INTEGRATED CARE FOR OLDER PEOPLE

Training package for Frontline Health Workers in South-East Asia Region

Facilitator’s Guide
INTEGRATED CARE FOR OLDER PEOPLE (ICOPE)

Training package for Frontline Health Workers in South-East Asia Region

Facilitator’s Guide
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The world is ageing, and the WHO South-East Asia Region is no exception. Almost all countries in the Region are experiencing rapid growth in the number and proportion of older people. The proportion of people in the Region over the age of 60 is currently more than 10%, which is expected to double over the next three decades. By 2050 the proportion of people in the Region over the age of 80 is expected to triple, from 1% to 3%.

To ensure that all older people in the Region can access quality health care that meets their health needs, countries must develop a health workforce that is appropriately trained, deployed and managed. As highlighted by the WHO Decade of Healthy Ageing and outlined in the Region’s Framework of Healthy Ageing 2018-2022, critical to achieving this objective is the dissemination of appropriate training tools for strengthening the competencies of different categories of health personnel within the health workforce.

All countries have now been oriented on the WHO-Integrated Care for Older People (ICOPE) approach, which will help stakeholders in health and social care understand, design, and implement a person-centred and coordinated model of care. This training package for frontline and community-based health workers encompasses the concept of ICOPE and provides guidance to help them promptly identify possible declines in intrinsic capacity and functional ability, enabling them to address such declines efficiently and with available resources. I urge all stakeholders to use this package to strengthen the capacity of frontline health workers to promote healthy ageing so that together we can achieve the future we want for present and coming generations.

Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia Region
## Acronyms & abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL</td>
<td>basic activity of daily living</td>
</tr>
<tr>
<td>FLHW</td>
<td>frontline health worker</td>
</tr>
<tr>
<td>ICOPE</td>
<td>integrated care for older people</td>
</tr>
<tr>
<td>Mini-Cog</td>
<td>mini cognitive assessment</td>
</tr>
<tr>
<td>MNA</td>
<td>mini-nutritional assessment</td>
</tr>
<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
</tr>
<tr>
<td>PPT</td>
<td>PowerPoint</td>
</tr>
<tr>
<td>SEARO</td>
<td>South-East Asia Regional Office</td>
</tr>
<tr>
<td>TUG test</td>
<td>Timed-up and go test</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
SECTION 1

Introduction
This manual is an instruction guide for facilitators to provide competence-based training to health professionals working as frontline health workers (FLHWs), also known as community health workers or basic health workers, for the integrated care of older people. The training is intended to help them learn and improve upon their skills to screen, assess as well as manage various physical, psychological and social aspects of old-age care in the community as well as in outpatient department (OPD) settings.

Facilitators are required to consult both the Facilitators’ Guide and the Participant’s Manual while training participants through interactive presentations, group discussions, role-plays, etc. The Facilitator’s guide contains detailed training methodologies, the structure of individual training sessions and guidelines for the assessment of participants. The Participant’s Manual contains different modules to assist participants with step-by-step learning of the various aspects of old-age care. Training resources are based on “Integrated Care for Older People: Training package for Frontline Health Workers (Participant’s Manual)” which will be the primary reference material for participants. Facilitators should be conversant with the contents of the Participant’s Manual.

Training objectives

The training module has been designed in a comprehensive manner to provide a holistic approach to short-term human resource development with the focus on FLHWs, who provide care to older people at the grass-roots level of health care facilities. The information on old-age care contained in these modules is meant to be incorporated into the everyday practice of FLHWs. The training package will be useful for the knowledge it imparts to FLHWs as well as for enhancing their skills. The training is expected to improve the approach to issues of old age, and act as a stimulant for the holistic care of older people to ultimately improve their quality of life. The objectives include both knowledge enhancement and skill development.

Knowledge-based objectives

By the end of the training, the participants will be able to:

» Describe the age-related physiological, as well as psychosocial changes in bodily systems as well as in the environment, their clinical implications, and the interventions that are necessary.

» Explain the management of geriatric syndromes, common morbidities, and common issues of old age.

Skill-based objectives

By the end of the training, participants will be able to:

» Perform the screening, assessment and management of age-related declines in intrinsic capacity and functional status.

» Provide preventive, promotive as well as rehabilitative services to older people.

» Provide professional care to the common morbidities of old age, with available resources.
» Provide support to caregivers, as well as manage caregivers’ burdens.
» Provide holistic care to older people with available resources.

Participant’s profiles
This training is intended for FLHWs who deliver health services at the grassroots level. They are known by different names in different member states; for example, they are called health assistants (HAs), auxiliary health workers (AHWs), community medical assistants (CMAs) in Nepal, community health workers (CHWs) in India and public health supervisors (PHSes) in Myanmar.

Facilitator’s profiles
Facilitators should have adequate knowledge and skills in the concerned subjects. They should preferably undergo training as trainers, to be conversant with objectives, methodologies, session plans and various kinds of training material. They should be conversant with the management of issues of older adults in their respective fields. The facilitator should preferably be a health professional (medical officer, nurse) dealing regularly with the care of older people.

Course coordinator
One facilitator will be designated course coordinator, with responsibilities as follows:
» Check the audiovisual system for proper functioning.
» Check availability of all training aids.
» Ensure that sessions are conducted as per schedule.
» Introduce the course.
» Oversee administrative aspects, including the maintenance of records.
» Check for general facilities like running water, washrooms, power back-up, refreshments.
» Check the functioning of all equipment.
» Check the availability of an adequate number/amount of instruments and consumables, including those required for simulation sessions.

Batch size of participants and number of facilitators
The total number of participants should not be more than 20 per batch. The number of facilitators per batch should be at least four.
Training material

The following training material will be provided:

» Integrated Care for Older People: Training package for Frontline Health Workers in South-East Asia Region (Facilitator’s Guide).

» Integrated Care for Older People: Training package for Frontline Health Workers in South-East Asia Region (Participant’s Manual).

» Flash drives containing PowerPoint presentations, digital images, videos of various assessment tests.

» Flip charts.

Table 1: Checklist of equipment and supplies required for the training

<table>
<thead>
<tr>
<th>Material for participants’ folders</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant’s handbook containing the modules for different training sessions</td>
<td></td>
</tr>
<tr>
<td>Participant’s log sheets</td>
<td></td>
</tr>
<tr>
<td>Flash drives containing PowerPoint presentations</td>
<td></td>
</tr>
<tr>
<td>Pen, pencil, eraser, sharpener</td>
<td></td>
</tr>
<tr>
<td>Writing pad</td>
<td></td>
</tr>
<tr>
<td>Agenda for the training programme</td>
<td></td>
</tr>
</tbody>
</table>
### Integrated Care for Older People (ICOPE): Training package for Frontline Health Workers in South-East Asia Region (Facilitator’s Guide)

<table>
<thead>
<tr>
<th>Name tags of participants and facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance sheet for participants and facilitators</td>
</tr>
<tr>
<td>Pens, pencils, A4 size paper, notepads, staplers, punching machine, cello tape, measuring tape</td>
</tr>
<tr>
<td>Laptop, LCD projector, extension cords, projection screen, microphone</td>
</tr>
<tr>
<td>Flip charts and stand, marking pens of various colours, large clips to hold flip chart paper</td>
</tr>
<tr>
<td>Whiteboard, duster, chart papers, tapes for posting papers on boards</td>
</tr>
<tr>
<td>PowerPoint presentations, images for demonstration, flash cards</td>
</tr>
<tr>
<td>Print outs of pre- and post-training knowledge assessment questionnaires, checklists, log sheets</td>
</tr>
</tbody>
</table>

### Material for demonstration sessions

<table>
<thead>
<tr>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standees per group</td>
</tr>
<tr>
<td>Measuring tape</td>
</tr>
<tr>
<td>Stopwatch</td>
</tr>
<tr>
<td>Chair without an armrest</td>
</tr>
</tbody>
</table>
## Training site

The training should be held in a well-equipped hall. Practical sessions should be carried out in a well-equipped OPD. The readiness of a proposed training site should be assessed by a competent person, using the checklist provided below.

### Table 2: Organization of training programme: infrastructure requirement

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Items</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Infrastructure for classroom teaching:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Hall with a minimum seating capacity of 25 (to accommodate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 participants, 4 facilitators and 1 observer)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Seating arrangement preferably U-shaped</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Classroom should be well-lit and ventilated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Lights and fans, or air-conditioner in working condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Audio-visual facilities in the classroom</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Electricity (sockets and extension cords)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Electrical power backup</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Toilet facilities and drinking water supply</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Training aids:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Audio-visual aids with accessories: LCD projector, TV monitor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or projection screen, microphone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Other teaching aids: Staplers, highlighters, stapler pins,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>punching machine, scissors, A4 size plain papers, coloured sticky</td>
<td></td>
</tr>
<tr>
<td></td>
<td>labels, cello tape, whiteboard, marker pens and duster</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Computer facilities: Computer with access to internet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>accessible to participants, printer, photocopier</td>
<td></td>
</tr>
</tbody>
</table>
Duration of clinical training
The total duration of the clinical training will be 3 days. Details of the training schedule and session plans are given in later sections.

Dos and don’ts for facilitators

Do

- Be conversant with the session plan and the training materials prior to start of training
- Ensure that the training site is ready prior to onset of training
- Maintain friendly and supportive environment
- Call participants by their name as much as possible
- Speak clearly and loudly
- Spend enough time with participants so that all their queries can be answered
- Give simple and clear instructions to participants
- Ensure clear visualization of the presentations/demonstrations by all participants
- Encourage participants to interact and be involved in all the sessions
- Strictly adhere to the session plan and the session contents

Don’t

- Make adverse/negative comments on any participant
- Be shy, nervous or worried
- Use one-way teaching without any interaction
- Ignore participant’s queries
- Make presentations without facing the participants, or by avoiding eye contact with them
- Use teaching aids or materials other than the prescribed ones
- Rush through any of the sessions
Training methodologies
Introduction

The training on “Integrated Care for Older People: Training for frontline health workers” involves knowledge development through the Participant’s Manual, interactive presentations and skill enhancement through facilitated group learning activities and clinical sessions. Facilitators should meet daily after all the sessions are over, to review the day’s activities, plan for the next day’s training and to ensure availability of all training materials and teaching aids. All facilitators should agree about each other’s roles and responsibilities, prior to the start of the training.

The training has two primary components

Classroom training

Role play and real case scenarios in the OPD

The second component includes facilitated group learning activities, for which breakout groups should be formed as instructed in Box 1.

Box 1: Formation of breakout groups

<table>
<thead>
<tr>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organize participants into smaller groups during the opening session.</td>
</tr>
<tr>
<td>Each group should not have more than five participants.</td>
</tr>
<tr>
<td>Designate one facilitator to each group.</td>
</tr>
<tr>
<td>Print a list showing the groups to which participants and facilitators have been assigned.</td>
</tr>
<tr>
<td>Display the list in the classroom and clinical stations for all participants to see.</td>
</tr>
<tr>
<td>Instruct participants not to change groups.</td>
</tr>
</tbody>
</table>

Guidelines for conducting classroom training

- Conduct all interactive presentations and the designated breakout facilitated group learning activities in the classroom.
- Start each day’s session in the classroom by reviewing the previous day’s activities, and discussing relevant queries of the participants. Let participants respond to each other’s queries. The facilitator may provide the correct explanation if the participants are not able to do so correctly.
- Review the day’s timetable along with the participants.
For each session

» Follow the instructions for conducting training, as per the corresponding modules given in Section 5 of the facilitator’s guide.

» Present learning objectives at the beginning of each session.

» Use the PowerPoint presentation included in the teaching aids for each module.

» Facilitate group learning activities in the classroom which includes:
  • Role plays
  • Case-based discussions
  • Real patient demonstration.

» At the end of each day, ask participants to summarize the day’s activities and key points.

» Brief participants on the next day’s agenda.

Guidelines for delivering PowerPoint presentations

Purpose: PowerPoint presentations serve as excellent teaching tools that help in the transfer of knowledge with focused content, clear messages and effective visuals. They enhance the learning process by allowing participants to analyse, interpret and interact on topics covered.

1. Familiarize yourself with the contents and sequence of the presentation
2. Refer to the key points for discussion from the corresponding module provided in this manual
3. Know the subject well by reading individual modules and the corresponding information in the participant’s manual, that is relevant to the PowerPoint presentation
4. You may add your own notes to emphasize issues of local importance
5. Rehearse the presentation so that all important points are covered within the time-limit
Delivering the presentation

01. Check the seating arrangement to make sure that slides are clearly visible to participants

02. Introduce yourself, if not already done

03. Speak clearly and ensure that all participants can hear you

04. Inform participants that they are free to ask questions anytime during the presentation, and can do so one at a time by raising their hands

05. Introduce the topic and give an overview of the content of the presentation

06. Face the participants and not the slides, while making presentations

07. You may use a pointer, stick or pencil, to indicate a specific part of the presentation

08. Explain each slide slowly, highlighting the key points and never read from slides

09. Make sure you cover all the information provided in the notes accompanying each slide

10. Maintain the logical order of ideas in the presentation

11. Do not give extra information, except when referring to updated information or relevant national/regional guidelines

12. Make the presentation interactive, by asking participants questions in between slides. This will also allow you to assess their understanding

13. Keep the interactive discussion focused on the topic of the presentation

14. Strictly adhere to the time limit of the presentation

15. Summarize key points at the end of the session

16. Allow time for questions from participants; provide complete answers

17. Thank participants after the presentation
Guidelines for managing a role play

Purpose: Role plays are conducted to give participants an opportunity to practice and improve their knowledge and skills of communication and counselling, in a non-threatening and simulated environment, before performing procedures on clients. Role plays help in changing attitudes of participants towards the problems concerned.

<table>
<thead>
<tr>
<th>Step</th>
<th>Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Check the list of suggested role plays</td>
</tr>
<tr>
<td>02</td>
<td>Identify, or ask participants to volunteer to enact the specified roles</td>
</tr>
<tr>
<td>03</td>
<td>Clearly describe each role to the participants</td>
</tr>
<tr>
<td>04</td>
<td>Brief participants about the background situation and focus of the role play</td>
</tr>
<tr>
<td>05</td>
<td>Encourage adherence to counseling steps given in the checklists, while enacting role plays for counseling</td>
</tr>
<tr>
<td>06</td>
<td>Assign the role of observers to the remaining participants</td>
</tr>
<tr>
<td>07</td>
<td>Observer participants should give feedback at the end</td>
</tr>
<tr>
<td>08</td>
<td>Set a time limit for the role play (approximately 60 min)</td>
</tr>
<tr>
<td>09</td>
<td>Ask participants to speak loudly and clearly</td>
</tr>
<tr>
<td>10</td>
<td>Ensure that the role play remains focused on the given situation</td>
</tr>
<tr>
<td>11</td>
<td>Thank the group after the role play is over</td>
</tr>
<tr>
<td>12</td>
<td>Ask participants (actors) how they felt, while performing the role</td>
</tr>
<tr>
<td>13</td>
<td>After completion of the act, facilitate debriefing by asking observer participants to provide constructive feedback</td>
</tr>
<tr>
<td>14</td>
<td>Provide constructive feedback and necessary improvements for the benefit of the group</td>
</tr>
<tr>
<td>15</td>
<td>Encourage all participants of the group to ask questions</td>
</tr>
<tr>
<td>16</td>
<td>Always ensure complete answers are given</td>
</tr>
</tbody>
</table>
Guidelines for conducting a case-study

Purpose: Case-studies allow participants to thoroughly analyse a situation, or a case that will reveal interesting and useful information, and their attitudes towards the issue depicted in the case study. Case studies are preferably done in small groups to allow everyone to participate, including those who might not speak in a larger group.

Preparation

» Check the suggested case-study and familiarize yourself with the case-study and the issue to be discussed.
» Prepare a slide of the case-study for projection during the session, or have print outs of it/them, for distribution to the groups.

How to conduct case studies?

» Identify groups for discussion of case studies and let each group select their group rapporteur.
» Project the slide of the selected case study describing a familiar problem/situation, or distribute handouts of the case study to small group.
» Include images where appropriate, and show the images along with the case study.
» Allow participants to go through the problem/situation, and discuss the diagnosis and the management of the case and the rationale for the recommendations, with them.
» Assign time for group work (approximately 15 minutes).
» Ask the group rapporteur to present the group’s point of view about the case along with further course of action and its rationale, if appropriate.
» Facilitate the necessary corrections with explanations and ask one member of the group to record the key points on a flip chart.
» Ask one participant to make a final summary of the case and the course of management.
» Encourage all participants to ask questions and give feedback.
Session plan
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00–9:30</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>9:30–10:30</td>
<td>Opening session</td>
<td></td>
</tr>
<tr>
<td>10:30–11:00</td>
<td>Pre-training assessment</td>
<td></td>
</tr>
<tr>
<td>11:00–12:00</td>
<td>Population ageing</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>12:00–13:00</td>
<td>WHO-Integrated Care for Older People (WHO-ICOPE)</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>13.00–14.00</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>14:00–15:00</td>
<td>Functional status of older people</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>15:00–16:00</td>
<td>Age-related changes in older people</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>16:00–17:00</td>
<td>Health promotion and disease prevention in later life</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>17:00–17:30</td>
<td>Wrap-up of Day 1</td>
<td>Course coordinator</td>
</tr>
<tr>
<td>Day 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00–9:30</td>
<td>Welcome: Recap of Day 1 and overview of Day 2</td>
<td>Course coordinator</td>
</tr>
<tr>
<td>9:30–10:00</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>10:00–11:00</td>
<td>Common problems of old age</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>11:00–12:00</td>
<td>Identification and management of common NCDs and complaints of old age</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>12:00–13:00</td>
<td>Identification and management of infections &amp; emergencies</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>13:00–14:00</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>14:00–15:00</td>
<td>Long-term care and caregiver support</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>15:00–16:00</td>
<td>Screening of intrinsic capacity in older people</td>
<td>Role play</td>
</tr>
<tr>
<td>16:00–16:30</td>
<td>Wrap-up of Day 2</td>
<td>Course coordinator</td>
</tr>
<tr>
<td>Time</td>
<td>Session Title</td>
<td>Method</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>9:00–9:30</td>
<td>Welcome</td>
<td>Course coordinator</td>
</tr>
<tr>
<td></td>
<td>Recap of Day 2 and overview of Day 3</td>
<td></td>
</tr>
<tr>
<td>9:30–10:00</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>10:00–11:00</td>
<td>Screening of functional status in older people</td>
<td>Role play</td>
</tr>
<tr>
<td>11:00–12:00</td>
<td>Urinary incontinence in older people &amp; Kegel's exercise</td>
<td>Role play</td>
</tr>
<tr>
<td>12:00–13:00</td>
<td>Post-training assessment</td>
<td>Course coordinator</td>
</tr>
<tr>
<td>13:00–14:00</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>14:00–15:00</td>
<td>Reflections from participants - Current practice, challenges and opportunities</td>
<td>Course coordinator</td>
</tr>
<tr>
<td>17:10–17:30</td>
<td>Closure session</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 4

Conducting the training
<table>
<thead>
<tr>
<th>Time</th>
<th>Session 1: Population ageing</th>
</tr>
</thead>
</table>
| 60 min | ✓ Demography of ageing  
✓ Challenges of population ageing  
✓ Healthy ageing |

**Methodology/Instructions/Activities**
- Show objectives of the session
- Illustrated lecture, discussions
- Summarize the content using PPT (50 min)
- Question-and-answer session (10 min)

**Materials/Resources**
- Markers
- Whiteboard
- PPT

<table>
<thead>
<tr>
<th>Time</th>
<th>Session 2: WHO-Integrated Care for Older People (WHO-ICOPE)</th>
</tr>
</thead>
</table>
| 60 min | ✓ Introduction to intrinsic capacity  
✓ WHO intrinsic capacity screening tool  
✓ WHO ICOPE assessment strategies |

**Methodology/Instructions/Activities**
- Show objectives of the session
- Illustrated lecture, discussions
- Summarize the content using PPT (50 min)
- Question-and-answer session (10 min)

**Materials/Resources**
- Markers
- Whiteboard
- PPT

<table>
<thead>
<tr>
<th>Time</th>
<th>Session 3: Age related changes in older people</th>
</tr>
</thead>
</table>
| 60 min | ✓ Introduction  
✓ Age related physical and physiological changes, their implications and interventions  
✓ Psycho-social changes in the older people, their implications and interventions |

**Methodology/Instructions/Activities**
- Show objectives of the session
- Illustrated lecture, discussions
- Summarize the content using PPT (50 min)
- Question-and-answer session (10 min)

**Materials/Resources**
- Whiteboard
- Marker
- PPT
### Session 4: Functional status assessment of older people

| 60 min | ✓ Introduction to functional status  
 ✓ Concept of basic, instrumental and advanced activities of daily living  
 ✓ Clinical implications of functional status  
 ✓ Commonly used scales for functional assessment and the interpretation of scores | Show objectives of the session  
 Illustrated lecture, discussions  
 » Summarize the content using PPT (50 min)  
 » Question-and-answer session (10 min) | Whiteboard  
 Marker  
 PPT |

### Session 5: Health promotion and disease prevention in later life

| 60 min | Health promotion strategies:  
 ✓ Nutrition  
 ✓ Exercise  
 ✓ Intergenerational engagement  
 ✓ Social support and social interaction  
 Disease prevention strategies:  
 ✓ Vaccination  
 ✓ Prevention of smoking and tobacco chewing  
 ✓ Prevention of alcoholism  
 ✓ Screening for disease prevention  
 ✓ Alarm symptoms and signs for cancer | Show objectives of the session  
 Illustrated lecture, discussions  
 » Summarize the content using PPT (50 min)  
 » Question-and-answer session (10 min) | Whiteboard  
 Marker  
 PPT |

### Session 6: Common problems of old age

| 60 min | » Common problems in older people:  
 ✓ Falls  
 ✓ Dementia  
 ✓ Depression  
 ✓ Incontinence  
 » Assessment and problem management | Show objectives of the session  
 Illustrated lecture, discussions  
 ✓ Summarize the content using PPT (50 min)  
 ✓ Question-and-answer session (10 min) | Whiteboard  
 Marker  
 PPT |
### Session 7: Identification and management of common NCDs and common complaints in older people

| 60 min | Burden of NCDs in geriatric population<br>Common NCDs in older population: <br>✔ Hypertension <br>✔ Diabetes Mellitus <br>✔ COPD <br>✔ Osteoarthritis <br>Common complaints of older people: <br>✔ Sleep issues <br>✔ Constipation <br>✔ Poor oral hygiene | Show objectives of the session<br>**Illustrated lecture, discussions**<br>✔ Summarize the content using PPT (50 min)<br>✔ Question-and-answer session (10 min) | Whiteboard Marker<br>PPT |

### Session 8: Identification and management of common infections and emergencies in older people

| 60 min | ✔ Common infections: UTI, community-acquired pneumonia (CAP) <br>✔ Common emergencies: stroke, myocardial infarction | Show objectives of the session<br>**Illustrated lecture, discussions**<br>✔ Summarize the content using PPT (50 min)<br>✔ Question-and-answer session (10 min) | Whiteboard Marker<br>PPT |

### Session 9: Screening of intrinsic capacities in an older person

| 60 min | Application of WHO-ICOPE screening questionnaire | **Role play and discussions**<br>✔ Divide the participants into proportionate groups (maximum 5 in each) <br>✔ The facilitator assigns the role of an older person to one of the participants. <br>✔ The facilitator assigns the role of assessor to another participant. <br>✔ The remaining participants are the observers. | Flip chart Marker |
The facilitator reveals the scene only to the participant acting as the older person.

All observers and facilitators observe the role play.

The assessor:

- Welcomes the older person to his/her clinic and makes him/her sit on a chair comfortably.
- Carries out preliminary screening with WHO-ICOPE screening tool (refer to Annexure).
- Reveals the conclusion of initial screening to the observers, and tells them that a detailed assessment of the domain of deficit is required.

The facilitator asks the other participants for their comments on the role play.

The facilitator gives his/her feedback.

The facilitator responds to questions and clears doubts of the participants.

The facilitator thanks the actors, as well as the other participants.

---

**Session 10: Assessment of functional status in an older person**

<table>
<thead>
<tr>
<th>60 min</th>
<th>Application of the Katz Index of activity of daily living</th>
<th><strong>Role play and discussions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Divide the participants into proportionate groups (maximum 5 in each)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The facilitator assigns the role of an older person to one of the participants.</td>
</tr>
</tbody>
</table>

Flip chart Marker
The facilitator assigns the role of assessor to another participant.

The remaining participants are the observers.

The facilitator reveals the scene only to the participant acting as the older person.

All the observers and facilitators observe the role play.

The assessor:

- Welcomes the older person to his/her clinic and makes him/her sit on a chair comfortably.

- Carries out functional assessment using the Katz Index of activity of daily living (refer to Annexure).

The facilitator asks the other participants for their comments on the role play.

The facilitator gives his/her feedback.

The facilitator responds to the questions and clears the doubts of the participants.

The facilitator thanks the actors as well as the other participants.

<table>
<thead>
<tr>
<th>Session 11: Kegel’s exercise for urinary incontinence</th>
<th>60 min</th>
<th>Performing Kegel’s exercise for urinary incontinence.</th>
<th>Role play and discussions</th>
<th>Whiteboard Marker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Divide the participants into proportionate groups (maximum 5 in each)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide the case-scenario.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>All participants will perform Kegel’s exercise.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The facilitator gives stepwise instructions to the participants for performing Kegel’s exercise. *(Refer to annexure for details)*

- The facilitator divides the group into couples, and observes the correctness of techniques used between them, to counsel on Kegel’s exercise.
- The facilitator responds to questions and clears the doubts of the participants.
- The facilitator thanks the participants.

**Session 12: Long-term care and caregiver support**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Topics</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 60 min   | ✓ Introduction to long-term care  
✓ Common issues related to older people requiring long-term care  
✓ Stresses related to caregiving  
✓ Support of the caregivers  
✓ Prevention of elder abuse  
✓ Care with empathy | Show objectives of the session  
**Illustrated lecture, discussions**  
» Summarize the contents using PPT (50 min)  
» Question-and-answer session (10 min) | Whiteboard Marker PPT |
Annexure I
Example of opening session (Session length: 60 minutes)

» Welcome participants.

» Display a slide showing the overall objectives of the training. Explain the objectives.

» Self-introduction of facilitators and participants:
  • Explain to the participants that a few minutes will be spent on introduction of facilitators and participants;
  • For the introduction of facilitators and participants, write the following points on a flip chart:
    ▪ Your name and place where you currently work
    ▪ A few words about the organization you work for
    ▪ Nature of your work.
  • You and your co-facilitators should introduce yourselves first, based on the points listed on the flip chart.
  • Ask each participant to introduce himself or herself briefly, based on the same points.

» Inform participants about the ground rules (show as a slide and explain).

» Inform participants about the available facilities (lunchroom, toilets, computers, internet facility etc.)

» Inform them about the reimbursement of expenses, and give them the names of the support staff providing secretarial assistance.

» Display a slide showing the contents of the folder given to the participants and ask them to verify.

» Explain the various parts of the training package.

» Divide participants into smaller groups as per the instructions given in Box 1 for group learning activities.

» Discuss the overall session plan: Show the agenda of the training on a slide (modify session time according to local needs).

» Discuss how to use the participant’s handbook:
  • Ask participants to take out the participant’s handbook from the folder.
  • Display the slide on the structure of a sample module.
  • Explain that each module presents key information to complement the materials in the corresponding chapter. Participants are required to be well-versed with the contents of the chapter, before they attend clinical sessions.
Ground rules for participants

- Adhere to the training schedule according to session plans
- Maintain an attendance record for certification
- Go through the subjects discussed during various sessions at the end of the day, for better understanding and discussion with the facilitator
- Attend all clinical sessions according to the schedule
- Participate in group activities according to the session plan
- Complete the specified number of worksheets during each clinical session, and get them certified by the facilitator
- Ensure and respect the privacy and rights of clients in examination rooms
List participant’s expectations:
- Put up a flip chart with the heading “Expectations”.
- Ask each participant to mention at least one expectation. Note it on the flip chart.
- At the end, discuss how expectations will be addressed during the training.

Display the slide listing dos and don’ts instructions for participants and discuss.

**Do**
- Reach the training venue at least 15 minutes before the session starts each day
- Put your mobile phones in silent mode
- Be familiar with training sessions and training materials provided
- Interact with facilitators as and when required, and get doubts cleared
- Get to know your group members and stay with your allocated group during group activities
- Listen carefully to the instructions given by facilitators for the clinical sessions
- Be respectful of each other and considerate to fellow colleagues

**Don’t**
- Crosstalk among yourselves during teaching sessions
- Use mobile phones, or do anything to distract your colleagues during training sessions
- Hesitate to ask questions
- Make racist or gender-biased comments
- Eat in the classrooms
Examples for the screening and assessment of intrinsic capacities

A. WHO-ICOPE screening questionnaire

<table>
<thead>
<tr>
<th>Priority conditions associated with declines in intrinsic capacity</th>
<th>Test</th>
<th>Assess fully any domain with a checked circle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COGNITIVE DECLINES</strong> (Chapter 4)</td>
<td>1. Remember three words: flower, door rice (for example)</td>
<td>□ Wrong to either question or does not know</td>
</tr>
<tr>
<td></td>
<td>2. Orientation in time and space: What is the full date today? Where are you now (home, clinic, etc.)?</td>
<td>□ cannot recall all three words</td>
</tr>
<tr>
<td></td>
<td>3. Recalls the three words?</td>
<td></td>
</tr>
<tr>
<td><strong>LIMITED MOBILITY</strong> (Chapter 5)</td>
<td>Chair rise test: Rise from chair five times without using arms. Did the person complete five chair rises within 14 seconds?</td>
<td>□ No</td>
</tr>
<tr>
<td><strong>MALNUTRITION</strong> (Chapter 6)</td>
<td>1. Weight loss: Have you unintentionally lost more than 3 kg over the last three months?</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td>2. Appetite loss: Have you experienced loss of appetite?</td>
<td>□ Yes</td>
</tr>
<tr>
<td><strong>VISUAL IMPAIRMENT</strong> (Chapter 7)</td>
<td>Do you have any problems with your eyes: difficulties in seeing far, reading, eye diseases or currently under medical treatment (e.g. diabetes, high blood pressure)?</td>
<td>□ Yes</td>
</tr>
<tr>
<td><strong>HEARING LOSS</strong> (Chapter 8)</td>
<td>Hears whispers (whisper test) or Screening audiometry result is 35 db or less or passes automated app based digit in noise test</td>
<td>□ Fail</td>
</tr>
<tr>
<td><strong>DEPRESSIVE SYMPTOMS</strong> (Chapter 9)</td>
<td>Over the past two weeks, have you been bothered by feeling down, depressed or hopeless? little interest or pleasure in doing things?</td>
<td>□ Yes □ Yes</td>
</tr>
</tbody>
</table>
B. ICOPE-based screening of intrinsic capacities and assessment of functional status

Example of a scene and role play:
The facilitator is to appoint a participant to act as an older person who has been coming to the OPD for periodic follow-ups for diabetes mellitus for the past one year. The person finds it difficult to walk because of some balancing issues, and has a history of a fall in the bathroom, one month ago. He/she also needs help from his/her family members to bathe and use the toilet.

» The assessor will make the following enquiries:

  a) Chief complaint (periodic follow-ups of diabetes mellitus, with recently increased difficulty in walking)
  b) History of geriatric syndromes (history of a fall, one month ago)
  c) Past history (history of stroke, TIA, syncopes, acute coronary syndromes, diabetes mellitus)
  d) Socioeconomic history (occupation/primary caregiver/living condition)
  e) History of addiction (smoking/alcohol/chewing tobacco)
  f) History of treatment/drugs
  g) History of vaccination.

» The assessor will do the general physical examination, including vitals.

» The assessor will carry out screening of the intrinsic capacities, based on WHO intrinsic capacity-screening questionnaire.

» The assessor will inform the participant about positive screening in the locomotor domain.

» The facilitator will inform the participants that a detailed assessment of the locomotor ability will be required, based on ICOPE strategies.

» The assessor will demonstrate screening for functionality (ADL) in the client by using the Katz ADL index, and calculate the total score.
Table 1: Katz Activities of Daily Living (ADL) assessment

<table>
<thead>
<tr>
<th>Activities points (1 or 0)</th>
<th>Independence: 1 point (No supervision, direction or personal assistance)</th>
<th>Dependence: 0 points (With supervision, direction, personal assistance or total care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Bathes self completely, or needs help in bathing only a single part of the body such as the back, genital area or a disabled extremity</td>
<td>Needs help with bathing more than one part of the body and for getting in or out of the tub, or shower</td>
</tr>
<tr>
<td>Dressing</td>
<td>Gets clothes from closets and drawers, puts on clothes and outer garments, complete with fasteners. May have help tying shoelaces</td>
<td>Needs help with dressing self, or needs to be completely dressed</td>
</tr>
<tr>
<td>Toileting</td>
<td>Goes to toilet, gets on and off, arranges clothes, cleans genital area without help</td>
<td>Needs help transferring to the toilet, cleaning self or, uses a bedpan or commode</td>
</tr>
<tr>
<td>Transferring</td>
<td>Moves in and out of bed or chair, unassisted. Mechanical transferring aids are acceptable</td>
<td>Needs help in moving from bed to chair, or requires a complete transfer</td>
</tr>
<tr>
<td>Continence</td>
<td>Exercises complete self-control over urination and defecation</td>
<td>Is partially or totally incontinent/bowel or bladder</td>
</tr>
<tr>
<td>Feeding</td>
<td>Gets food from plate into mouth without help. Preparation of food may be done by another person.</td>
<td>Needs partial or total help with feeding, or requires parenteral feeding.</td>
</tr>
</tbody>
</table>

Total score: 4/6

» The assessor will summarize the findings of the intrinsic capacity and functionality of this individual, to the participants.

» The facilitator will ask the other participants for their comments on the role play.

» The facilitator will give feedback.

» The facilitator will respond to the questions and address doubts of the participants.

» The facilitator will thank the actors, as well as the other participants.

C) Pelvic floor muscle exercises (Kegel’s exercise)- These exercises strengthen the pelvic floor muscles that help control urination.

» Make sure the bladder is empty, then make the older person sit, or lie down.

» Ask the older person to tighten the pelvic floor muscles. The older person must imagine that he/she is trying to stop urine flow, and then tighten (contract) the muscles to stop urinating.

» Hold tight and count from three to five seconds.

» Relax the muscles and count from three to five seconds.

» Repeat 10 times, three times a day (morning, afternoon and night).
Integrated Care for Older People (ICOPE):
Training package for Frontline Health Workers in South-East Asia Region (Facilitator’s Guide)
Annexure II: PowerPoint presentation slides
Talking points

FLHW 1: Population ageing

Slide 1:
In the life process of a human being, birth and growth followed by decline and death are phases that most people experience. The phase of decline and death marks old age for an individual. When a substantial number of people are old in the society, it is termed as population ageing. The current training program is about older persons and their care in the society.

Slide 2:
Ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. As the age advances, gradual decrease in physical and mental capacity occurs. This leads to an increased risk of disease and ultimately death. Beyond biological changes, ageing is also associated with other life transitions such as retirement, relocation to more appropriate housing, and the death of friends and partners.

Slides 3, 4 and 5:
In next three slides, we will discuss global demography of ageing. Read out the slides and explain the figures.
Slides 6 and 7:

The population of older people has been increasing globally as well in the regional levels. Virtually every Member State in the World Health Organization-South East Asia (WHO-SEA) region is experiencing growth in the number and proportion of older people in their population. This graph on the slide shows the estimates and projections of the increase in number of persons aged 60 years or over by development group. All SEAR countries belong to orange and expect huge increase in number in less developed countries. In terms of SEAR demographic, in 2017, 186 million accounted for around 10%, is projected to increase to 477 million accounting for 20%.
Slide 8:

In this slide, four challenges of population ageing will be discussed.

Population ageing poses a spectrum of health-related and socio-economic challenges. Diversity in older age is one of them. There is no ‘typical’ older person. Some 80-year-olds have physical and mental capacities similar to many 20-year-olds. Other people experience significant declines in physical and mental capacities at much younger ages.

Similarly, the diversity seen in older age is not random. A large part arises from people’s physical and social environments and the impact of these environments on their opportunities and health behaviour.

Outdated and ageist attitudes among the stakeholders ranging from the family to the society is one of the important challenges related to population ageing. Older people are often assumed to be frail or dependent, and a burden to society.

Globalization, technological developments (e.g. in transport and communication), urbanization, migration and changing gender norms are influencing the lives of older people in direct and indirect ways.

Slide 9:

In this slide, define healthy ageing.

WHO defines healthy ageing as “the process of developing and maintaining the functional ability that enables well-being in older age.” Functional ability is about having the capabilities that enable all people to be and do what they have reason to value. This includes a person’s ability to meet their basic needs; learn, grow and make decisions; be mobile; build and maintain relationships; and contribute to society.
Slide 10:

In this slide, discuss factors that influence healthy ageing.

Various factors affect healthy ageing. It ranges from the individual factors as well as the environments. Although some of the variations in older people’s health are genetic, much is due to people’s physical and social environments – including their homes, neighborhoods, and communities, as well as their personal characteristics – such as their sex, ethnicity, or socioeconomic status.

These factors start to influence the ageing process at an early stage. The environments that people live in as children – or even as developing fetus – combined with their personal characteristics, have long-term effects on how they age. This is called ‘Life course approach to Healthy Ageing’.

Slide 11:

In this slide, discuss factors that influence health in old age at individual as well as environment level. Discuss in detail with examples.

Slide 12:

The 73rd World Health Assembly had endorsed the proposal for a Decade of Healthy Ageing (2020–2030). On 14th December, 2020, the United Nations General Assembly welcomed the Decade proposal and decided to proclaim 2021–2030 the United Nations Decade of Healthy Ageing.

The United Nations Decade of Healthy Ageing (2021–2030) is an opportunity to bring together governments, civil society, international agencies, professionals, academia, the media, and the private sector for ten years of concerted, catalytic and collaborative action to improve the lives of older people, their families, and the communities in which they live.
Talking points

FLHW 2: Age-related changes in older people

Slide 1:
In the previous session, we have discussed about ageing and healthy ageing at individual level and the challenges of population ageing. In this session we will discuss the changes that take place in the structure and function of the body.

Slide 2:
After the end of this session, the participants will enumerate the structural and functional changes in organ systems, their clinical implications and interventions to ameliorate them.

Slide 3:
Discuss the points in the slide. Normal ageing produces changes in structure and function of organs. Normal changes vary widely among older people and must be differentiated from pathological processes to develop appropriate interventions. Older people and their caregivers often fail to recognize certain symptoms as abnormal. The frontline health workers should promptly recognize the pathological processes contributed by ageing and manage them with the available resources.
Slide 4:

In the subsequent slides, we will discuss the alterations along with their clinical relevance in a systematic manner.

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Slides 5 and 6:

In these two slides, the eye and vision issues are being discussed.

Various changes occurring in eyes and vision with ageing have their related implications. With age, gradual loss of elasticity and transparency of lens occurs which is known as cataract. Similarly, there is decrease in focus on near objects and light adaptation known as presbyopia. Similarly, there is decrease in dark adaptation, decrease in visual field, decrease in color perception/color blindness.

Various interventions related to support vision related changes are necessary in older people. Looking glasses are required for impairment of visual acuity. Artificial Tear drops can help in decrease in lachrymal secretion which results in dry eyes and itching. Fall prevention strategies at home and health facilities are required when impaired night vision can increase the risk of falls.
Interventions

- Presbycusis: Hearing aids can help
- Speak clearly in normal tone of voice.
- Face the older person when talking.
- Build breaks into your conversation with older people.
- Reduce distraction while conversing with the older person
- Advice for routine ear examination.
- Check for impacted cerumen and clean if present or refer to oto-rhino-laryngologist.

Changes in mouth, sense of taste and smell and implications

- Loss of teeth and decrease in mastication strength:
  Difficult and painful chewing
- Taste buds decrease in number and decreased sense of smell:
  Loss of taste of foods
- Saliva production decreases:
  Dry mouth and difficulty in swallowing
- All these changes result in poor appetite, impairment in nutritional status, decreased absorption of nutrients, loss of appetite (anorexia)

Slides 7 and 8:

In these two slides, the hearing issues are being discussed.

Various changes occur in ears and hearing function and have various implications: presbycusis or loss of hearing acuity. Similarly, impacted ear wax occurs as hair fibers in the ear canal become less able to help with earwax removal and protect the canal.

Various interventions are required to reduce the disability related to changes in hearing capacity with age. Hearing aids can help in presbycusis. So, the caregivers should make modifications while communicating with older people. The caregivers should speak clearly in normal tone of voice, face the older person when talking. Similarly, the caregiver should build breaks while speaking with older people and should reduce distraction while conversing with the older person. The health professionals should advice for routine ear examination. Similarly, the health professionals should check for impacted cerumen and clean if present or refer to Ear, Nose and Throat Specialist.

Slides 9 and 10:

In these two slides, the smell, taste and oral health issues are being discussed.

Various ageing related changes occur in mouth, sense of taste and smell. These changes can have profound implications. Difficult and painful chewing occurs due to loss of teeth and decrease in mastication strength.

Loss of taste of foods occurs as taste buds decrease in number and decreased sense of smell with ageing. Dry mouth and difficulty in swallowing is common as saliva production decreases with age. All these changes result in poor appetite, impairment in nutritional status, decreased absorption of nutrients and loss of appetite.
Various interventions should be carried out to improve the overall oral health in older people. The health workers should encourage the use of dentures; encourage extraction of loose teeth; encourage to maintain dental hygiene: brushing at least before sleep; encourage adequate nutritional intake with supplementation, if necessary; encourage the older person to take adequate time for eating and encourage periodic dental checkup.

**Interventions**
- Encourage the use of dentures.
- Encourage extraction of loose teeth.
- Encourage to maintain dental hygiene e.g. brushing at least before sleep
- Encourage adequate nutritional intake with supplementation, if necessary.
- Encourage the older person to take adequate time for eating.
- Encourage periodic dental checkup.

**Implications of changes in gastrointestinal system**
- Difficulty in swallowing (dysphagia)
- Poor appetite
- These changes can lead to malnutrition. Dysphagia can lead to aspiration of food contents into the lungs leading to pneumonia which can be life threatening at times.
- Constipation.

**Slides 11 and 12:**

In these two slides, changes in the digestive system are being discussed. Various changes occur in the gastrointestinal system in older people. Problems related to these are difficulty in swallowing (dysphagia), poor appetite. These changes can lead to malnutrition. Dysphagia can lead to aspiration of food contents into the lungs leading to pneumonia which can be life threatening at times. Similarly, constipation is also an important issue in older people.

The caregivers should encourage the family members to maintain a comfortable, clean and odor-free environment, along with comfortable positioning while feeding; provide meals associated to individual needs, encourage family members to provide love, support and encouragement. For bed bound patients, he/she should be placed in semi-fowler’s position and avoid heavy activity after eating. In order to manage constipation, the caregivers should encourage adequate fluids intake and foods rich in dietary fibers. Sometimes, the use of stool softeners may be required. Digital removal may be needed for fecal impaction.
Slides 13 and 14:

In these two slides, changes in the cardiovascular system are being discussed.

Changes in the cardiovascular system with ageing can have various implications. The age related changes lead to reduced exercise tolerance, fatigue and breathing difficulty; increased risk of syncope (fainting) and pre-syncope; palpitations (abnormal sensation of heartbeats).

Various interventions should be undertaken to minimize the implications of cardiovascular changes with ageing. Permitted level of physical activity should be carried out under supervision. Edema should be prevented or minimized by proper positioning, maintaining fluid balance, ensuring adherence to prescribed dietary regimen. Tight/restrictive clothing should be avoided. Similarly, the patients should be educated regarding the important side effects of drugs like diuretics, antiplatelet, anticoagulant etc.

Slides 15 and 16:

In these two slides, changes in the respiratory system are being discussed.

Various changes occur in the respiratory system with ageing which results in issues like decreased cough reflex effectiveness and decreased deep breathing capacity leads to increase in the risk of aspiration, infection and difficulty in breathing.
In order to minimize the implications resulting from the changes in respiratory system in older people, the health professionals should suggest for maintaining adequate rest and exercise; advice for cessation of smoking and avoiding smokes; ask to prevent from indoor and outdoor pollution. The health professionals should also suggest for vaccination against pneumonia as well as suggest for timely treatment of respiratory infections. Similarly, the older people should be taught deep breathing and coughing exercises as well.

Slides 17 and 18:

In these two slides, changes in the muscles, bones and joints are being discussed.

Various changes occur in muscles, bones and joints in older people. With ageing, there is loss of muscle mass as well as strength with age (sarcopenia), which increases the risk of falls, disability and causes unstable gait and need of assistive devices. Similarly, older people are susceptible to fractures even with trivial trauma, falls from minimal height due to osteoporosis (loss of bone mineral density with age). All these result in decreased self-esteem, dependency in activities of daily living and social withdrawal.

Various interventions are required in older people that minimize the implications of these changes. The older people should be encouraged for possible physical activity to preserve joint mobility and muscle strength. Similarly, the older people should be taught to avoid fatigue through balance of exercise and rest. The health professionals should make the family members aware about the necessity of providing diet rich in calcium and adequately exposing the older family members in direct sunlight exposure for vitamin D. The family members should be made aware of the ways to provide safe environment at home as well as community to prevent trauma and injuries. Similarly, the older people should be encouraged for the use of appropriate assistive devices to promote and maintain balance and mobility.
Slides 19 and 20:

In these two slides, changes in the brain and nerves are being discussed.

There are various implications of changes in nervous system with ageing. Slow coordinated movements and increase in response time can affect balance, gait, agility and can lead to functional status decline. Increased incidence of peripheral neuropathy can affect sleep (due to paraesthesias), balance and mobility as well. Similarly, various changes in the nervous system can lead to increased risk of sleep disorders and delirium during hospitalization.

Various interventions should be carried out to minimize the implications of changes in the nervous system. The health professionals should suggest family members to allow adequate time to carry out activities especially those requiring coordination; encourage family members to provide safe, calm and unhurried environment; work with team to provide appropriate therapies e.g. occupational, speech and physical therapies; assist patient/family/care provider to accept patient’s limitations; encourage self-care and independence.

Teach family members about avoiding sensory overload or sensory deprivation. Every time, the caregivers should encourage the older people for self-care and independence.

Slides 21 and 22:

In these two slides, changes in the kidneys and urinary system are being discussed.

Various changes occur in the renal and genitourinary system with ageing. Impairment of thirst mechanism can lead to dehydration and its complications. Enlargement of the prostate (BEP) can cause urgency, hesitancy and frequency. It can also impact the socio-economic involvement of the older individual. Nocturia can lead to sleep disturbances. BEP can also lead to incontinence in the males. Similarly, weakening of the pelvic floor muscles in females can lead to prolapse, incontinence.
Various interventions are required in older people for maintaining the renal and the genitourinary health. Education about maintaining perineal hygiene is very important. The family members should be taught to provide adequate fluid in daytime and limit fluid at evening. High fiber diet should be provided to prevent constipation. Similarly, the health professionals should refer to appropriate place for surgical correction for genital prolapse.

**Interventions**

- Education about maintaining perineal hygiene.
- Teach family members to provide adequate fluid in daytime and limit fluid at evening.
- Avoid unnecessary use of urinary catheter.
- Provide catheter care adequately and appropriately.
- Maintain cleanliness of bedpan.
- Refer for surgical correction for genital prolapse.
- Provide high fiber diet to prevent constipation
- Educate and instruct for Kegel’s exercise daily.

**Psychosocial changes and implications in old age**

**1. Neuropsychiatric changes:**
- The older individuals take longer to learn new material, but complete learning can still occur at all ages.
- Visual ability is maintained with age.
- Psychomotor speed declines with age.

**2. Cognition and memory:**
- Learning ability is not diminished with age.
- Short-term memory seems to deteriorate with age; long-term memory is preserved.
- Intellectual functioning remains constant over lifetime.
- Reaction time slows with age.

**3. Socio-economic activity:**
- Because of physical illnesses or death of relatives or friends, social interaction might decline with age.
- Retirement from job may also lead to stress, especially when it leads to role-changes in and out of the family, economic problems or a loss of self-esteem.

**Interventions**

- Encourage the younger generation of the family (especially grandchildren) to engage with older family members (grandparents), e.g., intergenerational learning.
- Use older people as consultants and teachers of the culture.
- Teach relaxation techniques to reduce anxiety about memory and enhance attention, rehearsal, motivation and general function.
- Encourage the person to remain active in family and community.
- Avoid sensory overload. Avoid hearing, visual and tactile functions.
- Teach older person to use variety of associative and memory strategies to enhance recall.
- Give person adequate time to recall.
- Allow person to proceed at own pace in learning, making decision or doing task.
- Do not consider slower response, the same as confusion or dementia.
- Recognize and reinforce capabilities.
- Engage person in goal setting and problem solving.
- Provide pleasing environment and opportunity.

**Slides 23 and 24:**

In these two slides, psychological changes are being discussed. With ageing, various neurocognitive and mood related changes can occur in older people. If these changes occur at an unusual level, these can interfere with the normal day-to-day functioning in older people. Depression and dementia are common conditions in older people. The health professionals should be vigilant on the emergence of related symptoms in older people. They should use appropriate ICOPE questionnaires to screen the related disorders and appropriately manage them with the available resources.
Talking points

FLHW 3: Intrinsic capacity in older people

Slide 1:
In previous sessions, we have discussed about ageing and age related changes in structure and function of organ systems in human beings. The results of these changes lie in loss of intrinsic capacity and in functional ability.

Slide 2:
Read out the slide and discuss in detail.

On 1 October 2019, WHO launched ICOPE (Integrated Care for Older People) programme which addresses the pressing need to develop comprehensive community-based approaches that include interventions to prevent declines in intrinsic capacity, foster healthy ageing and support caregivers of the older people.

Slide 3:
Read out the slide and discuss in detail.

Five domains of intrinsic capacity of an older individual can be screened with the help of ICOPE screening questionnaires.

Based on WHO ICOPE screening questionnaire, the health professionals should screen for the losses in intrinsic capacity in the older person and identify the domain of deficit. If the older person has a certain deficit, he/she should be managed with the locally available resources or make an appropriate referral.
Slides 4 and 5:
Read out the slide and discuss in detail about screening and assessment of cognitive capacity.

**Screening for cognitive decline**

Step 1: Ask the older person to remember three words: flower, door, rice (for example)
Step 2: Assess the orientation in time and space by asking:
- What is the full date today?
- Where are you now (home, clinic, etc.)?
Step 3: Ask the older person to recall the three words.

**Interpretation and further action**

A. If the person can recall all the 3 words or answers both of the questions in the orientation test:
   - No cognitive impairment
B. If the person can’t recall all the 3 words:
   - Possible cognitive impairment
   - Action: Further assessment required; refer to a primary care physician for further assessment of cognition
C. If the person is wrong to either question of orientation test or does not know:
   - Possible cognitive impairment
   - Action: Further assessment required; refer to a primary care physician for further assessment of cognition.

Slide 6:
Read out the slide and discuss in detail about locomotor capacity.

**Screening for Locomotor capacity**

- Ask the older person to rise from chair 5 times without using arms?
- Interpretation and further action:
  A. If the person can rise from chair 5 times without using arms:
     - Normal locomotive capacity
  B. If the person can rise from chair 5 times without using arms:
     - Compromised locomotive capacity
     - Refer to a primary care physician for further assessment of locomotive capacity.

Slide 7:
Read out the slide and discuss in detail about vitality and nutrition.

**Screening for vitality/nutrition**

- Enquire about weight loss or loss of appetite:
  - “Have you unintentionally lost more than 3 kg over the last three months?”
  - And,
  - “Have you experienced loss of appetite?”
- Interpretation and further action:
  A. If answer to either of the question is “No”, No further assessment required.
  B. If answer to either of the question is “Yes”, Refer to a primary care physician for further assessment of nutrition.
Slide 8:
Read out the slide and discuss in detail about visual impairment.

Slide 9:
Read out the slide and discuss in detail about hearing impairment.

Slide 10:
Read out the slide and discuss in detail about psychological capacity/depression.
Talking points

FLHW 4: Functional assessment in older people

Slide 1:
In previous sessions, we have discussed about ageing, age-related changes in structure and function of organ systems in human beings; and the resultant loss/decline in intrinsic capacity and functional ability.

Assessment of intrinsic capacity has been discussed in previous session. In this session we will discuss assessment of functional ability.

Slide 2:
In this slide, we will explain the concept of functional assessment, read the contents and discuss.

Slide 3:
In this slide, we will explain and discuss the utility of functional assessment in old-age care.
Slide 4:
In this slide, we will explain and discuss various methods of functional assessment in old-age care.

Slide 5:
In this slide, we will explain and discuss activity of daily living as a reflection of functional assessment. Functional status is to measure the ability of an individual to perform the physical and social tasks necessary for usual activities and roles. The most commonly used measures of functional status evaluate three levels of activities of daily living:

» Basic activities of daily living (BADLs)
» Instrumental activities of daily living (IADLs)
» Advanced activities of daily living (AADLs)

BADLs are self-care activities that are independent of culture and education. IADLs are higher-level activities that individuals must perform to remain independent in their homes. AADLs are dependent on culture, socio-economic status and the past profession, and include recreational, occupational and community activities. AADLs are both personal and optional and can change with time for health reasons or simply because of personal preferences.

Slide 6, 7 and 8:
In these slides, we will explain and discuss the components of BADL and its clinical value.
• Depend on the person’s culture and socioeconomic status
• Provides a basis for considering the type of services necessary for the patient to maintain his/her independence
• Includes:
  - using a telephone,
  - shopping, preparing meals,
  - housekeeping, using public transport,
  - taking medication, handling money
  - nowadays, using technology such as cell phones and computers.

Slide 9, 10 and 11:
In these slides, we will explain and discuss the components of IADL and its clinical value.
A practical approach to collecting information on ADL and IADL consists of administering a pre-visit questionnaire that the patient or caregiver can complete.

These self-administered questionnaires also allow for the identification of those who help when assistance is needed.

While evaluating their functional status, individuals tend to over-report, whereas their family members may under-report their abilities.

A functional assessment can help guide rehabilitation goals and care needs.

**Needs for assessment**

- Functional assessment should be part of the evaluation of a geriatric patient.
- An assessment of the BADLs and IADLs provides an insight into the patient’s abilities and the effects of illness.
- Understanding the baseline function allows one to set appropriate expectations and goals with respect to medical therapy.
- A functional assessment can provide valuable prognostic information to direct the necessary diagnostic evaluation, treatment plans and discussions on goals.

**Contd...**

- Measuring the functional status is an excellent way to follow the progress of a patient with chronic disabilities and acute illness.
- Functional loss is a final common pathway for most clinical problems in older patients, especially after the age of 75.
- Impaired functional status can often be the first sign of disease onset, deconditioning, or inadequate social support. Similarly, ADL impairment is also a risk factor for long-term care, emergency room visits, and death among community-dwelling adults.

- Impairment of ADLs is a stronger predictor of hospital outcomes (functional decline, length of stay, institutionalization and death) than diagnoses at admission and other physiological indices of the burden of illness.
- Functional impairment affects the targets of disease management in older people.
- Impairment of ADLs is also a risk factor for long-term care, emergency room visits and death among community-dwelling adults.

**Slides 12, 13 and 14:**

In these slides, we will explain and discuss the importance of ADL and their assessment. Read the contents and discuss in detail.

Finally, conclude the session with the following paragraph.

Impairment in the domains of BADLs result in inability to independently perform even the basic element of self-care and may indicate a need for supportive services or long-term care; are associated with loss of independence and social role in the community and provide a basis for considering the type of services necessary in maintaining independence. Impaired functional status can often be the first sign of disease onset, deconditioning, or inadequate social support. Similarly, ADL impairment is also a risk factor for long-term, emergency room visits, and death among community-dwelling adults.
Talking points

FLHW 5: Health promotion and disease prevention in old age

Slide 1:
We have discussed the impact of ageing on human health in the previous session. The process of deterioration of intrinsic capacity and functional ability is gradual over years and decades in adult life and does not have a chronological starting point. Thus measures to improve health and prevent disease have to start early and must be pursued continuously.

In this session, we will discuss such measures which can lead to healthy ageing.

Slide 2:
At the end of this session, the participants will be able to enumerate strategies for health promotion and disease prevention for older population.

Learning objectives

- To enumerate strategies for health promotion among older people
- To enumerate strategies for disease prevention in old age.

Slide 3:
In next section, we will discuss various methods of health promotion.
Slides 4, 5 and 6:

In these slides, discuss about nutrition requirement in old age.

Adequate nutrition is one of the important health promotion strategies in older people. Ageing is associated with an increasing incidence of weight loss, being underweight and protein-energy malnutrition. Under-nutrition leads to sarcopenia, frailty, physical dependence and premature death, in addition to impairment of the immune system, an increased risk of infection and poor wound-healing. In general, the requirement for energy declines with age due to a reduction in the body mass, metabolism and physical activity.

Older people are at a higher risk of malnutrition for various reasons. Food is less palatable than before due to changes in taste and smell. Lack of teeth, gum problems and ill-fitting dentures make eating painful. The appetite decreases due to lack of exercise, loneliness, depression, chronic debilitating disease, confusion, forgetfulness, side-effects of drugs, alcohol and smoking.

Slide 7:

Read the slide in detail and discuss screening for vitality and nutrition. The health professionals should screen for vitality/nutrition using the WHO-ICOPE screening questionnaire; refer the older people vulnerable to malnutrition to the primary care physicians for further assessment and offer nutritional/dietary advice to the older person and his/her family members.
Slides 8 and 9:
Read out the slides and discuss in detail with examples.

Dietary advice for older adults
- Healthy diet varies widely depending on the availability and cultural acceptability of foods.
- Most traditional diets are now considered to be close to being ideal, at least for adults and the older adults.
- As vitamin D is necessary not only for bone and muscle health but overall health, the health professionals should advise adequate exposure to the sun.
- Plant proteins are partial proteins; two different partial proteins must be eaten together for complete nutrition, for example, cereals and pulses.

Slides 10, 11 and 12:
Read the slides in detail and discuss WHO recommendations about physical exercise in old age.

Exercise is another important health promotion strategy. Ageing causes a progressive decline in the power, strength and endurance of the skeletal and cardiac musculature. A sedentary lifestyle and lack of physical activity accelerate this decline and are associated with a higher risk of morbidity and mortality. Strong evidence that compared to less active men and women, older adults who are physically active have lower rates of all-cause mortality, coronary heart disease, high blood pressure, stroke, type 2 diabetes, cancer of

Dietary advice for older adults
- Intake of complex carbohydrates and fibres (fruits, vegetables and greens): be increased.
- Intake of salt: limited to not more than half a teaspoon every day.
- Certain foods with antioxidant properties (green, yellow and orange vegetables and fruits, such as carrots, sweet potatoes, spinach, tomato and orange) are recommended.
- Routine prescription of multivitamin supplements: Not indicated for older adults.
- Intake of calcium and vitamin D in the form of milk, curd, cheese, small fish and certain green vegetables should be increased to compensate for osteoporotic changes.
- Vegetarians require vitamin B-12 supplementation.

Health promotion: Exercise
Role of frontline health-care workers in promoting physical activity in older adults:
- The frontline health care workers should encourage the older people to engage in physical activities as per WHO recommendation.

Exercise recommendations: WHO
- Older adults should perform at least 150 minutes of moderate-intensity aerobic physical activity throughout the week or at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week or an equivalent combination of moderate- and vigorous-intensity activity.
- Aerobic activity should be performed in spells of at least 10 minutes' duration.
- Muscle-strengthening activities, involving the major muscle groups, should be done 2 or more days of the week.
- Older adults with poor mobility should perform physical activity to enhance their balance and prevent falls 3 or more days of the week.
- When older adults cannot perform the recommended amounts of physical activity due to their health condition, they should be as physically active as their abilities and conditions allow.
the colon or breast. Higher levels of functional health, and have a lower risk of falling, better cognitive function, and a reduced risk of moderate and severe functional limitations and role limitations. The frontline health workers should encourage the older people to engage in physical activities as per WHO recommendation.

Slide 13:
In this slide, discuss about precaution while carrying out physical exercise.

<table>
<thead>
<tr>
<th>Type of physical activity</th>
<th>Effect and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate intensity</td>
<td>Cause older adults to get warmer, breathe harder and their hearts to beat faster, but they should still be able to carry on a conversation. Examples: brisk walking, tai chi, yoga.</td>
</tr>
<tr>
<td>Vigorous intensity</td>
<td>Cause older adults to sweat more, feel less relaxed and need to cool down, making it more difficult to carry on a conversation. Examples: climbing stairs, running, swimming.</td>
</tr>
<tr>
<td>Strength exercise</td>
<td>Cause older adults to use all the major muscle groups. Examples: carrying or moving heavy loads such as groceries, activities that involve stepping and jumping such as dancing, chair aerobics.</td>
</tr>
<tr>
<td>Improving balance and coordination</td>
<td>Balance tasks such as carrying grocery bags, throwing a frisbee, using chopsticks.</td>
</tr>
</tbody>
</table>

While prescribing physical exercise
- Evaluate the risks of exercise, potential for falls and accidents, and the medication the person is on.
- Physical exercise in old age is limited by reduced maximum exercise capacity, IHD and chronic degenerative diseases of the musculoskeletal system, which reduce exercise tolerance.
- The nutritional adequacy and motivation of the person must also be taken into account.
- Older person must be advised on self-monitoring of the symptoms of ischaemic heart disease (IHD) and must know when to stop if symptoms appear.

Slide 14:
Read out the slide and discuss with examples.

Intergenerational engagement is an important health promotion strategy in older people. The frontline health workers should encourage the older people as well as the family members or community members for intergenerational engagement.

Intergenerational engagement
Role of frontline health workers in intergenerational engagement:
The frontline health workers should encourage the older people as well as the family members or community members for intergenerational engagement. The ways of engagement can be tailored depending upon the societies and cultures.
Few of the examples can be as follows:
- Combination of old age homes with orphanages in the same premises
- Retired teachers voluntarily teaching in the schools, orphanages
- Initiatives from the young where youth/children provide a service for the older people, such as school visits to old people’s homes to serve as volunteers and provide companionship to the older residents
- Sharing of experiences or demonstration of arts/ crafts by the older people with the younger people
- Younger generation teaching techniques to use mobile phones, social platform in smart phones
Slide 15:
Read out the slide and discuss with examples.

Intergenerational engagement, social support and social interactions are other important health promotion strategies in older people. The frontline health workers should also encourage the younger family members to facilitate social interaction for older members of the family.

Slide 16:
In next section, we will discuss about disease prevention strategies for older persons.

Slides 17 and 18:
In these two slides, we will discuss about addictions and their cessation.

Intake of tobacco products in the form of smoking or chewing and excess intake of alcohol have profound negative health implications. These are associated with a spectrum of diseases related to various organ systems. Avoiding tobacco products and alcohol is one of the major disease prevention strategies at all ages. The frontline health worker should encourage older people to quit alcohol, smoking and tobacco-chewing and should also make the family member aware of the expert services in the health facilities which would help in quitting alcohol, smoking or tobacco-chewing.
Slide 19:
Early diagnosis of old age diseases prevents organ damage and complications.
Periodic screening of common diseases is an ideal way early diagnosis. Read out and discuss in detail how the frontline health workers can make the older person as well as the family member aware about the various screening strategies for disease prevention and their availability in the concerned health facilities.

Slide 20:
In this slide, we will discuss cancer detection strategies. Read out and discuss each of the danger symptom of cancer with example.

Slide 21:
Various vaccines are also indicated for older people. The frontline health workers should be aware of the indication of vaccination and also of their availability. Read out and discuss each of the vaccine and its use.
Talking points

FLHW 6: Common complains of old age

Slide 1:
Older people have multiple diseases and disabilities. In view of multiplicity of organ involvement, they have complex way of manifesting. In this session common complaints of older patients will be discussed.

Slide 2:
Some of the problems that accompany old age are common but don’t fall into discrete disease categories. These are also called geriatric syndromes. This slide gives a concept of geriatric syndrome.

Slide 3:
This slide provides a list of geriatric syndromes. They are often the consequence of multiple underlying factors and can’t be attributed to one impairment in a discrete organ system. Geriatric syndromes increase complexity and cost of care; affect mobility, autonomy and independence; impair quality of life and add to burden of care and caregiver stress.
Slide 4:
In this slide, we will discuss about falls in old age. Read out the slide and discuss.

Slide 5:
In this slide, we will discuss about falls in old age. Read out the slide and discuss. Falls are a leading cause of injury and accidental death among older people. Injuries sustained after fall include fractures (hip, spine, and wrist), soft tissue injury and head injury.

Slide 6:
In this slide, we will discuss about the role of front line health workers in fall management using ICOPE screening tool for locomotion capacity.

Slide 7:
In this slide, we will discuss about risk factors of falls. Read out the slide and discuss with examples.
Slide 8:
In this slide, we will discuss about assessment of falls. Read out the slide and discuss with examples about possible causes.

**Assessment of falls**

The frontline health workers should:
1. Ask questions related to falls and balance:
   - Do you feel unsteady when standing or walking?
   - Are you worried about falling?
   - Have you fallen in the past year? (If yes: frequency, any injury)
2. Identify medications that increase the risk of falls. If any, consult with the team and decide about its continuation.
3. Check visual acuity. If there is an issue, refer to primary care physician.
4. Assess feet/footwear that might increase the risk of falls.

Slide 9:
In this slide, we will discuss about prevention of falls. Read out the slide and discuss with examples about universal fall precautions.

**Universal fall precautions**

1. Familiarize the older person with the home or community environment.
2. Maintain bedside light within reach.
3. Ensure that the older person’s personal possessions are within the person’s safe reach.
4. Get sturdy handrails in bathrooms, room, hallway and stairs.
5. Stabilize the legs of the bed.
6. Keep wheelchair wheels in locked position when stationary.
7. Ensure person is in a comfortable, well-fitting footwear on the person.
8. Use night lights or supplemental lighting.
9. Ensure that the floor surfaces are clean and dry.
10. Ensure that all the spills are cleaned up promptly.
11. Ensure that the older person’s spaces are uncluttered.

Slide 10:
In next few slides, we will discuss about dementia or falling cognitive capacity. In this slide discuss the components of manifestations of dementia with examples. Dementia is a chronic or progressive disorder, in which there is deterioration in cognitive functions and the ability to perform everyday activities. The higher mental functions which can be affected in dementia are: memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgment.

**Dementia**

- Deterioration in cognitive functions and the ability to perform everyday activities
- Consciousness is not affected
- Impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behavior, or motivation

Slide 11:
In this slide, discuss the role of frontline health workers in dementia care using ICOPE screening tool for cognition and planning referral.

**Role of frontline health care workers in dementia management**

1. To educate the older person and their family members the difference between normal age-related memory changes and cognitive impairment.
2. Screen for cognitive impairment using the WHO-ICOPE screening questionnaire.
3. Refer to primary care physician if the older person screens positive for cognitive impairment.
4. Teach the family members about ways of communicating with the older people with dementia.
Slide 12:
In this slide, we will discuss about communicating with the older people with dementia. Read out the content and discuss with examples.

Communicating with the older people with dementia
- Always make time for people with dementia and remain patient in every situation.
- Make use of the person’s past experiences and life story to support communicating with them.
- Consider a person’s usual communication skills and background culture.
- Try to keep the environment calm and as quiet as possible when communicating, allowing plenty of time to have conversations.
- Always face the person in conversation and be reassuring in your expressions, tone of voice and words, to reduce frustration.
- To attract attention, call the older person directly with his/her name, gain eye contact and speak directly to them.
- To maintain attention, use appropriate gestures such as gently touching the person’s arm.
- Encourage family members to make use of following verbal techniques.
- Encourage family members to make use of the following non-verbal techniques as well.

Slides 13 and 14:
In these two slides, we will discuss about non-verbal techniques of communicating with the older people with dementia. Read out the content and discuss with examples.

Non-verbal techniques
i. Use short simple sentences: speak slowly and clearly with easy-to-understand sentences.
ii. Repeat sentences or change words with ones with the same meaning if the person does not seem to understand.
iii. Be specific.
iv. Do not say: Don’t you remember?
v. Offer simple choices – closed questions.
vi. Give instructions one step at a time.

Non-verbal techniques
I. Use labels that can be words or pictures.
II. Use signals – touching an arm, pointing to things, body language (smiling, frowning etc.).
III. Listen – use reflection and paraphrasing.
IV. Give time for the person to answer.
V. Reduce distractions.

Slide 15:
In this slide, we will discuss about depression in older persons. This is the most common mental disorder in older population. Mental health problems are under-identified by health-care professionals and older people themselves, and the stigma surrounding these conditions makes people reluctant to seek help. Many older people with depression may complain about somatic symptoms and may be less likely to report the emotional or ideational components of their condition. Common are physical symptoms, such as headaches, fatigue, disturbed sleep, dizziness, chest pain and vague joint or limb pain.

Depression
- Depression is the commonest mental health problem in older people.
- Depression and suicide are two causes of death that are increasing in prevalence even in the older people.
- Depression in later life is a public health problem. If left untreated, it causes considerable distress and disability, affecting the individual, family and society.
Slide 16:

In this slide, we will discuss about role of frontline health worker in depression management in older persons. ICOPE Screening tool for depression can be used for detection and further referral.

Slide 17:

In rest of this session, we will discuss about urinary incontinence.

In this slide, common facts about urine incontinence are discussed. Urinary incontinence is defined as the involuntary loss of urine in sufficient amount or frequency to be a social and/or health problem. It is a common, potentially disabling problem, which is often curable when identified. The prevalence of urinary incontinence is higher among women than men, and increases with ageing and disability. In the community, the prevalence varies from 15–20% above the age of 70 years, and reaches 50% in older adults placed in long-term care facilities. Unfortunately, urinary incontinence is often neglected by the patient as well as the health professionals, leading to under-reporting and under-treatment. Specific and direct questioning on incontinence should be a part of the geriatric screening and history-taking, so that this potentially treatable medical and social problem can be identified.

Slide 18:

In this slide, common risk factors of urine incontinence are discussed. Read out and discuss with examples.
Slide 19:
In this slide, common complications of urine incontinence are discussed. Read out and discuss with examples.

Slide 20:
In this slide, the role of frontline health worker is being discussed. Read out and discuss with examples.

Slide 21:
In this slide, the role of frontline health worker will be to advise behavioral techniques for urinary incontinence. Read out and discuss with examples.

Slide 22:
In this slide, the role of frontline health worker will be to advise Kegel exercise for urinary incontinence. Read out and discuss with examples.

Behavioral techniques for urinary incontinence

- Bladder training: To delay urination after one gets the urge to go; starting with holding off for 10 minutes and prolonging the hold until the time between trips to the toilet reaches every two to four hours.
- Double voiding: Urinating, then waiting a few minutes and trying again.
- Scheduled toilet trips: Urinating every two to four hours rather than waiting for the need.
- Fluid and diet management: Reducing intake of caffeine, acidic foods and liquid consumption especially during evening hours.
- Pelvic floor muscle exercises (Kegel's exercise)

Kegel's exercise steps

These exercises strengthen the pelvic floor muscles that help control urination.
- Make sure the bladder is empty, then make the older person to sit or lie down.
- Ask the older person to tighten the pelvic floor muscles. The older person must imagine that he/she is trying to stop the urine flow and then tighten (contract) the muscles to stop urinating.
- Hold tight and count 3 to 5 seconds.
- Relax the muscles and count 3 to 5 seconds.
- Repeat 10 times, 3 times a day (morning, afternoon, and night).

Complications

Medical repercussions
- Urinary tract infections
- Decubitus ulcers
- Sepsis
- Renal failure
- Increased mortality

Social repercussions
- Loss of self-esteem
- Restriction of social and sexual activities
- Depression
Talking points

FLHW 7: Identification and management of common NCDs of old age

Slide 1:
In previous sessions, we have discussed about health and well-being issues of older people along with the complexity of their manifestations. In this session, we will deal with common noncommunicable diseases and their management.

Slide 2:
After this session, the participants will be able to detect and manage common noncommunicable diseases (NCDs) of old age.

Slide 3:
NCDs are chronic diseases, and are the result of a combination of genetic, physiological, environmental and behavioral factors. The main types of NCDs are cardiovascular diseases (heart attacks and stroke), cancers, chronic respiratory diseases (chronic obstructive pulmonary disease and asthma) and diabetes. NCDs disproportionately affect people in low- and middle-income countries. Older people carry a great burden of diseases and disability. NCDs are common among older people. The important risk factors for NCDs are raised blood pressure, raised cholesterol, use of tobacco, consumption of alcohol, sedentary lifestyle and overweight/obesity.
Slide 4:
In this slide, we will discuss about hypertension or high blood pressure. Hypertension is a serious medical condition and can increase the risk of heart, brain, kidney and other diseases. The burden of hypertension is felt disproportionately in low- and middle-income countries, where two thirds of cases are found, largely due to increased risk factors in those populations in recent decades.

Slide 5:
In this slide, we will discuss the role of frontline health worker in managing hypertension. Read the slide and discuss in detail with example.

Slide 6:
In this slide, we will discuss the role of lifestyle modification for the control of hypertension in management of hypertension. Read the slide and discuss in detail with example.
Slide 7:
In this slide, we will discuss about diabetes. Diabetes mellitus is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar), which leads over time to serious damage to the heart, blood vessels, eyes, kidneys and nerves. Read out the slide and discuss in detail.

Diabetes Mellitus
- Commonest endocrine problem in the older people
- Associated with a huge burden of serious long-term complications, such as retinopathy, nephropathy, neuropathy, vascular complications, foot ulcers and depression.
- Diabetes also raises the risk of dementia.

Slide 8:
In this slide, we will discuss about the role of frontline health care workers in management of diabetes. Read out the slide and discuss in detail.

Role of frontline health care workers in DM management
- Encourage at least one blood sugar measurement annually in every older person for the diagnosis of DM
- Diagnose DM using Glucometer (May send the blood sample to the laboratory, if available)
  - Fasting blood glucose (FBG) level: 126 mg/dl or above on 2 or more occasions
  - Random blood glucose level (RBS): 200 mg/dl or above with
- If FBG is between 100-125 or RBS is between 140-200 mg/dl: Prediabetes
- If the older person is diagnosed with DM, refer him/her to primary care physician for further management.
- If the older person is pre-diabetic or is under medications for the control of DM, provide counselling on changing lifestyle, including diet, physical activity and smoking cessation.

Slide 9:
Joint diseases are as common in older people as hypertension. In this slide, we will discuss about osteoarthritis (OA), which is one of the commonest joint disorders in older people and the commonest cause of chronic pain and functional limitation among older adults living in the community.

Osteoarthritis (OA)
- OA is the most common chronic joint disorder among older adults
- OA of the knee is the most important cause of chronic pain and functional limitation among older adults living in the community.
- Clinical features of OA are
  - Pain
  - Stiffness
  - Bony swelling and crepitus
  - Loss of movement
  - Instability and
  - Loss of function

Slide 10:
In this slide, we will discuss about severity of OA, which may affect quality of life and management plan. Read out the slide and discuss in detail.

Severity of OA
- Patients with mild OA of the knee have low levels of or intermittent knee pain. The joint function and quality of life are relatively well-preserved.
- Patients with moderate to severe OA of the knee have persistent pain, which significantly impairs functionality, participation in activities and the quality of life.
Role of frontline health care workers in OA management

- Offer pharmacological therapy for pain due to OA:
  - Topical NSAIDs generally provide short-term relief from painful symptoms of OA of the knee.
  - Paracetamol remains the drug of choice for the management of OA.
  - It should be used at a dose not exceeding 1 g two to three times daily.

- Offer non-pharmacological therapy for OA in addition to the pharmacological one.

- Refer the older person to a primary care physician/specialist if he/she has moderate to severe OA of the knee/hip that significantly impairs functionality, participation in activities and the quality of life.

Non-pharmacological therapy for OA

- Patients should use a walking stick (cane), held in the contralateral hand (unaffected side), if there is significant impairment of mobility.
- Encourage low-impact aerobic fitness training, e.g. walking and cycling, combined with exercises to strengthen the lower limbs, e.g. for the quadriceps and hamstrings.
- Exercises that have a high impact on the joints, such as running and jumping, are usually discouraged.
- Use commode-type toilets/commode chairs instead of pan-type toilets.
- Avoid sitting/working on the floor with knees flexed.

Slide 11:

In this slide, we will discuss about the role of frontline health care workers in management of OA. Read out the slide and discuss in detail.

Slide 12:

In this slide, we will discuss about the role of pharmacological as well as non-pharmacological therapy including lifestyle modification in OA management. Read out the slide and discuss in detail.
Talking points

FLHW 8: Common complaints of old age

Slide 1:
In addition to common NCDs discussed earlier, older people have multiple complaints which may not be life threatening but have an adverse impact on quality of life.

Slide 2:
Dry skin and pruritus are one of the commonest complaints of old age. The frontline health workers should make the older person as well as the family members on various methods of caring for the skin and relieving pruritus.

Slide 3:
More than half of older men and women complain of at least one sleep problem. Many older people experience insomnia and other sleep difficulties on a regular basis. There are various causes of poor-quality sleep in older people. Read the slide and discuss various aspects of sleeplessness.
**Slide 4:**

Poor sleep habits, chronic medical illnesses, neuropsychiatric illnesses, some kinds of medicines and sleep disorders lead to poor sleep in older people. The frontline health workers should educate the older person as well as the family members about good sleep hygiene. Sleep hygiene refers to actions that tend to improve and maintain good sleep. Read the slide and discuss various aspects of sleep hygiene.

- Sleep as long as necessary to feel rested (usually seven to eight hours for adults) and then get out of bed.
- Maintain a regular sleep schedule, particularly a regular wake-up time in the morning.
- Try not to force sleep.
- Avoid caffeinated beverages after lunch and dinner.
- Avoid alcohol near bedtime (e.g., late afternoon and evening).
- Avoid smoking or other nicotine intake, particularly during the evening.
- Adjust the bedroom environment as needed to decrease stimuli (e.g., reduce ambient light, turn-off the television or radio).
- Avoid prolonged use of light-emitting screens (laptops, tablets, smartphones, e-books) before bedtime.
- Resolve concerns or worries before bedtime.
- Exercise regularly for at least 20 minutes, preferably more than four to five hours prior to bedtime.
- Avoid daytime naps, especially if they are longer than 20 to 30 minutes or occur late in the day.

**Slide 5:**

Constipation is a common complaint in older people. Explain the importance of this symptom on quality of life.

Constipation in the older adult may be due to functional chronic constipation or secondary to other etiologic factors. In addition to age, risk factors for chronic constipation include poor physical inactivity, concurrent medication use and depression.

**Constipation in older people**

- Decrease in stool frequency (less than three bowel movements per week) is defined as constipation.
- Associated with straining, lumpy hard stools and sensation of incomplete evacuation.

**Slide 6:**

In this slide, discuss the medications that cause constipation.

**Medications that can cause constipation**

- Iron supplements, calcium supplements
- Opiates like tramadol, codeine
- Anticholinergic like trihexyphenidyl
- Antidepressants like amitriptyline
- Calcium channel blockers like verapamil
- Pain medications like Aspirin, Ibuprofen
- Diuretics
Slide 7:
In this slide, discuss the role of frontline health workers in addressing constipation in older people. The frontline health workers should educate the older people and their family members about lifestyle modification for reducing the burden of constipation.

Slide 8:
In this slide, discuss the role of life-style modification in addressing constipation in older people. Read the slide and discuss in detail with examples.

Slide 9:
In this slide, discuss the role of medications in addressing constipation in older people. Read the slide and discuss in detail with examples.

Slide 10:
Poor oral hygiene in older people can be a cause for difficulty and painful chewing, difficulty in swallowing and infections in the oral cavity. These problems can lead to malnutrition in older people. Untreated tooth decay, gum disease, tooth loss, oral cancer, bad breath are few of the common issues related to dentition and oral hygiene in older people. Discuss the contents with examples.
Slide 11:

The frontline health workers must educate the older person as well as the family members about the importance of good oral hygiene and make them aware about the measures to follow for good oral hygiene. Discuss the contents with examples.

Role of the frontline health workers

The frontline health workers must educate the older person as well as the family members about the importance of good oral hygiene and make them aware about the following:

- Brush with fluoride containing toothpaste.
- Brush teeth thoroughly twice a day. If twice brushing is not possible, at least once before going to bed.
- Visit dentist at least once a year for review of oral hygiene.
- Do not use any tobacco products.
- Diabetes mellitus should be under control as it may lead to gum diseases.
- Report to the physician if dry mouth occurs after starting of a new medicine.
- If dry mouth cannot be avoided and no direct causes are found, drink plenty of water, chew sugarless gum, and avoid tobacco products and alcohol.
- Report to the health facility if there are sudden changes in taste and smell.
- Any loose tooth needs to be extracted.
Talking points

FLHW 9: Emergency care

Slide 1:
Older persons do have serious and life-threatening health situations as part of overall disease profile. In this session, we will discuss about some major emergencies and infectious diseases which can be life threatening.

Slide 2:
After this session, the participants will be able to identify and guide management of common emergencies among older patients.

Slide 3:
Stroke is the commonest neurological diseases in old age. Discuss the facts about stroke in this slide in detail. Outcome from stroke depended on the speed at which medical attention is accessed.
Slide 4:
In this slide, symptoms of stroke are provided. Discuss each point in detail with examples.

Stroke symptoms
Prompt recognition of stroke symptoms and prompt referral to a specialised centre can result in good outcomes in an older person. Stroke can present in any of the following ways and the frontline health worker should have a very high clinical suspicion of stroke on observing the sudden onset of the following symptoms:
- Numbness or weakness of face, arm or leg, especially on one side of the body
- Confusion, trouble speaking or understanding
- Trouble seeing with one or both eyes
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause.

Slide 5:
Myocardial infarction or heart attack is the commonest cause of death in old age. In this slide, typical symptoms of Myocardial infarction are provided. Discuss each point in detail with examples.

Myocardial infarction (MI)
- MI (commonly understood as heart attack), remain among the commonest life-threatening illnesses in old age, irrespective of socioeconomic status and gender.
Typical symptoms suggestive of an ACS
- Chest pain and/or pain in areas such as the upper arms, back and jaw, lasting longer than 15 minutes
- Chest pain in combination with nausea and vomiting, sweating, breathlessness, and particularly a combination of all these symptoms
- Chest pain in combination with dizziness or feeling light-headed

Atypical symptoms of MI: Common in old age and diabetics
- Older adults may also present with MI without chest pain (silent MI). Chest pain as a presenting symptom occurs in only 40% of patients older than 85 years.
- In patients who present without chest pain, the diagnosis of MI is often missed or delayed, leading to worse outcomes.
- Among older adults, acute-onset dyspnoea, epigastric discomfort, diaphoresis, nausea and vomiting, and syncope may be the symptoms of MI.
- The health worker must be vigilant about both the typical as well as atypical symptoms of MI.
- Prompt recognition of MI symptoms and prompt referral to a specialised centre can result in good outcomes in an older person.

Slide 6:
Often diagnosis of myocardial infarction is missed by caregivers of older patients due to unusual symptoms. In this slide, atypical symptoms of myocardial infarction are provided. Discuss each point in detail with examples.

Slide 7:
Lower respiratory tract infection or pneumonia is the commonest infectious disease in old age. In this slide, some important fact about pneumonia are provided. Discuss each point in detail with examples.

Community acquired pneumonia
- Commonest infectious disease among older adults, causing 50% of all deaths due to respiratory disease.
- The third most frequent cause of the hospitalization of older adults, the first and second being myocardial infarction and stroke.
- Pulmonary infections are the terminal event in patients with other serious or chronic diseases, such as stroke, degenerative neuro-muscular diseases, dementia, congestive heart failure and malignancies.
- One-third of older adults requiring hospitalization die of severe pneumonia.
Slide 8:
In this slide, symptoms of pneumonia are provided. Discuss each point in detail with examples.

Slide 9:
Often, the diagnosis of pneumonia is missed due to unusual symptoms. In this slide atypical symptoms of pneumonia are provided. Discuss each point in detail with examples.

Slide 10:
Urinary tract infection most commonly occurs in old age. In this slide, some important facts about urinary tract infection are provided. Discuss each point in detail with examples.

Slide 11:
In this slide, symptoms of urinary tract infection are provided. Discuss each point in detail with examples.
Talking points

FLHW 10: Long-term care and caregiver support

Slide 1:
As age advances, there is a decline in the physical function, and the person becomes susceptible to both acute and chronic health problems. It makes them frequent user of health care services and becoming a consumer of long-term care. Depending on the type of health condition, long-term care can be both temporary and permanent in nature.

In this session, we will discuss about long-term care in old age.

Slide 2:
After this session, the participants will be able to provide and train family members in long-term care of older patient.

Slide 3:
This slide provides various definitions and concepts of long-term care. Read the slide out and discuss various issues with examples.
Slide 4:
This slide provides various situations where pronged care is required. Read the points in slide out and discuss various issues with examples.

Slide 5:
In this slide, we will discuss the role of front line health workers in long-term care. Read the points in slide out and discuss various issues with examples.

Slide 6:
In subsequent slides, we will discuss common issues in older people receiving long-term care due to limited mobility. Read the points in slide out and discuss various issues with examples.

Slide 7:
In this slide, we will discuss about pruritus in older people receiving long-term care. Read the points in slide out and discuss various issues with examples.
Slide 8:
In this slide, we will discuss about prevention of pressure ulcers or bed sores in older people receiving long-term care. Read the points in slide out and discuss various issues with examples.

Slide 9:
In this slide, we will discuss about role of frontline health workers in pressure ulcer management in older people receiving long-term care. Read the points in slide out and discuss various issues with examples.

Slide 10:
In this slide, we will discuss about various sites that are prone to be pressure ulcer sites. Discuss the importance of various sites of pressure ulcer, shown on the diagram, in life process.

Slide 11:
Loss of weight and muscle mass is a major concern in old age. In this slide, we will discuss about various issues related to sarcopenia or loss of muscle mass.
Slide 12:
In this slide, we will discuss about various strategies to prevent sarcopenia or loss of muscle mass which can be implemented by front line health workers. Read the points in slide and discuss various issues with examples.

Role of FLHWs in prevention of sarcopenia
The health care workers should suggest the following for the prevention of sarcopenia in older people:

• Encourage the older person for increasing the intake of diets rich in proteins.
• A dietician may be involved for designing the meal patterns for meeting this purpose.
• Encourage and involve older person for possible resistance exercises.
• A physiotherapist may be involved for training the older person as well as the caregiver for this purpose.

Slide 13:
Loss of bone mass or osteoporosis, falls and fractures are common in older persons especially older women. In this slide we will discuss about various strategies to prevent these conditions.

Prevention of osteoporosis, fall and associated complications
• Osteoporosis is a significant problem among older adults, with a significantly high prevalence among older people requiring long-term care.
• Fractures, even resulting from trivial injury/falls, are the main burden associated with osteoporosis.

Role of FLHWs for the prevention of osteoporosis and falls in older people
• Make the older people (especially residing in higher latitudes) to sit in the daytime sun with light clothing for a period of 30 minutes to 1 hour. This will help them in generating Vitamin-D in their body with the help of sunlight.
• The caregivers should discuss with the primary care physicians about the possible deficiency of Vitamin-D in the older person as well the possibility of osteoporosis.
• Encourage older people to increase dietary intake of calcium available in dairy products.
• Advise caregivers to follow fall prevention strategies. (Already discussed in the presentation on geriatric syndromes)

Slide 14:
In this slide, we will discuss about various strategies to prevent osteoporosis, falls and fractures which can be implemented by frontline health workers. Read the points in slide and discuss various issues with examples.

Slide 15:
Fall in blood pressure on standing up or postural hypotension is an important drug side effect as well as indicator of cardiovascular dysfunction in older persons. In this slide, we will discuss about various strategies to prevent these conditions.

Prevention of postural hypotension
• Persistent confinement in the bed may lead to various cardiovascular complications such as postural hypotension.
• Postural hypotension is one of the common causes for falls in older people.
• Orthostatic hypotension = A decline of ≥20mm Hg in systolic or ≥10 mm Hg in diastolic blood pressure after 3 minutes of standing from supine position.
Slide 16:
In this slide, we will discuss about various strategies to prevent postural hypotension which can be implemented by frontline health workers. Read the points in slide and discuss various issues with examples.

The frontline health workers should suggest the following to the caregivers for the prevention of postural hypotension in older people:

- The caregivers should be vigilant for the symptoms of postural hypotension like light-headedness, weakness or tiredness, blurring of vision. These can happen especially while changing positions like waking up from supine position, getting out of the bed, standing from a chair.
- The caregivers should consult the health workers if such symptoms are often present.
- Older people with postural hypotension symptoms should be asked to avoid overeating.
- Alcohol should be avoided.
- Adequate hydration must be encouraged (around 5-6 glasses of water per day or depending on the morbidities of the person).
- Encourage physical activity as tolerated. Regular cardiovascular and strengthening exercises can help reduce the symptoms of postural hypotension.
- The older person prone for postural hypotension should move slowly from supine to standing position. Also, when getting out of bed, sit on the edge of the bed for a minute before standing.

Slide 17:
Clotting of blood in lower limbs or deep vein thrombosis can be life threatening as a piece of clot can get dislodged and reach the lungs (pulmonary embolism) in older persons. In this slide, we will discuss about various strategies to detect these conditions.

Prompt recognition of deep vein thrombosis (DVT) and pulmonary embolism (PE):

- DVT and resultant PE can be life threatening at times.
- Immobility is one of the potential causes for DVT.
- The frontline health workers should make the caregivers aware about the symptoms of DVT and PE and urge them to seek medical attention immediately on observing the symptoms.

DVT can cause the following symptoms in the involved limb:

- Swelling
- Pain
- Warmth and redness

Blood clots in the lungs (pulmonary embolism) can cause the following:

- Panting, shortness of breath, or trouble breathing
- Sharp, knife-like chest pain when the person breathes in or strains
- Coughing or coughing up blood

Slide 18:
In this slide, we will discuss the symptoms of deep vein thrombosis. Read the points in slide and discuss various issues with the enclosed figures.

Slide 19:
In this slide, we will discuss the symptoms of pulmonary embolism. Read the points in slide and discuss with examples.
Prevention of aspiration in older people

- Aspiration of food/gastric contents can be potentially serious.
- It can lead to life threatening pneumonia in older people.
- Older people are prone to aspiration of feed/gastric contents owing to various neurological as well as age-related issues.
- The frontline health workers should make the caregivers aware of the various methods to prevent the occurrence of aspiration while hand-feeding or while tube feeding.

Prevention of aspiration during hand-feeding

- Provide a 30-minute rest period prior to feeding time; a rested person will likely have less difficulty swallowing.
- Sit the person upright in a chair; if confined to bed, elevate the backrest to a 90-degree angle.
- Adjust rate of feeding and size of bites to the person’s tolerance; avoid rushed or forced feeding.
- Alternate solid and liquid boluses.
- Vary placement of food in the person’s mouth according to the type of deficit. For example, food may be placed on the right side of the mouth if left facial weakness is present.
- Determine the food viscosity that is best tolerated by the individual. For example, some persons swallow thickened liquids more easily than thin liquids. Increasing food viscosity greatly improves swallowing in neurological patients.

Prevention of aspiration during tube feeding

- Keep the bed’s backrest elevated to at least 30 degrees during feedings.
- Be vigilant for symptoms like nausea, abdominal pain.
- These are indicative of slowed gastric emptying that may, in turn, increase the probability for regurgitation and aspiration of gastric contents.

Caregiver stress syndrome

- Long-term care of a frail and physically dependent older person leads to a variety of physical, emotional, social and financial stress for the caregiver, which is termed as ‘caregiver burden’.
- Caregiver syndrome or caregiver stress is a condition that strongly manifests exhaustion, anger, rage, or guilt resulting from unrelieved caring for a chronically ill.
- It is acute when caring for an individual with behavioral difficulties, such as: fecal incontinence, memory issues, sleep problems, wandering, and aggression.
- Common-symptoms include fatigue, insomnia and stomach aches.
- It is also associated with other issues like depression, anxiety and anger.
- Chronic stress can lead to hypertension as well as diabetes mellitus.
- Has a negative impact on the quality of care.
- It can also give rise to abuse of the care-recipient.
Role of frontline health workers in addressing caregiver stress syndrome

- The health workers should be aware of the possible caregiver stress and caregiver burden in family members providing chronic care for older people.
- The health workers should take the following aspects into consideration while assessing the burden of the caregivers:
  - Capability of the older person in self-caring; ADL and IADL in-dependency
  - Type of care required by the older person (bedding, dressing, bathing, and toileting)
  - Amount of extra time the caregiver needs to spend in caring for the older person
  - Arrangements for rest and relaxation for the caregiver
  - Resources and support systems available for the caregiver
- The health workers should have a high index of suspicion of mental health issues in chronic caregivers and redirect them to available services.

Slide 24:

In this slide, we will discuss about various strategies to prevent Caregiver stress syndrome which can be implemented by frontline health workers. Read the points in slide and discuss various issues with examples.