

---

# The Impact of Community Nursing on Health Behavior and Quality of Life of Elderly Patients with Chronic Diseases

Xiaojun Xu, Xidi Yin\*

Chengnan Street Community Health Service Center, Suzhou 215000, Jiangsu, China

\*Author to whom correspondence should be addressed.

**Copyright:** © 2026 Author(s). This is an open-access article distributed under the terms of the Creative Commons Attribution License (CC BY 4.0), permitting distribution and reproduction in any medium, provided the original work is cited.

---

**Abstract:** *Objective:* To analyze the impact of community nursing on the health behavior and quality of life of elderly patients with chronic diseases. *Methods:* 82 elderly patients with chronic diseases were selected for data analysis in our hospital from April 2024 to March 2025. They were divided into groups by lottery, with 41 patients in each group. The research group applied community nursing, and the control group applied routine nursing. The data between the groups were compared. *Results:* Compared with the control group, the health behavior scores and quality of life scores of the study group were significantly higher after the intervention,  $p < 0.05$ ; compared with the health behavior scores and quality of life scores of the two groups before the intervention,  $p > 0.05$ . *Conclusion:* The application of community nursing to elderly patients with chronic diseases has a positive impact on patients' health behavior and quality of life, can be significantly improved, and is worthy of clinical use and promotion.

**Keywords:** Community nursing; Elderly; Chronic disease; Health behavior; Quality of life

---

**Online publication:** February 26, 2026

## 1. Introduction

The number of elderly patients with chronic diseases has increased dramatically in recent years, including hypertension, diabetes, coronary heart disease, etc. The occurrence of diseases will have a serious impact on the health of the elderly. They are characterized by long course, protracted illness, and multiple complications.

Due to the impact of the disease, patients suffer from organ function damage, their daily activities and mental health are affected, and their quality of life is reduced<sup>[1]</sup>. At the same time, because most patients do not understand the disease and how to regulate self-management, bad health behaviors are common, which accelerates the progression of the disease and increases the medical burden.

If routine care is implemented for patients, continuous health guidance and nursing intervention cannot be carried out for patients after discharge, and the long-term rehabilitation management needs of patients cannot be effectively met<sup>[2]</sup>. Clinical research on community nursing can rely on the community to provide continued care for patients. The

specific content includes personalized health education, medication guidance, dietary intervention, exercise guidance, psychological counseling, etc., and its clinical application value is very high<sup>[3]</sup>. At present, it is gradually being applied to the management of chronic diseases in the elderly. However, there is still a lack of in-depth clinical research on its impact on patients' health behaviors and quality of life. This article selects 82 patients to analyze the impact of community nursing on the health behavior and quality of life of elderly patients with chronic diseases.

## 2. Materials and methods

### 2.1. Information

From April 2024 to March 2025, 82 elderly patients with chronic diseases were selected for data analysis in our hospital and divided into groups by lottery, with 41 patients in each group. There were 21/20 men and women in the study group, aged 61–89 ( $72.65 \pm 5.28$ ) years old, and 22/19 men and women in the control group, aged 62–88 ( $72.64 \pm 5.21$ ) years old. Comparing the two sets of data,  $p > 0.05$  was obtained.

#### 2.1.1. Inclusion criteria

Diagnosed chronic disease with duration of 6 months or more; elderly; good communication skills and good language; informed consent.

#### 2.1.2. Exclusion criteria

severe heart, liver, kidney and other important organ failure; malignant tumors, acute infections, etc.; severe limb dysfunction; severe impairment of vision or hearing.

### 2.2. Method

The control group applies routine care, carries out condition monitoring and basic care for inpatients, provides nursing guidance based on the patient's medication, and provides patient discharge guidance, which includes dietary precautions, medication methods, regular reviews, etc., and can use telephone follow-up every month to understand the patient's condition and provide detailed answers to questions raised by the patient and their family members.

The research team applies community nursing. The specific contents are:

(1) Constructing health files

Construct detailed files to record relevant content, such as disease diagnosis, treatment plan, medication status, etc., and update them regularly to gain a dynamic understanding of the patient's condition.

(2) Health education

Hold a community health lecture once a month, invite experts to explain in detail the pathogenesis of the disease, symptom manifestations, prevention of complications, treatment methods, etc., distribute health education manuals, provide illustrated and one-on-one explanations for patients with low education levels and poor understanding, and carry out personalized health education.

(3) Medication guidance

Community nurses should conduct door-to-door follow-up visits for patients once a week to understand the patient's medication status, carefully check the patient's medication storage and medication records, and ensure that the patient follows the doctor's instructions. The nurse should also explain medication knowledge to the patient and their family members, emphasize precautions, and inform the patient how to store medications correctly. If the patient has poor memory, provide the patient with interventions such as issuing a medication calendar and setting medication reminders.

(4) Dietary intervention

Based on the patient's condition, we work with a nutritionist to help the patient construct a personalized diet

plan. Patients with hypertension are advised to eat low salt and low fat, and their daily salt intake is less than 5 g. Patients with diabetes are advised to eat low sugar and high fiber, reasonably control their total calorie intake, and eat regularly. Patients with coronary heart disease should pay attention to low fat, high protein, and high vitamins in their diet. Nurses should regularly evaluate the patient's diet implementation, and make reasonable adjustments to the patient's diet plan based on changes in the patient's condition and body response.

(5) Exercise guidance

Determine the content of the personalized exercise plan based on the patient's condition. The exercise methods can be walking, Tai Chi, square dancing, jogging, etc., 3–5 times a week, 30–60 minutes each time, and the patient is consciously sweating slightly and has no obvious fatigue. Before exercise, the nurse should instruct the patient to warm up. During the exercise, the nurse should pay close attention to the patient's physical condition. If the patient's exercise ability is weak, the patient's family members should accompany him or he should be guided and supervised by the nurse.

(6) Psychological counseling

Patients are prone to negative emotions due to the impact of the disease. Nurses can communicate with patients by phone or door-to-door, understand the patient's situation during follow-up, and provide emotional counseling. Nurses should encourage patients to express themselves, provide emotional support to patients, and organize patients to participate in community entertainment activities such as calligraphy and painting, chess and card competitions, etc., to relieve patients' anxiety and loneliness, and promote patients' positive attitude.

(7) Regular review and monitoring

Nurses should make a review plan for the patient, remind the patient, monitor blood sugar and blood pressure for the patient, measure the patient's blood pressure 1–2 times a week, record the monitoring results, detect abnormalities in a timely manner, contact clinicians to deal with them, and adjust the care plan based on changes in the patient's condition.

### 2.3. Observation indicators

- (1) Compare the health behavior scores of the two groups. Use the Health Behavior Scale HPL to measure, and a high score indicates positive health behavior.
- (2) Compare the quality-of-life scores of the two groups. Measured using the WHOQOL-BREF quality of life scale, higher scores indicate higher quality.

### 2.4. Statistics

Data calculation was completed with statistical SPSS 28.0 software. Measurement data were described with mean  $\pm$  standard deviation ( $\bar{x} \pm s$ ), *t* test, count data was described with %,  $\chi^2$  test,  $p < 0.05$ , statistically significant.

## 3. Results

Compared with the control group, the health behavior scores and quality of life scores of the study group were significantly higher after the intervention,  $p < 0.05$ ; comparing the health behavior scores and quality of life scores of the two groups before the intervention,  $p > 0.05$ . See **Table 1**.

**Table 1.** Comparison of health behavior scores between the two groups (points)

Group	Self-actualization		Health responsibility		Exercise		Nutritious diet		Interpersonal support		Stress coping	
	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After
Research group (n = 41)	22.36 ± 3.11	31.55 ± 2.88	21.67 ± 3.04	30.25 ± 2.77	20.88 ± 3.22	29.88 ± 2.66	22.14 ± 2.99	31.01 ± 2.55	21.55 ± 3.11	29.66 ± 2.77	20.01 ± 3.02	24.54 ± 2.62
Control group (n = 41)	22.11 ± 3.21	25.67 ± 3.02	21.44 ± 3.11	24.88 ± 2.99	20.68 ± 3.24	23.99 ± 3.11	21.99 ± 3.01	25.33 ± 2.88	21.33 ± 3.14	24.55 ± 3.01	19.36 ± 3.07	21.58 ± 2.94
<i>t</i>	0.3582	9.0221	0.3386	8.4361	0.2804	9.2157	0.2264	9.4549	0.3187	7.9988	0.9665	4.8129
<i>p</i>	> 0.05	< 0.05	> 0.05	< 0.05	> 0.05	< 0.05	> 0.05	< 0.05	> 0.05	< 0.05	> 0.05	< 0.05

**Table 2.** Comparison of quality-of-life scores between the two groups (points)

Group	Social relations field		Physiological field		Psychological realm		Environmental field	
	Before intervention	After intervention	Before intervention	After intervention	Before intervention	After intervention	Before intervention	After intervention
Research group (n = 41)	16.88 ± 2.55	23.55 ± 2.11	15.68 ± 2.44	21.88 ± 2.02	15.22 ± 2.37	20.41 ± 2.18	17.52 ± 2.51	20.41 ± 2.18
Control group (n = 41)	16.77 ± 2.61	19.22 ± 2.44	15.44 ± 2.51	17.88 ± 2.33	15.01 ± 2.41	17.55 ± 2.24	17.65 ± 2.54	17.78 ± 2.47
<i>t</i>	0.1930	8.5950	0.4390	8.3057	0.3978	5.8588	0.2331	5.1117
<i>p</i>	> 0.05	< 0.05	> 0.05	< 0.05	> 0.05	< 0.05	> 0.05	< 0.05

## 4. Discussion

Core topics in the field of public health include long-term management of chronic diseases in the elderly, which is not only related to the individual health of patients, but also to the health level and medical burden of the entire population. If routine care is implemented for elderly patients with chronic diseases, it cannot adapt to the management needs of patients with delayed recovery<sup>[4]</sup>. Therefore, it is proposed to apply community care, which has the characteristics of convenience, sustainability and personalization, and can solve the above problems. This article studies it, and the results suggest that after intervention, the scores of all dimensions of health behavior and quality of life in the research group were significantly higher than those in the control group. Its clinical application meets the long-term management needs of patients and has high clinical application value<sup>[5]</sup>.

The research team significantly improved the scores of each dimension of health behavior because community nursing has multi-dimensional precise intervention and plays a positive role. First, hierarchical health education is carried out in nursing to improve awareness. The main reason for adverse health behaviors in elderly patients is a lack of disease awareness. Community care uses multiple forms, such as regular lectures, personalized one-on-one explanations, graphic manuals, etc., to carry out education based on patients' educational level and understanding ability, systematically transfer knowledge, and emphasize the key points of health management, so as to encourage patients to mentally identify with healthy behaviors and form healthy behavior changes<sup>[6]</sup>. Second, implementing refined medication management for patients can significantly improve compliance. Elderly patients have irregularities in medication due to memory loss and insufficient cognitive medication. Weekly follow-up visits are carried out in the care, medication records are checked,

medication is replenished for patients, medication reminders and medication calendars are adopted, and methods such as medication reminders and medication calendars are used. Detailed explanations of medication knowledge can be organically combined to significantly reduce the risk of medication use for patients and strengthen the healthy behavior of patients with standardized medication use. Third, the implementation of personalized diet and exercise intervention strengthens the practicality of nursing operations. In nursing care, combined with the patient's disease type, physical condition and dietary preferences, we work with nutritionists to formulate an exclusive plan for the patient<sup>[7]</sup>. The dietary taboos are clear, the intensity and frequency of the patient's exercise are clarified, and regular evaluation and adjustment can promote the patient's scientific diet and regular exercise, etc., and comprehensively improve the patient's health behavior.

The comprehensive improvement of patients' quality of life is due to the positive promotion effect of multi-dimensional intervention synergy in community care. At the patient's physiological level, providing patients with standardized medication guidance, regular monitoring of patients' blood pressure and blood glucose, and timely intervention for abnormalities can effectively control the patient's disease progression, significantly reduce the patient's risk of complications, and alleviate the patient's symptoms of dizziness, fatigue, and other discomforts, thus significantly improving the patient's physical comfort and physiological functions. At the patient's psychological level, nurses combine the actual situation of the patient with regular psychological counseling, guide the patient to participate in recreational activities, enrich the patient's spiritual life, help the patient further alleviate negative emotions, promote the patient's positive attitude during treatment, and form a virtuous circle<sup>[8]</sup>. When the patient's psychological condition improves, he or she can actively participate in health management, obtain good disease control effects, and psychological optimization. At the level of patients' social relations, by guiding patients to participate in cultural and recreational activities, a communication platform is established so that patients can share experiences and encourage each other. In addition, community nurses provide continuous care for patients. The distance between nurses and patients will be significantly closer, social support will be strengthened, and the quality of patients' social relationships will be significantly improved<sup>[9]</sup>. At the patient environment level, through convenient re-examination reminders and community monitoring services, patients can reduce their travel for medical treatment. By building dynamic health files and tracking patients' health status in real time, a safe and convenient health management environment is created, and patients' satisfaction with the environment is significantly improved.

What needs to be noted is that community care has continuity, so it achieves ideal application results. Because elderly patients with chronic diseases need long-term health management, a community care model needs to be adopted. Health records can be used as the basis and various interventions carried out by the community, such as regular follow-up and continuous guidance, to ensure the continuity of health management for patients, provide patients with long-term nursing professional support, consolidate patients' healthy behaviors, and continuously improve patients' quality of life. At the same time, providing door-to-door services and community stations for patients can help elderly patients with mobility difficulties, increase participation, and provide guarantee for the comprehensive implementation of community care measures.

In summary, the application of community nursing to elderly patients with chronic diseases has a positive impact on patients' health behavior and quality of life, can be significantly improved, and is worthy of clinical use and promotion.

## About the author

Xu Xiaojun (1990–), female, Han nationality, native of Suzhou, Jiangsu, with a bachelor's degree, is currently a supervisor nurse, and works at the Chengnan Street Community Health Service Center. Her research direction is related to community nursing.

Yin Xidi (1978–), female, Han nationality, native of Suzhou, Jiangsu Province, bachelor's degree, current title of deputy chief nurse, works at the Community Health Service Center of Chengnan Street, Wuzhong District, Suzhou City,

research direction community nursing management.

## Disclosure statement

The authors declare no conflict of interest.

## References

- [1] Wang L, 2025, The Application Effect of Community Nursing Intervention in the Care of Elderly Patients with Chronic Diseases. *Chinese and Foreign Medical Research*, 4(1): 136–138.
- [2] Hu W, 2024, Survey on the Needs and Analysis of Influencing Factors for Elderly Patients with Chronic Diseases in the Community to Participate in Dual-Line Care. *Primary Medicine Forum*, 28(36): 125–127.
- [3] Liu L, Hu W, 2024, Analysis of Community Nursing Needs and Influencing Factors of Elderly Patients with Chronic Diseases. *Fujian Medical Journal*, 46(1): 170–173.
- [4] Zi J, Fu Y, Fan J, 2023, Research Progress on Continuous Care Measures for Elderly Patients with Chronic Diseases in the Community. *Chinese Community Physician*, 39(36): 7–9.
- [5] Zheng H, 2023, Effect of Community Nursing Intervention on Elderly Patients with Chronic Diseases. *Henan Medical Research*, 32(24): 4601–4605.
- [6] Sun X, 2023, Analysis of the Application Effect of the Continuous Care Model in Community Care for Elderly Patients with Chronic Diseases. *Chinese Community Physician*, 39(31): 141–143.
- [7] Sun J, 2023, The Application Effect of Community Nursing Services in the Management of Elderly Patients with Chronic Diseases in the Community. *Chinese Community Physician*, 39(28): 119–121.
- [8] Anonymous, 2023, “Practical Community Nursing” Published: Research on the Application of Community Nursing Intervention in Elderly Patients with Chronic Diseases. *Journal of Interventional Radiology*, 32(7): 730.
- [9] Li Y, 2023, Analysis of the Application Effect of the Family Contract Service Model in Community Care for Elderly Chronic Diseases. *Marriage, Childbirth and Health*, 29(1): 91–93.

### **Publisher’s note**

*Whioce Publishing remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.*