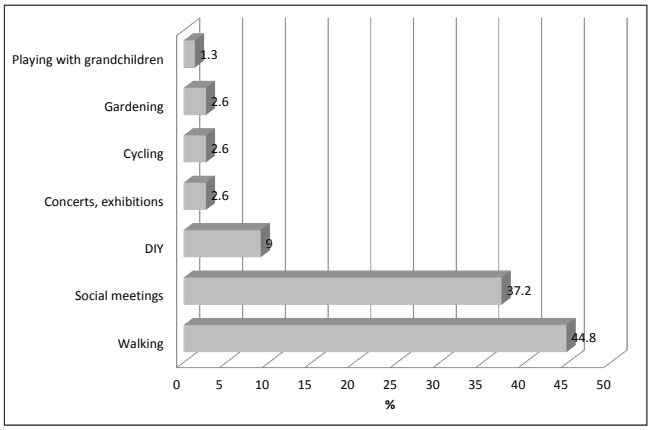


FIGURE 5. Active forms of relaxation for disabled people.

Analyses of relaxation of disabled people confirmed that people after brain stroke were choosing active forms of resting more often (30.2%) than patients after hip joint surgery (20.3%).

DISCUSSION

Patient's education is a process which consists in preparing a ward to cooperate in the process of care, treatment and rehabilitation, and in providing unprofessional care, preparing for self-care [3]. By self-care people understand coping in the new circumstances arising from a disease that causes disability.

The content of the education for disabled elderly patient includes health education and actions connected with formation of practical s kills to cope with disease, disability, being patient in health-care institution. According to K. Szczerbińska, the properly carried out education focused on patient can alleviate the course of chronic diseases, slowing its progress and reducing frequency of complications [4].

In the health situation of the elderly after brain stroke or hip joint surgery prevention of deterioration of somatic condition, and thus a positive impact on the psychological and social function is very important in the individual, family and social scale. The slowdown in chronic diseases in the research group or reducing the number and severity of complications following the diagnosis can be achieved by education activities and thus will improve the quality of seniors' life.

In education of patients not only concept of health education but also individual aims resulting from the evaluation of health and social situation, are realized. Despite the diversity of the study group of the disabled elderly, both in demographic, social and health terms there are some common educational goals. These goals stem from the WHO recommendations concerning the elderly health promotion, aging process, specificity of nursing and caring problems of patients with varying degrees of disability after brain stroke or hip joint/knee surgery and health problems in the group of elderly people [2,5].

The effectiveness of education depends on the preparation of the public to this process, i.e. self-acceptance in the role of patient – as a health care client, expressing willingness to cooperate and partner participation, knowledge and acceptance of aims to achieve.

The method of teaching is very important, as one of the factors, which determined the effectiveness of patients' education. Education conducted according with the program tailored for the group of patients with the same health problems gives better results than the spontaneous and unsystematic advising or individual guidance [4].

Education is a conscious communication with the patient with goals to help in making decisions about health issues and/or to provide arguments to develop positive attitudes towards health and health behaviours [6]. In accordance with such a rule, education must be preceded by diagnosis of patient condition and the needs of patients, their family or carers.

Education should be conducted as an organized action and passed on in successive stages – diagnosis, planning, realization and evaluation. In the diagnosis stage, the assessment of current state of knowledge is made; then the skills and motivation of the patient follow, including the need and motivation as a basis for learning, intellectual ability, physical and theoretical knowledge, practical skills, the patient's expectations regarding the scope and ability to acquire knowledge, results and effectiveness of education conducted in the pastor the sources of knowledge and the most effective learning methods in the case of education planned for the first time [7].

In the planning stage it is necessary to take into consideration differences connected with the people's age and motivation to learn, which is important for education of the elderly. The elderly are reluctant to learn new education program; they focus more on programs, which are useful in their daily lives. Aims should be defined in a way, which gives the opportunity for them to be achieved. This stage should include variety of methods and ways of teaching, ability to create attitudes or prompting of activities of the elderly, which help them to choose the most appropriate way to learn. Expectations of seniors regarding education are varied within the same group and changed simultaneously with age. The group of the elderly is interested in cases connected with their own mood, behaviour and safety [6]. The education content should include contemporary information, for instance the Internet use, which can help to develop their quality of life.

The research showed that more than half of the elderly had lower education, i.e. primary or incomplete primary. The content type, way and pace of transmission of knowledge should be included in planning education and teaching aids, which make the goals be achieved easier. K. Pucharski states that "health education, to a much greater extent than so far, should take into account the specific character of its addresses with regard to their education level. A particular attention should be paid to adapting the contents, the methods and the transmitters of education to specific health awareness (…) of the groups with the lowest education level" [8].

Seniors' education can be implemented in mixed groups made of the disabled, their spouses, and partners. The transferred knowledge will be analyzed by recipients for its use in the lives of disabled people, their spouses who look after them or participate in this care. In addition, a lot of information and skills acquired during education provides general guidelines for health promotion in the field of prevention of

dependence in daily life by improving and maintaining physical and mental fitness, nutrition, care about their own health, stimulation and maintaining social ties or improving quality of life. [5].

Seniors from the research group, like other Polish seniors [9,10], in most cases chose passive forms of spending their free time, i.e. watching TV, listening to the radio, reading newspapers and books. The interest of mass media by the elderly creates a special situation for their use in health education. The contents for the elderly broadcast in television and radio, separate sections in some magazines, guide books, can effectively popularize certain patterns of behavior with regard to maintaining physical and mental fitness, leisure activities, institutions acting on behalf of seniors, etc.

A minority of patients spends their free time on solving crosswords, which are a desirable kind of mental activity, preventing from dementia, improving imagination, attention and active thinking. This kind of activities, similar to others like puzzles or card games (chess, draughts, bridge) are essential for planning programmes for seniors. Few people from the research group were inactive. On the one hand, 'the right for laziness is a sacred right of human being, especially the elderly' [9] and it is highly evaluated by specialists in psychic hygiene. On the other hand, long break from any kind of activities causes different unfavorable after-effects in seniors' intellectual and physical efficiency. The most popular form of activity in the research group was walking. B. Becker and co-authors claim that walking is not only body exercise but also mental exercise. During walking people can meet friends and enjoy their leisure time. Walking ability is an art and every walk is a therapy [11].

Active forms of relaxation in the research group (family and social meeting) reflect seniors' preferences regarding people with whom they spent most of their free time, i.e. family members. Family is most important for elderly people because of their strong emotional bonds and help in difficult life situations [9].

Hobby classes, such as DIY or knitting are examples of active work done in silence, peace and solitude.

Gardening done by people with limited dexterity is an example of free time activity, which can be realized as a pleasant activity, involving and active exercise, free and independent. These can help establish and maintain social contacts with a group of hobbyists with similar interests.

RESULTS

1. The disabled elderly people spend their free time mostly in passive forms making use of mass media, doing religious practices, or just being inactive.
2. The most popular way of active forms of leisure time for seniors are walking, social or family meetings.
3. There is a possibility of using some of free time of elderly people for health-related purposes.
4. In planning health education of disabled patients aged $\geq$ 65, the age diversity, education methodology, WHO recommendations related to seniors' health and individual recipients' needs, should be considered.

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