INTEGRATED CARE FOR OLDER PEOPLE

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

Participant’s Manual
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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.
Preface

Frontline health workers (FLHWs), also known as community health workers or basic health workers, are those who take health services directly to the grassroots level in communities where access to health services is often limited. They are the key players in implementing universal health coverage. They are the peripheral health workers of the government, and provide services in clinic and outreach settings in Member States of the WHO South-East Asia (SEA) Region.

Demographic ageing has posed various unanticipated challenges to health-care systems and services. With ageing, the physical and mental capacities (intrinsic capacities) of an individual decline. Trained FLHWs can detect such declines in intrinsic capacity, and deliver effective interventions to prevent and delay progression, if they are provided with the required knowledge and skills. FLHWs can not only act as an essential link to health facilities by bringing services to older people’s doorsteps, but also be a lifeline for them.

By virtue of this training, FLHWs are expected to be competent to handle various responsibilities. These include conducting regular health surveys of families (including older people), maintaining files and records, spreading awareness on health and nutrition, screening noncommunicable diseases (NCDs) in older people, assessing their intrinsic capacities at their doorsteps and, integrating services between homes and health service or wellness centres. FLHWs should also be able to guide and facilitate the process of temporary rehabilitation and the early discovery of functional impairment.

The training is intended to teach FLHWs to improve their skills in screening, assessing and managing various physical, psychological as well as social aspects of old-age care in the community, as well as in the outpatient department (OPD) settings.
Acronyms and abbreviations

ADL : activity of daily living
FLHW : frontline health worker
ICOPE : integrated care for older people
MINI-COG : mini-cognitive assessment
MNA : mini-nutritional assessment
NCD : noncommunicable disease
SEARO : South-East Asia Regional Office
TUG test : timed-up and go test
WHO : World Health Organization
Population ageing

As age advances, a 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. In developing a public-health response to ageing, it is important to not just consider approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth.

Demography of population ageing

The population of older people has been increasing globally as well at the regional level. Virtually every Member State of the World Health Organization’s South-East Asia (SEA) Region is experiencing growth in the numbers and proportions of older people among their populations.

Table 1: Trend of population ageing at global and regional level

<table>
<thead>
<tr>
<th>Year</th>
<th>Global estimate of 60-plus population</th>
<th>WHO SEA regional estimate of 60-plus population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>959 million</td>
<td>187 million</td>
</tr>
<tr>
<td>2030</td>
<td>1407 million</td>
<td>293 million</td>
</tr>
<tr>
<td>2050</td>
<td>2080 million</td>
<td>487 million</td>
</tr>
</tbody>
</table>


What is healthy ageing?

Healthy ageing is the process of developing and maintaining the functional ability that enables well-being at an older age. Functional ability is about having capabilities that enable all people to be and do what they have reason to value.

Factors promoting healthy ageing

1. 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 and communities, as well as their personal characteristics – such as their gender, ethnicity or socioeconomic status. These factors start to influence the ageing process right from an early age.
2. Maintaining healthy behaviour throughout life, particularly eating a balanced diet, engaging in regular physical activity and refraining from tobacco use, all contribute to reducing the risk of noncommunicable diseases (NCDs) and improving physical and mental capacity.

3. Supportive environments enable people to do what is important to them, despite losses in capacity. The availability of safe and accessible public buildings and transport, and environments that are easy to walk around, are examples of supportive environments.
Age-related changes in older people
Learning objectives

» To enumerate age-related physical and functional changes in old age.
» To enumerate the clinical implications and interventions of age-related problems.

Introduction

» Normal ageing produces changes in the 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.
» FLHWs should promptly recognize the pathological processes contributed by ageing and manage them with the available resources.

Physical and functional changes in old age and Interventions to address them

Changes in eyes and vision

- Cataract due to gradual loss of transparency of lens
- Decrease in colour and depth perception
- Decrease in vision due to macular degeneration
- Dry eyes due to decline in tear production

Interventions

- Referral for cataract surgery
- Referral for eye testing for appropriate spectacles
- Magnifying glasses for older people with impairment of visual acuity
- Artificial teardrops can help for dry eyes and pruritus
Changes in the ears and hearing function

- Age-related hearing loss
- Impacted ear wax

Interventions

- Referral for hearing testing for hearing aids prescription
- Referral for routine ear examination and removal of impacted wax if present

Changes in the mouth, sense of taste and smell

- Loss of teeth and decrease in mastication strength: Difficult and painful chewing
- Decrease in the number of taste buds and sense of smell: Loss of taste of food
- 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)

Interventions

- Encourage the use of dentures
- Encourage the extraction of loose teeth
- Encourage the improvement of dental hygiene, e.g. brushing at least before going to bed
- Encourage periodic dental check-ups
Changes in the gastrointestinal system

Difficulty in swallowing (dysphagia) leading to aspiration of food contents into the lungs and lead to aspiration pneumonia

Poor appetite

Malnutrition

Interventions

Encourage family members to comfortable positioning, while feeding

Advise constipation management with intake of adequate fluids and foods rich in fibres and physical activity. Sometimes, the use of stool softeners may be required
Changes in the cardiovascular system

- Reduced exercise tolerance, fatigue and breathing difficulty
- Increase in risk of high blood pressure, and fainting

Interventions

- Educate on regular checkup of blood pressure, blood sugar and blood lipids and their treatment if detected
- Educate on the important adverse effects of cardiovascular drugs: antihypertensives, antiplatelets, anticoagulants, etc.
- Educate on regular exercise and salt and fat restricted diet

Changes in the respiratory system

- Decreased cough reflex effectiveness, and deep breathing capacity
- Increase in the risk of aspiration, infection and difficulty in breathing

Interventions

- Advice on cessation of smoking
- Ask to prevent indoor pollution, and protect against outdoor pollution
- Suggest influenza and pneumonia vaccination
### Changes in muscles, bones and joints

- **Increased risk of falls, disability and unstable gait**
- **Impaired mobility due to painful joint disease**
- **Increased susceptibility to fractures, even with trivial trauma**
- **Decreased self-esteem, dependency in activities of daily living, social withdrawal**

### Interventions

- Encourage older people to indulge in manageable physical activity
- Encourage family members to provide a diet rich in dairy products (calcium)
- Encourage older people to ensure direct exposure to sunlight for vitamin-D
- Teach family members ways to provide a safe environment at home, as well as create similar awareness in the community, to prevent trauma and injuries
- Advise referral for appropriate physical and occupational therapies
- Encourage the use of appropriate assistive technology to promote balance and mobility
Changes in the nervous system

- Increased risk of sleep disorders and delirium, during hospitalization
- Increased incidence of peripheral neuropathy. It may cause pain, sense of imbalance and affect mobility as well

Interventions

- Suggest to family members to allow adequate time to carry out activities, especially those requiring coordination
- Encourage family members to provide a safe, calm and unhurried environment
- Advise referral for appropriate therapies e.g. occupational, speech and physical therapies
- Encourage self-care and independence
Changes in genito-urinary system

Impairment of the thirst mechanism can lead to dehydration

Enlargement of the prostate can cause urgency, hesitancy and frequency. It can also impact the socioeconomic interactions of the older individual. Nocturia can lead to sleep disturbances. It can also lead to incontinence in males

Weakening of the pelvic floor muscles in females can lead to prolapse, incontinence

Interventions

Education about maintaining perineal hygiene

Teach family members to provide adequate fluids in the daytime, and less fluids after evening

Refer for surgical correction for genital prolapse

Provide a high-fibre diet to prevent constipation

Educate and instruct in the daily practice of Kegel’s exercise (details in Module 4)
Psychosocial changes in old age

» Older individuals take longer to learn, but complete learning can still occur in old age.

» Verbal ability is maintained with age.

» Individual’s ability to detect and respond to changes in the environment, such as the presence of a stimulus, declines with age.

» Short-term memory seems to weaken but long-term memory is preserved.

» Decline in social interaction occurs due to physical illnesses; sensory decline or depressed mood.

» Retirement may also lead to economic distress, changes roles, and loss of self-esteem.

Interventions

» Screen memory as well as mood for depression by means of the WHO-ICOPE screening questionnaire. (Refer to Module 2 for details).

» Teach family members about the prevention and early symptoms of cognitive decline and depression.
Intrinsic capacity and functional status of older people
Learning objectives

» To enumerate the concept of ICOPE.
» To demonstrate skills to measure intrinsic capacity in older people.
» To enumerate the concept of functional status in older people and ways to measure it.

Introduction to intrinsic capacity

WHO defines intrinsic capacity as a combination of the individual’s physical and mental, including psychological, capacities. On 1 October 2019, WHO launched the ICOPE (Integrated Care for Older People) programme to address 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 older people. The WHO Intrinsic capacity screening tool consists of certain assessment techniques that measure intrinsic capacity in an older individual.

WHO intrinsic capacity screening

The various domains of intrinsic capacity (locomotion, vitality, cognition, sensory impairment and mood) of an older individual can be screened with the help of ICOPE screening questionnaires.

5 key domains of intrinsic capacity

- Cognitive capacity
- Locomotor capacity
- Psychological capacity
- Sensory capacity
- Vitality/nutrition
Screening for cognitive decline

Step 1: Ask the older person to remember three words: flower, door, rice (for example).

Step 2: Assess 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. Patient can recall all the 3 words or answers both of the questions in the orientation test:
     - No cognitive impairment.
  B. Patient can’t recall all the 3 words:
     - Possible cognitive impairment.
     - Action: Further assessment required; refer to a primary care physician for detailed assessment of cognition.
  C. Patient answers either question of the orientation test incorrectly, or does not know.
     - Possible cognitive impairment.
     - Action: Further assessment required; refer to a primary care physician for detailed assessment of cognition.

Screening for locomotor capacity

- Ask the older person to rise from a chair five times, without using his/her arms against a timer.
- Interpretation and further action:
  A. If the person can rise from a chair five times without using arms within 14 seconds:
     - Normal locomotor capacity.
  B. If the person cannot rise from chair five times without using arms within 14 seconds:
     - Compromised locomotive capacity.
     - Refer to a primary care physician for further assessment of locomotive capacity.
### WHO ICOPE SCREENING TOOL

<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>
</table>
| **COGNITIVE DECLINES** (Chapter 4) | 1. Remember three words: flower, door rice (for example)  
2. Orientation in time and space: What is the full date today? Where are you now (home, clinic, etc.)?  
3. Recalls the three words? | Wrong to either question or does not know  
cannot recall all three words |
| **LIMITED MOBILITY** (Chapter 5) | Chair rise test: Rise from chair five times without using arms. Did the person complete five chair rises within 14 seconds? | No |
| **MALNUTRITION** (Chapter 6) | 1. Weight loss: Have you unintentionally lost more than 3 kg over the last three months?  
2. Appetite loss: Have you experienced loss of appetite? | Yes  
Yes |
| **VISUAL IMPAIRMENT** (Chapter 7) | 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)? | Yes |
| **HEARING LOSS** (Chapter 8) | Hears whispers (whisper test) or Screening audiometry result is 35 db or less or passes automated app based digit in noise test | Fail |
| **DEPRESSIVE SYMPTOMS** (Chapter 9) | Over the past two weeks, have you been bothered by  
- feeling down, depressed or hopeless?  
- little interest or pleasure in doing things? | Yes  
Yes |

**Figure 1:** WHO intrinsic capacity screening questionnaire
Screening for vitality/nutrition

» Enquire about weight loss or loss of appetite:
  • Have you unintentionally lost more than three kilograms over the last three months?
  • Have you experienced loss of appetite?

> Interpretation and further action:
  A. If the answer to either question is “no”: no further assessment required.
  B. If the answer to either question is “yes”: refer to a primary care physician for further assessment of nutrition.

Screening for visual assessment

» Ask the older person:
  A. Do you have any problems with your eyes: difficulties in seeing distant objects or in reading, or eye diseases?
  B. Are you currently under medical treatment (e.g. for diabetes, high blood pressure)?

> Interpretation and further action:
  A. If the answer to either question is “no”: no further assessment required.
  B. If the answer to either question is “yes”: refer to a primary care physician for further assessment of visual impairment.

Screening for hearing impairment

» Perform a whisper test to screen for hearing in both ears.

> Interpretation and further action:
  A. If the person passes the whisper test in both ears: no further assessment required.
  B. If the person fails, the whisper test in either of the ears: refer to a primary care physician for further assessment of hearing loss.

Screening for psychological capacity/depression

» Ask the older person:

» Over the past two weeks, have you been bothered by:
  A. Feeling down, depressed or hopeless? Or,
  B. Having little interest or pleasure in doing things?
» Interpretation and further action:
  ✓ If answer to either question is “no”: no further assessment required.
  ✓ If answer to either question is “yes”: depression is likely; refer to a primary care physician for further assessment of depression.

**Introduction to functional ability**

Functional status is a measure of the ability of an individual to perform the physical and social tasks necessary for routine activities and roles.

The 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)

**Basic activities of daily living (BADL):** These are self-care activities that are independent of culture and education and include bathing, dressing, going to the toilet, transferring (moving from place to place), continence and feeding.

**Instrumental activities of daily living (IADL):** IADLs are higher-level activities that individuals must perform to remain independent in their homes. These include using a telephone, shopping, preparing meals, housekeeping, cleaning clothes, using public transport, taking medication, handling money and (nowadays) the ability to use technology (e.g. mobile phones, email and the Internet).

**Advanced activities of daily living (AADL):** AADLs are dependent on culture, socio-economic status and past professions 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: engaging in an occupation, participating in religious activities, etc.

**Implications of functional impairment**

» Impairment in the domain of BADL results in the inability to perform even the basic element of self-care independently, and may indicate a need for supportive services, or long-term care.

» Impairment in IADL is associated with the loss of a social role in the community, and provide a basis for considering services necessary to maintain independence.

» Impaired functional status can often be the first sign of disease onset, deconditioning, or inadequate social support.
BADL impairment is also a risk factor for long-term care, emergency room visits, and death among community-dwelling adults.

**Assessment of functional status**

The most commonly assessed domain is BADL. The following scale is commonly used for the assessment of BADL.

**Katz index of activities of daily living**

**Instructions:**

- Choose the scoring point for the statement that most closely corresponds to the patient’s current level of ability for each of the following six items.
- Record actual, not potential functioning.
- Information can be obtained from the patient’s self-report, from a separate party who is familiar with the patient’s abilities (such as a relative), or from observation.

**Interpretation:**

- The lower the score, the higher is the disability, which is proportional to the amount of care required by the older person.
- The lower the pre-morbid score, the poorer are the outcomes of the older person.

**Table 2: Katz index of activities of daily living**

<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><strong>Bathing</strong></td>
<td>Bathes self completely or needs help in bathing only a single part of the body, such as the back, genital area or disabled extremity</td>
<td>Needs help with bathing more than one part of the body, getting in or out of the tub or shower</td>
</tr>
<tr>
<td><strong>Dressing</strong></td>
<td>Gets clothes from closets and drawers and puts on clothes and outer garments, complete with fasteners. May have help tying shoe</td>
<td>Needs help with dressing self, or needs to be completely dressed</td>
</tr>
<tr>
<td><strong>Toileting</strong></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 bedpan or commode</td>
</tr>
<tr>
<td>Activities</td>
<td>independence: 1 point (no supervision, direction or personal assistance)</td>
<td>dependence: 0 points (with supervision, direction, personal assistance or total care)</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Transferring</td>
<td>Moves in and out of bed or chair unassisted. Mechanical transferring aides 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 of 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>

After the assessment of BADL, the older person must be referred to the primary care physician for further assessment.
Health promotion and disease prevention in later life
Learning objectives

» To enumerate the strategies for health promotion in older people.
» To enumerate the strategies for disease prevention older people.

Introduction

The rate of decline of intrinsic capacities and functional ability is largely determined by individual factors related to adult lifestyles, which can be potentially slowed down with interventions such as a healthy diet, physical activity and the cessation of the consumption of tobacco products and alcohol.

Health promotion strategies

A. Proper nutrition

Role of FLHWs in nutritional management:
» Screen for vitality/nutrition (details in Module 2/WHO-ICOPE screening questionnaire).
» Refer older people vulnerable to malnutrition to primary care physicians for further assessment.
» Offer nutritional/dietary advice to the older person and his/her family members:
B. Optimal physical activity

Role of FLHWs in promoting physical activity in older adults

FLHWs should encourage older people to engage in physical activities as per the WHO recommendation which is as follows:

» Older people should do at least 30 minutes of aerobic physical activity of moderate intensity daily throughout the week.

» Aerobic activity should be performed in bouts of ten minutes each.

» Muscle-strengthening activities involving major muscle groups should be done on two or more days a week.

» Older people with poor mobility should perform physical activity to enhance balance and prevent falls, on three or more days per week.

» When older people cannot do the recommended amounts of physical activity due to health conditions, they should be as physically active as their abilities and conditions allow.
Table 3: Physical activity in old age

<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 people to get warmer, breathe harder and their hearts to beat faster, but they should still be able to carry on a conversation; e.g. brisk walking.</td>
</tr>
<tr>
<td>Vigorous intensity</td>
<td>Cause older people to get warmer, breathe much harder and their hearts to beat rapidly, making it more difficult to carry on a conversation; e.g. climbing stairs, running</td>
</tr>
<tr>
<td>Strength exercise</td>
<td>Carrying or moving heavy loads such as groceries, activities that involve stepping and jumping such as dancing, chair aerobics, dancing</td>
</tr>
<tr>
<td>Improving balance and coordination</td>
<td>Yoga, Tai-chi</td>
</tr>
</tbody>
</table>
| Minimizing sedentary behaviour | Reducing time spent watching TV  
Taking regular walk breaks around the garden or street |

C. Intergenerational engagement

Role of FLHWs in intergenerational engagement:
FLHWs should encourage older people as well as their families and community members to take up any form of intergenerational engagement; this can be tailored according to societies and cultures.

Some examples:
» A combination of old-age homes with orphanages on the same premises
» Retired teachers voluntarily teaching in schools, orphanages
» Initiatives by which youth/children provide a service for older people, such as school visits to old people’s homes, to serve as volunteers and provide companionship to older residents
» Sharing of experiences with or demonstrations of arts-skills for younger people, by older people
» Younger generation teaching techniques to older people for using mobile phones and social platforms on smart phones.

D. Social support and social interaction
FLHWs should encourage younger family members to facilitate social interaction for older members of the family, for the following reasons:
» Social support, family and community strengths and abilities are important for health promotion and for the prevention and treatment of disease and disability.
» Social networks and interactions with older people help promote mental health and prevent mental illnesses.

» Strengthening social support and social networks by establishing networks to prevent loneliness and enrich friendships, promotes health in the elderly.

**For example:**

» Participation in social and community activities.

» Participation in religious and spiritual activities.

» Interaction with like-minded and like-aged people in old-age clubs/groups in the community.

### Disease prevention strategies

#### A. Vaccination

FLHWs should make older people and their family members aware of the need of vaccines even at an old age.

**Some vaccines recommended for older people are:**

a. Annual influenza vaccine, with the WHO-recommended vaccine for that particular year

b. Pneumococcal vaccines every five years

c. Tetanus toxoid every 10 years.

Ideally, influenza and pneumococcal vaccines should be administered to all older people. However, in resource-restricted settings, persons with co-morbidities such as diabetes mellitus, heart disease, chronic kidney disease, chronic liver disease, cancer, COPPD and bronchial asthma and current or de-addicted smokers and alcoholics, should receive these vaccines.

#### B. Avoidance of alcohol, smoking and chewing tobacco

» The FLHW should encourage older people to quit alcohol, smoking and chewing tobacco.

» The FLHW should make family members aware of expert services at health facilities for help in quitting alcohol, smoking and chewing tobacco.

#### C. Screening for disease prevention

FLHWs should make the patient as well as family members aware of the following screening strategies for disease prevention, and their availability at the health facilities concerned:

» Screening for hypertension, diabetes and hypercholesterolaemia (increase in blood cholesterol levels) should be carried out at least once a year.

» Vision, hearing and the teeth and feet of older people should be inspected periodically.
FLHWs should suspect the possibility of cancer of an organ system if he/she observes the following symptoms in an older person, and should refer to primary care physicians for further evaluation.

» Changes in bowel or bladder habits
» A wound that does not heal
» Unusual bleeding or discharge from any orifices
» Thickening or lump in a breast, or any other part of the body
» Difficulty in swallowing
» Recent change in wart or mole, or any new skin change
» Nagging cough or hoarseness
» White patches inside the mouth, or white spots on the tongue.
MODULE 4

Common problems of old age
Learning objectives

» To enumerate common problems of old age.
» To enumerate assessment and management of these problems.

Introduction

Some problems that accompany old age are common, but do not fall under discrete disease categories. These are also called geriatric syndromes. They are often the consequence of multiple underlying factors, and cannot be attributed to an impairment in a discrete organ system.

Four major problems are described in greater detail in this module. They are: falls, dementia, depression and urinary incontinence.

Falls

Falls are a leading cause of injury and accidental death among older people.

Injuries sustained after a fall include fractures, soft tissue injuries and head injuries.

Role of FLHWs in fall risk assessment and management

To look for possible risk factors for falls

To screen for the locomotive capacity of an older person using the ICOPE screening questionnaire (refer to Module 2 for details)

To educate patients and families about fall prevention in homes and the community
Risk factors of falls:

**There are several risk factors for falls within the community:** FLHWs should take them into consideration for evaluation.

**Personal factor:** Advanced age, living alone and homebound on most days.

**Chronic diseases:** Dementia, Parkinson disease, any neuromuscular disease, visual and hearing impairment, arthritis of the lower limbs and joints, balance impairment.

**Medication:** Medicine for high blood pressure and heart disease, sleeping tablets, painkillers.

**Environmental factors:** Inadequate lighting, wet floors, slippery bathrooms, cluttered furniture and other articles in walking areas, improper footwear, crossing roads, climbing steps/stairs.

**Evaluation of falls:**
FLHWs should ask the following questions:

- Have you fallen in the past year? (If yes: frequency, injury, if any)
- Are you afraid of falling?
- Do you feel unsteady when standing or walking?
- Do you have difficulty in your vision?

FLHWs should identify medications that increase the risk of falls. If any, consult with the team and decide about their continuation. FLHWs should also assess the footwear that may be the cause of falls.

**Universal fall precautions:**
FLHWs should teach the older person as well as his/her family members about universal measures to prevent falls, as follows:

- Familiarize the older person with the home or community environment
- Use proper lighting in the bedroom and bathroom
- Stabilize the legs of the bed
- Get sturdy handrails in bathrooms, rooms, hallways and stairs
- Ensure that the older person’s spaces are uncluttered
- Ensure that all spills are cleaned up promptly
- Ensure that floor surfaces are clean and dry
- Ensure non-slip, comfortable, well-fitting footwear on the person
- Keep wheelchairs in the locked position, when stationary
- Ensure that the older person’s personal possessions are within the person’s safe reach
B) Dementia

Higher mental functions which can be affected by dementia are: memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgment. Consciousness is not affected in dementia. The impairment in cognitive functions is commonly accompanied, and occasionally preceded by a deterioration in emotional control, social behaviour, or motivation.

Table 4: Age-related changes in cognition and dementia warning signs

<table>
<thead>
<tr>
<th>Typical age-related changes</th>
<th>Dementia warning symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forgets but remembers later (e.g. forgets where the vehicle was parked, but remembers in seconds)</td>
<td>Experiences memory loss that interferes with daily routine (e.g. forgets how to make tea, or wash clothes)</td>
</tr>
<tr>
<td>Experiences occasional gaps in memory (e.g. forgets some mathematics formula, but remembers it later)</td>
<td>Has challenges solving problems performed for years (e.g. mathematics teacher now takes much longer to solve problems)</td>
</tr>
<tr>
<td>Occasionally needs help (e.g. needs help writing the grocery list)</td>
<td>Has difficulty accomplishing routine activities (e.g. no memory of the location of the market visited for years)</td>
</tr>
<tr>
<td>Occasionally forgets (e.g. forgets daughter's birthday, but remembers it later)</td>
<td>Has confusion about a specific or usual place (e.g. doesn't know home address, despite having lived there for years)</td>
</tr>
<tr>
<td>Experiences visual changes related to ageing (e.g. cataracts that affect vision)</td>
<td>Has trouble understanding visual images (e.g. has difficulty deciding between a bus or a truck)</td>
</tr>
<tr>
<td>Occasionally has gaps in conversation (e.g. stops conversation to search for a particular word)</td>
<td>Experiences increased problems speaking or writing (e.g. difficulty in following a conversation and frequently repeats the same information)</td>
</tr>
<tr>
<td>Forgets placement of object, but remembers later (e.g. forgets putting keys in purse, but remembers later)</td>
<td>Puts things in their usual place, but is never able to remember the thing or place; never remembers the loss (e.g. loses entire wallet and does not know he/ she had one)</td>
</tr>
<tr>
<td>Makes an occasional wrong, or bad decision (e.g. decides to walk half a kilometre after recent knee surgery, realizing afterwards that he/she probably shouldn't have)</td>
<td>Applies poor judgment with no thought (e.g. overpays the newspaper delivery person, but doesn't remember doing so, or ever seeing the person)</td>
</tr>
<tr>
<td>Adapts activities for a good reason (e.g. decreases work schedule from 5 days a week to 3 days a week after 25 years)</td>
<td>Becomes disinterested in usual social activities (e.g. has difficulty playing cards with social group after enjoying it for 25 years)</td>
</tr>
<tr>
<td>Gets upset with changes in an established routine (e.g. watches TV daily in afternoon, gets irritated if doctor's appointment is scheduled for the afternoon).</td>
<td>Has unpleasant mood or personality changes that may be frightening because of memory loss (e.g. visits relatives in their homes and gets anxious because of the strange environment).</td>
</tr>
</tbody>
</table>
FLHWs should carry out the following tasks:

» Educate the older person and their family members on the difference between normal, age-related memory changes, and cognitive impairment.

» Screen for cognitive impairment using the WHO-ICOPE screening questionnaire. (Refer to Module 2 for details)

» Refer to primary care physician if the older person screens positive for cognitive impairment.

» Teach family members about ways of communicating with 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 as calm and 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 by his/her name, gain eye contact and speak directly to him/her.
  ✓ To maintain attention, use appropriate gestures such as gently touching the person’s arm.
  ✓ Encourage family members to make use of the following verbal techniques:
    • Use short simple sentences: speak slowly and clearly, with easy-to-understand sentences.
    • Repeat sentences or use different words with the same meaning, if the person does not seem to understand.
    • Be specific.
    • Do not say: Don’t you remember?
    • Offer simple choices, closed questions.
    • Give instructions one step at a time.
    • Encourage family members to make use of the following non-verbal techniques as well:
      • Use labels that can be words or pictures.
      • Use signals like touching an arm, pointing to things, body language (smiling, frowning).
      • Listen: use reflection and paraphrasing.
      • Give the person time to answer.
  ✓ Reduce distractions.
C) 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 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.

» 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 signs are physical symptoms such as headaches, fatigue, disturbed sleep, dizziness, chest pain and vague joint or limb pain.

Role of FLHWs in depression management:

» Screen older people for depressive symptoms based on the ICOPE intrinsic capacity screening questionnaire (Refer to Module 2 for details).

» Refer to primary care physician if the older person screens positive for depression.

D) Urinary incontinence

Urinary incontinence is defined as the involuntary loss of urine in sufficient amount or frequency, and is a social and/or health problem. Unfortunately, urinary incontinence is often neglected by the patient as well as health professionals, leading to underreporting and undertreatment.

Types of urinary incontinence:

» Stress incontinence is the involuntary loss of urine, usually in small quantities due to increased abdominal pressure while coughing, laughing, etc. It is common in older women due to weakness of the pelvic floor musculature and the sphincter, multi-parity, surgery, instrumentation, etc.

» Urge incontinence, or an overactive bladder is due to an inability to delay voiding, resulting in small, frequent voids, urgency and leakage of urine. It is common in older males with a prostate enlargement.

» Functional incontinence is due to the inability to reach the toilet, and it is secondary to physical and/or cognitive incompetence.

Role of FLHWs in the management of urinary incontinence:

» FLHWs should question specifically and directly about incontinence, to identify this potentially treatable medical and social problem.

» FLHWs should record a high index of suspicion regarding incontinence if they smell the odour of urine while evaluating the older person for other issues.

» Family members as well as the older person should be taught about the behavioral techniques.
Behavioural 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 the intake of caffeine, acidic foods and liquids, especially during evening hours.

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 the urine flow and tighten (contract) the muscles to stop urinating.

- Hold tight and count 3 to 5 seconds and then relax the muscles and count 3 to 5 seconds.

- Repeat 10 times, 3 times a day (morning, afternoon, and night).
Identification and management of common complaints and morbidities of older people
Learning objectives

» To enumerate the diagnosis and management of common noncommunicable diseases (NCDs) in older people.
» To enumerate the management of common complaints among older people.
» To enumerate the recognition of typical and atypical symptoms of common geriatric emergencies, and their management.

Introduction

Older people carry a great burden of diseases and disabilities. Chronic NCDs are common among older people. The important risk factors for NCDs are raised blood pressure, raised cholesterol, the use of tobacco, the consumption of alcohol, sedentary lifestyles and overweight/obesity. Similarly, older people frequently have acute illnesses that require intervention by the health system. Acute health problems usually result from vascular events, infections, accidents and injuries. Acute health problems in older people may not present with classical symptoms of the disease (atypical presentation). Non-specific symptoms like delirium (an acute onset of fluctuating consciousness with disorientation), falls, anorexia and a deterioration in functional status, may be the only symptoms of the disease. Fever may not be present in infections in old age.

This module deals with few of the common NCDs in old age, regular complaints during old age as well as few of the emergency conditions that require prompt recognition and management.

Common NCDS in older people

A) Hypertension

Hypertension is the commonest NCD in old people and is associated with an increased risk of adverse outcomes such as stroke, coronary artery disease (CAD), congestive heart failure (CHF) and mortality. Hypertension being a “silent” disease, every older person must be subjected to blood pressure measurements during each visit to the health facility.

Role of FLHWs in hypertension management:

» Encourage at least one blood pressure measurement annually in every older person for the diagnosis of hypertension.

» Diagnose hypertension: In general, hypertension is diagnosed if:

  ✓ the systolic blood pressure is ≥140 mmHg and/or,
  ✓ the diastolic blood pressure is ≥90 mmHg.
If hypertension is diagnosed, refer the older person to a primary care physician for further management.

Provide advice or support for lifestyle modification for the control of hypertension:

- A diet that emphasizes vegetables, fruits, and whole grains is recommended to lower blood pressure.
- Limiting sodium intake to half a teaspoonful per day is recommended to lower blood pressure.
- To lower blood pressure, older people should engage in moderate to vigorous aerobic physical activity.
- All older people should be asked about tobacco use. In a clear, strong, and personalized manner, urge every older person who uses tobacco, to quit.
- Alcohol consumption should be limited to no more than two drinks per day for most men, and one drink per day for women.

B) Diabetes mellitus

Type-2 diabetes mellitus is the commonest endocrine problem in older people. Diabetes in old age is associated with a huge burden of serious long-term complications, such as retinopathy, nephropathy, neuropathy, vascular complications, foot ulcers and depression.

Role of FLHWs in diabetes mellitus management:

- Encourage at least one blood pressure measurement annually in every older person for the diagnosis of diabetes mellitus.
- Diagnose diabetes mellitus using a glucometer (the blood sample may be sent to a laboratory, if available).
  - Fasting blood glucose (FBG) level: 126 mg/dl or above, on two or more occasions.
  - Random blood glucose level (RBG): 200 mg/dl or above.
  - If FBG is between 100–125, or RBG is between 140–200 mg/dl: prediabetes.
- If the older person is diagnosed with diabetes mellitus, refer him/her to a primary care physician for further management.
- If the older person is pre-diabetic or, under medications for the control of diabetes mellitus, provide counselling on changing lifestyle, including diet, physical activity and the cessation of smoking.

C) Osteoarthritis

Osteoarthritis (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. The clinical features of OA are pain, stiffness, bony swelling and
crepitus, loss of movement, instability and loss of function. Patients with mild OA of the knee have intermittent, or low levels of 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 FLHWs in osteoarthritis management:**

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

» Offer non-pharmacological therapy for OA in addition to the pharmacological one; such as use a walking stick (cane), held in the hand of the 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.

» 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.
Common complaints of old age

A) Skin pruritus and care of the skin

Suggestions by FLHW to older person and their family members for skin-care

Older people should bathe periodically to relieve dry skin

Health workers should examine the skin for any signs of skin cancer

Caregivers dealing with older adults in long-term care should be educated on how to prevent pressure damage to the skin/ pressure ulcers

Older people should be encouraged to wear gloves while doing household or other work

The use of coconut oil and other emollients can help relieve pruritus induced by dry skin

B) Sleep issues in older people

More than half of men and women over the age of 65 complain of at least one sleep problem. Many older people experience insomnia, and other sleep difficulties on a regular basis.

Role of FLHWs in addressing sleep issues in older people:

» Enquire about the duration of sleep and whether the disturbance is in initiation, or continuation of sleep.

» Assess for any medical, or neuropsychiatric condition affecting sleep. E.g. prostate issues, depression.

» If the sleep issues are significantly affecting daily activities as well as social engagement in older people, refer the person to a primary care physician for further assessment and management.

» Educate the older person as well as family members about good sleep hygiene. Sleep hygiene refers to actions that tend to improve and maintain good sleep.
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.

» 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 (TV, mobile phones) 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 longer than 30 minutes or, occur late in the day.

C) Constipation in older people

Decrease in stool frequency (less than three bowel movements per week) is defined as constipation. It is also associated with straining, lumpy hard stools and sensation of incomplete evacuation. It is a common complaint in older people.

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 use of medication and depression.

Some medications that can cause constipation are as follows:

» 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.
Role of FLHWs in addressing constipation in older people:

» Enquire about the frequency and consistency of stools. Most older people think that bowel movements must occur on a daily basis. They perceive constipation as not being able to pass stools on a daily basis. Reassurance works in such cases.

» Suggest lifestyle modification before prescribing drugs for older people.

Life-style modifications for constipation:

» Encourage older people to establish a regular pattern of bowel movement.

» Timed toilet training: consists of educating patients to attempt a bowel movement at least twice a day, usually 30 minutes after meals, and to strain for no more than five minutes.

» Encourage increased fluid intake.

» Encourage optimal exercise/physical activity.

» Increase the consumption of foods rich in dietary fibre. Some food items rich in fibre are as follows:

- Whole-grain breakfast cereals, whole-wheat pasta, whole-grain bread and oats
- Fruit like berries, pears, melons and oranges
- Vegetables like broccoli, carrots and sweet corn
- Peas, beans and pulses
- Nuts and seeds.

» If the older person has persistent difficulty in passing stool despite lifestyle modifications, the FLHW can give him/her a trial of available stool softeners. Preference should be given to bulk laxatives (e.g. methylcellulose, isabgol (psyllium) husk.

D) Oral hygiene and dental issues in older people

Poor oral hygiene in older people can be a cause for difficult 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 and bad breath are some of the common issues related to dentition and oral hygiene in older people.

Role of FLHWs

FLHWs must educate older persons as well as their family members about the importance of good oral hygiene, and make them aware of the following:

» Brush teeth with fluoride containing toothpaste.

» Brush thoroughly and twice a day; if twice is not possible, at least once before going to bed.

» Visit a dentist at least once a year, for a 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 a dry mouth occurs after starting a new medicine.
» If a 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.

Geriatric emergencies

FLHWs must be vigilant of the various signs and symptoms of emergency conditions which need urgent management in the hands of a trained physician or a specialist.

A) Stroke

Any abrupt onset of focal neurological deficit should be taken as stroke, unless proved otherwise.

Stroke can present in any of the following ways and the FLHW 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.

Role of the FLHW:

» Prompt recognition of stroke symptoms and prompt referral to a specialized centre can result in good outcomes in an older person.

B) Myocardial infarction (MI)

MI (commonly understood as heart attack), remains among the commonest life-threatening illnesses in old age, irrespective of socioeconomic status and gender.
Role of the FLHW:

» 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.

### C) Community-acquired pneumonia

**Typical symptoms suggestive of pneumonia:**

Atypical features of pneumonia in old age: The clinical manifestation and outcome of pneumonia among older adults tend to be different from those among other age groups. Similarly, the resolution of pneumonia is slower in old age, and the patient must prepare for a prolonged stay in hospital.

» The presentation of pneumonia in older adults is often atypical, with prominent non-respiratory symptoms like confusion/delirium, incontinence, immobility or falls.
Fever may be absent.

The patient may not produce sputum.

**Role of the FLHW:**

The health worker must be vigilant about both the typical as well as atypical symptoms of pneumonia in old age.

Prompt recognition of pneumonia symptoms and prompt referral to a primary care physician result in good outcomes in an older person.

**D) Urinary tract infection (UTI)**

UTI is one of the most commonly diagnosed infections in older adults, and the most frequently diagnosed infection in long-term care residents.

The most significant risk factor associated with UTI in older people in long-term care settings is the presence of a urinary catheter.

**Typical symptom of UTI:**

In older adults who are cognitively intact, the diagnosis of symptomatic UTI is relatively straightforward.

Common urinary symptoms suggestive of cystitis (infection of the urinary bladder) include urgency, frequency, dysuria and suprapubic tenderness with or without fever.

**Atypical symptoms of UTI:**

Older people can also present with nonspecific generalized symptoms, such as lower abdominal pain, back pain, chills and constipation.

Frail older people or those with cognitive impairment can present with anorexia, fall, confusion (delirium) and a decline in functional status.
Long-term care and caregiver support
Learning objectives

» To enumerate the concept of long-term care, caregiving and caregiver stress syndrome.

» To enumerate the management of common issues in older people with limited mobility requiring long-term care in home or institutional settings.

Introduction

As age advances, there is a decline in physical functions, and a person becomes susceptible to both acute and chronic health problems. It makes them frequent users of health-care services and consumers of long-term care. Other than health professionals, most long-term care is provided by family members, friends and volunteers. Therefore, they need to be supported, educated and trained adequately, to provide quality long-term care services.

Role of FLHWs in long-term care

» FLHWs should be aware of the indications for long-term care for older people.

» Health workers should be aware of formal long-term care services, available in and around the community.

» Health workers should make caregivers aware of possible issues and complications in older people, which require long-term care.

Common issues in older people with limited mobility, requiring long-term care in home or institutional settings:
Pruritus
Skin infections
Pressure ulcers

Musculoskeletal related
Postural hypotension
Clotting of blood in veins (venous thrombosis)
Blood clots in lungs (pulmonary embolism)

Cardiovascular
Loss of muscle mass and strength (sarcopenia)
Contractures
Loss of bone mass (osteoporosis)

Pulmonary
Anorexia
Constipation and fecal impaction (refer to Module 5)

Gastrointestinal
Aspiration pneumonia
Urinary tract infection (refer to Module 5 for details)
Urinary incontinence (refer to Module 4 for details)

Genitourinary
Depression (refer to Module 4 for details)

Psychological
Loss of muscle mass and strength (sarcopenia)
Contractures
Loss of bone mass (osteoporosis)
Management of skin pruritus

Dryness of skin is the most common cause of pruritus in the absence of an identifiable skin lesion.

Suggestions to caregivers for managing skin pruritus

1. Liberal use of coconut oil or other emollients on damp skin, after the shower
2. Use of soap-free substitutes in the shower
3. Avoiding excessive room heating in winter
4. Avoiding the use of electric blankets in bed
5. Using a humidifier if possible, to enhance ambient indoor humidity, especially in dry, cold winter months
6. Minimizing direct contact with woollen and synthetic garments
7. Keeping fingernails trimmed short to minimize complications from scratching
8. Quick, cool showers (<2–3 minutes)
9. Patting dry skin (avoiding vigorous rubbing) can soothe pruritus
10. Using a humidifier if possible, to enhance ambient indoor humidity, especially in dry, cold winter months
11. Minimizing direct contact with woollen and synthetic garments

Prevention of pressure ulcers

Older people with significantly limited mobility, a significant loss of sensation, malnutrition, an inability to reposition themselves and significant cognitive impairment, are at the greatest risk for the development of pressure ulcers.

FLHWs should suggest the following to caregivers:

» The bed should be made wrinkle-free.

» Caregivers should regularly inspect areas of the skin overlying bony prominences, for skin integrity, change in colour or discolouration.

» Small, regular and frequent changes of position can significantly prevent the development of pressure ulcers. If the older person is in a wheelchair, his/her position has to be changed every 30 minutes. If the older person is in bed, his/her position has to be changed every four hours.

» High-specification foam mattresses, or pressure redistribution cushions (air mattresses) should be arranged for older people who are at high risk of developing pressure ulcers.
**Prevention of sarcopenia in older people at home or in institutions for long-term care**

Persistent confinement in bed is one of the major causes for the loss of muscle mass and strength in older people. Severe sarcopenia prevents an individual from accomplishing activities of daily living, and initiates a downward spiral in their clinical prognosis.

Health-care workers should suggest the following for the prevention of sarcopenia in older people:

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

**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.

Health-care workers should suggest the following to caregivers for the prevention of osteoporosis and falls in older people:

- Make older people to sit in the daytime sun dressed in light clothing, for a period of 30 minutes to an hour. This will help them generate vitamin D in their body with the help of sunlight.
- Caregivers should discuss with primary care physicians about the possible deficiency of vitamin D in an older person, as well the possibility of osteoporosis.
- Encourage older people to increase their dietary intake of the calcium available in dairy products.
- Advise caregivers to follow fall prevention strategies. (Details in Module 4/geriatric syndromes/falls).

**Prevention of contractures**

FLHWs should advise caregivers to carry out basic joint mobility exercises in affected limbs (especially for bed-bound older people), for the prevention of contracture development. Caregivers may seek help from a physiotherapist, as needed.

**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.
FLHWs should suggest the following to the caregivers for the prevention of postural hypotension in older people:

» 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 a supine position, getting out of bed, rising from a chair.

» Caregivers should consult health workers if such symptoms are often present.

» Older people with symptoms of postural hypotension should be asked to avoid overeating.

» Alcohol should be avoided.

» Adequate hydration must be encouraged (around 5–6 glasses of water per day, depending on the morbidities of the person).

» Encourage physical activity as tolerated. Regular cardiovascular and strengthening exercises can help reduce symptoms of postural hypotension.

» Older persons prone for postural hypotension should move slowly from a supine to a standing position. When getting out of bed, they must sit on the edge of the bed for a minute, before standing.

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. FLHWs should make the caregivers aware about the following symptoms of DVT and PE and urge them to seek medical attention immediately, on observing the following 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:

» Panting, shortness of breath, or trouble breathing

» Sharp, knife-like chest pain, when the person breathes in, or strains

» Coughing, or coughing up blood.

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 food/gastric contents, owing to various neurological as well as age-related issues.
FLHWs should make caregivers aware of various methods to prevent the occurrence of aspiration, while hand-feeding or tube-feeding.

**Hand-feeding**

» Provide a 30 minute rest period prior to feeding time; a rested person will likely have less difficulty swallowing.

» Make the person sit upright in a chair; if confined to bed, elevate the backrest to a 90-degree angle.

» Adjust the rate of feeding and the size of bites according to the person’s tolerance; avoid rushed, or forced feeding. Alternate solid and liquid boluses.

» Vary the 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.

**Tube-feeding**

» Keep the bed’s backrest elevated to at least 30 degrees, during feeds.

» Be vigilant for symptoms like nausea, abdominal pain. These are indicative of slowed gastric emptying that may, in turn, increase the probability of regurgitation and aspiration of gastric contents.

**Caregiver stress**

» Long-term care of a frail and physically dependent older person leads to various physical, emotional, social and financial forms of stress for the caregiver; this is termed ‘caregiver burden’.

» Caregiver syndrome, or caregiver stress is a condition that manifests itself as exhaustion, anger, rage, or guilt, resulting from unrelieved caring for a chronically ill person.

» It is acute when caring for an individual with behavioural difficulties such as: faecal incontinence, memory issues, sleep problems, wandering and aggression.

» Common symptoms of caregiver syndrome include fatigue, insomnia and stomachaches. Similarly, it is also associated with other issues like depression, anxiety and anger. Chronic stress can lead to hypertension, as well as diabetes mellitus.

» Caregiver burden has a negative impact on the quality of care. It can also give rise to abuse of the recipient of care.
Role of FLHWs in addressing caregiver stress:

1. Health workers should be aware of possible caregiver stress, and the caregiver burden in family members providing chronic care for older people.

2. Health workers should take the following aspects into consideration, when assessing the burden of caregivers:
   - Capability of the older person in self-caring: ADL and IADL in-dependency
   - Type of care required by the older person (feeding, dressing, bathing, and toileting)
   - Amount of extra time the caregiver needs to spend, caring for the older person
   - Arrangements for rest and relaxation for the caregiver
   - Resources and support systems available for the caregiver.

3. Health workers should have a high index of suspicion of mental health issues in chronic caregivers and redirect them to available services.
Module 7

Prevention of elder abuse and care with empathy
Learning objectives

» To enumerate the concept of abuse and neglect of older people.
» To enumerate the concept of empathetic care of older people.

Introduction

WHO defines elder abuse (abuse of older people) as “a single, or repeated acts, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person”.

From available evidence, WHO estimates that nearly one in six persons over 60 years and older, is subjected to abuse. These prevalence rates are likely to be underestimated as a large number of abuse cases are not reported. Elder abuse is an important public health problem. Globally, the number of cases of elder abuse is projected to increase as many countries have rapidly ageing populations whose needs may not be fully met due to resource constraints.

Table 5: Types of abuse of older people

<table>
<thead>
<tr>
<th>Types of abuse</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological/</td>
<td>Verbal assaults, insults, threats, intimidation, humiliation, harassment, treating an older person like an infant, isolating an older person from his/her family, friends or regular activities, forced social isolation</td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>Refusal or failure to provide an older person with: food, water, clothing, shelter, personal hygiene, medicine, personal safety and other essential needs</td>
</tr>
<tr>
<td>Abandonment</td>
<td>The desertion of an older person at a hospital, a nursing care facility, or other similar institution. The desertion of an older person at a shopping centre or other public location</td>
</tr>
<tr>
<td>Physical</td>
<td>Striking (with or without an object), hitting, beating, pushing and shoving, shaking, slapping, kicking, pinching, burning, inappropriate use of drugs, physical restraints, force-feeding, and physical punishment of any kind</td>
</tr>
<tr>
<td>Sexual</td>
<td>Unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photography, forcing an individual to watch sex acts, showing an older person pornography and forcing older people to undress</td>
</tr>
<tr>
<td>Financial</td>
<td>Cashing an older person’s cheques without authorization or permission, forging an older person’s signature, misusing or stealing an older person’s money or possessions. Coercing or deceiving an older person into signing any document (e.g. contracts or will) and an improper use of conservatorship, guardianship or power of attorney</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Unreasonable control of a person’s basic right to make a choice on spiritual matters, prevention from practicing faith.</td>
</tr>
</tbody>
</table>
Risk factors for abuse of the older people

Older persons with dementia, poor educational status, physical disabilities, depression, loneliness or lack of social support, who abuse alcohol or other substances, are verbally or physically combative with the caregiver, or who has a shared living situation, social isolation and mental impairment, and are dependent on their care-provider are commonly abused.

Places of abuse of older people and common perpetrators

Older people are commonly abused in homes, work places, public places, public transportation, crowded places and health care centres. Common perpetrators are family members, spouses, neighbors, caregivers, health care providers, colleagues, society and strangers.

Signs and symptoms of abuse of older people

Health workers should take the following information into consideration when registering/noting high suspicion of abuse of older persons:

» Bruises, pressure marks, abrasions, scars, untreated ulcers, bedsores, burns, weight loss, dehydration and malnutrition may be indications of physical abuse, neglect, or mistreatment

» Fractures of bones other than at the usual sites like hips, vertebrae or wrists, e.g. a rib fracture

» Poor foot care

» Unexplained withdrawal from normal activities, a sudden change in alertness and unusual depression, may be indicators of emotional abuse

» Bruises around the breasts or genital area can occur from sexual abuse

» Sudden changes in financial situations may be the result of exploitation

» Bedsores, unattended medical needs, poor hygiene, and unusual weight loss are indicators of possible neglect

» Strained or tense relationships, frequent arguments between the caregiver and the older person are also signs of abuse

» Changes in personality or behavior in the older person.

Empathetic care

Empathy is more than just loving an older person. It is more than simply making the decisions that health workers may feel are best for older clients. Empathy requires internalizing the patient’s feelings, and acting accordingly. It is a crucial component of health care of older people.

As people grow older, they become increasingly vulnerable and their needs increase. However, it can be quite difficult for older people to show and explain their needs to family and friends. They may try to tackle issues such as financial stress, physical limitations, poor health, or loneliness on their own, to avoid “imposing” or “being a burden” to others. This is where empathy comes in. Given that an older person may be reluctant to ask for help, health workers must be actively listening and looking out for signs of a problem. Health workers must be ready to help, sometimes
before help is sought. In many cases, empathy is the most important thing that health workers can provide. Older people want them to be on their side when they feel frail, or are in distress.

The following are some of the ways the health workers can empathize with older people:

» Understanding that listening is more important than talking.

» Talking in a soft voice, while showing concern.

» Focusing on their feelings and their needs.

» Asking them how they are feeling, when the health worker senses that something is wrong.

» Not pushing if an offer of help is refused. It is better to back off, give it a little time and try again with a different approach.