

Gerontology and Geriatrics

Gerontology: Study of old age

Geriatrics: Branch of medical science dealing with clinical problems of old age

Ageing: Variable process with some elderly having little changes in psychological variables over time while others such as 80 years plus show functional and mobility impairment

Demographic Changes

Demography is the science which deals with the size, geographic distribution, structure and composition of human population. It also deals with the principal factors that account for the changes in population size and composition such as births, deaths and migration.

Determinants

Birth Rate

Mortality Rate

Migration

Demographic Transition

Three – stage process whereby a population moves from high fertility and high mortality to low fertility and low mortality.

Consequently changes the population structure from a low proportion to a high proportion of older persons.

Life Expectancy

Average numbers of years of life remaining to persons of a given age on the basis of current age specific mortality rates.

Male's life expectancy is of 80 years

Female's life expectancy is of 85 years.

Contributors to life expectancy

Medical advances and awareness

Improved standards of living

Control of communicable diseases

Improvements in nutrition

Socio – economic conditions

Consequences

Increased life expectancy and **reduced** birth rate

Population Ageing: One of the most significant phenomena of this century. This is so called **Age of Ageing**.

Socially: majority of women are widowed and become lonely

Economically such as pension

Health prone to diseases and impairment

Psychologically such as depression

Needs of old persons

More health care than younger groups

Frail and at risk

Can become dependent

Facing loss such as status partner, friends, health stimulation and independence

Can become isolated in the community (segregated)

May need institutionalization

Physiological Changes

Biological Aspects of Ageing

- Changes that occur in ageing
- Changes affecting the cells
- Changes affecting the tissues
- Changes affecting organs
- Changing affecting the whole body

Main Factors

- Genetic Aspects
- Cell Damage
- Decline in Function
- Collagen Changes
- Thermoregulatory Mechanism

Genetic Aspects

Genes that promote early ageing such as tumour suppressor

Some genes cause disease in early life and decrease longevity such as cystic fibrosis which predisposes to early death

Genes that cause age- related disease

Alzheimer's disease

Hypercholesterolemia

Coronary Heart Disease

Cerebral - vascular accident

Diabetes

Cell Damage Is Caused by Free Radicals

Free Radicals are naturally-occurring metabolic by-products and strong oxidizing agents

Free Radicals are:

- Highly reactive
- Cytotoxic
- Very unstable and short-lasting

Free Radicals are also:

- Generated by carcinogens, mutagens, radiation
- Contained in foods, additives, tobacco and environmental pollutants

Free Radicals in Ageing

Free Radicals may damage DNA

Free Radicals oxidise fatty acids, main constituents of cell membranes

Beneficial effects in phagocytosis and immune system

Protective Mechanisms against Free Radicals

- Enzymes such as catalase, peroxidase inactivate free radicals
- Substances that remove free radicals:
 - Metalloproteins: Iron, Copper, Selenium
 - Antioxidants: Vitamins C, E, Beta carotene
 - Metabolites: Uric Acid

Remember

Ageing has been attributed to increased cell damage caused by free radicals
In ageing, the protective mechanisms against free radicals are decreased

Decline in Function

- Ageing process itself
- Disease
- Disuse

Ageing affects many systems

Cardiovascular

Respiratory

Renal and Urinary

Gastro-intestinal

Skeletal

Nervous

Skin

Changes with Collagen

Collagen fibres are widespread in the body.
They undergo continuous change with age.

Increased cross-linkage causes collagen fibres to become stiffer, less flexible and more fragile

This effect is most marked in:

The lungs which become stiffer and less elastic

The skin becomes creased and less pliable

Ageing of Elastin results in reduced elasticity and thickening of elastic fibres

The lungs loses elastic recoil, reduces compliance and decreases reserves

Elasticity is lost in arteries. They become thicker and calcified.

Thermoregulatory Mechanisms

In normal environmental situation, voluntary remedial action is taken to the perception of heat and cold.

1. Feeling Hot:

Light clothing

Drink cold water

Swimming

Switch on fan or air conditioner

2. Feeling Cold:

Wear more clothes

Take hot drinks

Get active

Switch on heater

In Old Persons

- Thermoregulatory mechanisms are not usually deranged
- Perception of cold, heat and thirst are decreased
- Tolerance may be increased
- There is a tendency of lethargy. This prevents remedial action to be taken
- There may be fear of catching cold or using appliances
- Poverty may contribute to lack of use of appliances.

However

Elderly persons are very sensitive to very cold and very hot weather

Therefore

Under low ambient temperature

Warm clothing

Ventilated room

Avoid draughts

Switch on heater

Given hot food and drink

Under high ambient temperature

Light clothing

Intermittent cool drinks

Ventilated room

Switch on fan/air conditioner

Immune System

Ageing attributes to abnormal function of the immune system

The Thymus gland atrophy with age (source of T-Lymphocytes)

B-Lymphocytes slightly reduced

Avoid Relapses

- Immunization against influenza is effective in the elderly- it is recommended
- Avoid cross infection
- Healthy diet

Conclusions

- Healthy diet: Low fat high fibre diet is highly recommended
- Exercise if started early enough can diminish some of the effects of ageing.
- Exercise can prevent or diminish the long-term effects of various diseases
 - Atherosclerosis
 - Hypertension
 - Coronary Heart Disease
 - Diabetes
- Healthy diet and exercise are the main criteria of a healthy lifestyle

Exercise and diet are lifelong

COMMON PROBLEMS IN AGEING

Ageing: Variable process with some elderly having little chances in psychological variables over time while others such as 80 years plus show functional and mobility impairment

Types of Ageing

- A. Usual Ageing: Expected physiological ageing.
- B. Successful Ageing: Minimal or no physiological losses such as level that are similar to younger age groups.
- C. Frailty: Reduced physiological and prone to get disabled.

Frail Elderly – Possible Characteristics

Vulnerability

Medical Complexity

Illness which could be obscure, atypical presentation (altered pain response or painless presentation e.g. I.H.D. Peptic ulcers, retention of urine)

Cognitive problems

Affective problems

Can deteriorate through medicine

Socially isolated

Economically deprived

High risk for premature or inappropriate institutionalization

Common Problems

Instability

Immobility

Incontinence

Intellectual Impairment

Iatrogenic

Instability: Falls

Definition:

A fall is an event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness. (Oxford Textbook of Geriatric Medicine 2000).

Causes

May range from a heart attack to a wet floor. From medical reasons to accidents. It may also be more than one cause in an individual.

Rate increases in falls in old age

- Community Dwellers: 28% - 35% (65yrs – 70yrs.)
32% - 42% (74yrs. Plus)
- Institutional Care: 50% Of residents at least sustain one fall over one year period (Tinetti 1989)
- Hospital Admissions: 21% fall precipitated admission
26% recurrent falls per year.
(Exton – Smith – Wekslen 1985)

Falls may be under- reported.

Description of Falls

Explained	vs	Unexplained
Intrinsic	vs	Extrinsic
Accidental	vs	Non – Accidental
Injurious	vs	Non – Injurious
Outdoors	vs	In-doors

Potential Complications

- Fracture (osteoporosis, slow protective reflexes)
- Fear and loss of confidence
- Other injuries
- Chronic institutionalization
- Stay in bed (plus functional decline)
- Hypothermia
- Subdural Haematoma
- Hospital Admission

Why Elderly might have problems?

Increased Frailty + Co-morbidity + Extrinsic Environment = Increased tendency to falls.

Trips and accidents (House hazards)

- Poor lighting
- Polished floor
- Rugs
- Carpet edges
- Steps between rooms
- No support appliances such as grab rails.

Hazards on their feet

- Slippers
- Shoes too big
- High heels

Hard Headedness

- Walking frame used to hang up clothes
- Walking stick kept in cupboard.

Cardio-vascular

- Syncope:

Age associated impairments in physiological responses to compensate for the reduction of cerebral blood flow.

- Postural Hypotension:

20mmHg. Drop in systolic blood pressure or 10mm Hg drop in diastolic on assuming an upright position from a supine position.

Medications:

Sedatives	Balance problems
Antidepressants	Balance problems
Antihypertensives	Postural hypotension
Anti Parkinson's	Postural hypotension
Hypoglycaemia	Blood sugar low

Assessment

History

What led to fall either accidental or not

Frequency

Consciousness lost?

Any witness

List of medication

Alcohol

Co-Morbidity such as Parkinson's

Examination

Blood pressure (lying and standing)

Heart rate

Any visual problems

Neurological examination (motor nerve dysfunction)

Sensory problems (Parkinson features)

Musculoskeletal (muscle strengths, knee joints)

Balance and gait (getting up/walking, turning, sitting down)

Feet and shoes

Investigations and Management

Check electrolytes and full blood count.

ECG

Medication: might be reviewed

Postural retraining

Visual or vertigo: refer to relevant specialist.

Walking aides

Safe environment (own home, institutions)

Preventions

Exercise programmes

Muscle strengthening

Improving balance

Risk factor reductions

Safe environment: aids and appliances, bed side support, chair restraints Identify 'high risk potential fallers'

Treat Medical Conditions:

Neurological problems

Locomotor problems

Prevent Injuries:

Hip protectors

Prevent/treat osteoporosis

Intellectual Impairment Confusional States

Though shalt not think, let alone state that all confused old people are suffering from dementia and people with dementia are suffering from Alzheimer's disease.

- **Acute Confusional State:**
Delirium: Acute brain failure

- **Chronic Confusional State:**
Dementia: Chronic brain failure

Delirium:

Definition: A confusional state, usually of acute onset, characterised by disturbances of memory and orientation, which can be accompanied by abnormal movements, hallucinations, illusions and change in affect confabulation.

- Acute confusional state is a geriatric problem especially in the Frail Elderly.
- Can be a non specific sign of illness
- Any illness in the elderly can give rise to an acute confusional state.

Precipitating Factors

1. Infections – chest, urinary
2. Medications – precipitated by prescribing and withdrawing
3. Blood sugar levels – too low; too high
4. Hypotension – heart attacks, haemorrhage
5. Stroke
6. Alcohol – too much intake or withdrawal
7. Pain
8. Change in environment
9. Urinary retention
10. Faecal impaction
11. Trauma
12. Anaesthetic

Predisposing Factors

1. Advance age
2. Frailty
3. Dementia
4. Psychiatric illness
5. Malnutrition
6. Sensory impairment
7. Chronic anticholinergic drug use such as anti-depressants

Assessing

History: Whether confused. Sudden onset
Any other symptoms (especially acute illness)
Any medication (recently started, stopped)

Examination: Neurological – Dehydrated?
Cardiovascular – Malnourished?
Respiratory – Any infection?

Investigations: Full blood count
Urea and electrolytes
Blood glucose
Blood cultures
Chest X-ray
E.C.G.
Urine for culture and sensitivity

Managing a patient:

- Identify cause
- Treat cause
- Reassure (patient, carers, staff)
- Fluids
- Sedation if agitation cannot be controlled by other means
- Consider physical restraint to prevent further injuries and not a replacement for adequate staffing levels.

Dementia

Definition: An acquired impairment of memory and intellectual function, caused by disease of the brain which is not associated with disturbances in the level of consciousness.

Common Causes in the Elderly

1. Alzheimer's Disease
2. Vascular Dementia
3. Lewy Body Dementia
4. Associated with Parkinson's Disease

Potentially Treatable Dementia

- Hypothyroidism
- Vitamin B12 deficiency
- Depression (pseudo – dementia)

Prevalence of Different Types of dementia

TYPE	
Alzheimer's	60%
Vascular	20%
Lewy Body	20%
Treatable	5% to 10%

Prevalence varies between counties

We have to remember that patient could have more than one dementia.

Alzheimer's Disease

- Memory loss could be first symptom. Most marked abnormality.
- Impairment of:
 - Attention
 - Language (word finding)
 - Visual and spatial (rote, drawing)
 - Learned activities
 - Calculation
 - Problem solving
 - Judgement
 - Visual, auditory perception

Pathology

Alzheimer's Disease is due to loss of neurones caused by Neuro – chemical deficiency (acetyl choline neuro transmitter).

Alzheimer's Disease

- Gradual Onset
- Course is usually progressive
- Course and problems vary from patient to patient

Vascular Dementia

- Usually caused by several brain infarcts (multi – infarct)
- Can arise from a single large infarct
- All sizes of blood vessels can be involved

Characteristics

- Typical sudden onset and stepwise decline
- Cognitive impairment
- There may be emotional liability
- History of strokes and/or Transient Ischaemic Attacks
- Focal neurological signs on examination
- Presence of hypertension +/- generalized atherosclerosis
- Presence of source of thrombo – embolism (atrial fibrillation)
- Neuro – imaging evidence of cerebrovascular disease

Lewy Body Dementia

- Fluctuating cognition with pronounced variations in attention and alertness
- Cognitive slowing, impaired problem solving and reduced visuo- spatial abilities
- Visual hallucinations (people, animals)
- Mild Parkinson's
- Repeated falls
- Delusions

Evaluation

History: Especially from carers

Memory and cognitive decline

Onset and progression

Medication

Past medical history such as strokes

Examination

Neurological

Cardiovascular

Cognitive function

Investigations

Blood tests: Thyroid function test
 Vit.B12 and folate level
 Calcium levels
 Blood count
 ESR
 Electrolytes
 Liver function test

C.T. Brain

M.R.I.

Isotope brain scan

Management

- Treat 'treatable dementias' i.e. problem of permanent damages
- No treatment yet available to reverse the effects of:
 - Alzheimer's
 - Vascular
 - Lewy Body
- Medication exists to:
 - Slow down the disease process and to prevent further damage.
 - To improve memory, cognition and activities of daily living
 - To treat behaviour problems such as: Agitation
 - Sleep disturbance
 - Depression

Medication to prevent further vascular damage: Antihypertensive

Aspirin

Warfarin if atrial fibrillation

- Avoid anticholinergics
- Reality orientation
- User friendly environment: safety, labelling
- Respite
- Dementia Associations
- Long term institutionalization such as psycho-geriatric units and mentally infirm units.

Incontinence of Urine and Faeces

Incontinence of Urine

Definition: A condition in which involuntary loss of urine occurs, which is a social and hygienic problem, and which is objectively demonstrable.
(International Continence Society)

How Common

Data varies (developed countries), in elderly age, from 65 years onwards

Community Dwellers	10% -- 20% Females 7% -- 10% Males
Residential Homes	25%
Long Term Wards	50%
Long Term Psycho-Geriatric Wards	80%
Hospital Wards	50% -- 70%

Incontinence is:

- Increased association with age
- Increased association with physical activity
- Increased association with faecal incontinence especially in nursing homes and long-stay wards.

Potential Effect

Wet: cellulitis and pressure sores

Retention and Catheter: urinary tract infection

Wet floor: falls and fractures

Wet sheets: sleep interruptions

Odor: embarrassment, depression, social withdrawal

Carer breakdown: chronic institution

Causes

Usually multifunctional such as

Specific genitourinary pathology

+/-

Age associated changes

+/-

Co-morbid conditions

Types of Incontinence

- Transient
- Established

Causes of Transient Incontinence

1. Delirium
2. Infection
3. Atrophic vaginitis and erythritus
4. Pharmaceuticals
5. Psychological
6. Excessive urine output
7. Restricted mobility
8. Stool impaction

Established Incontinence

- Urge (most common)
- Stress
- Overflow

Urge Incontinence

Symptoms of urgency, frequency, leakage

Problems is of detrusor over activity (uninhibited bladder contraction)

Can be due to a neurological condition. Such as: Strokes, Alzheimer's and spinal cord injuries.

Can occur without a neurological problem (detrusor instability, unstable bladder)

It is usually idiopathic (without specific cause)

It is usually age related

Can be caused by local bladder pathology and irritation e.g. cancer, stones, obstruction.

Stress

Symptoms or leakage with increased abdominal pressure

Caused by impaired urethral closure due to insufficient support from the pelvic muscles

- A. Second most common cause in females
- B. Can also occur in males as a result of post prostatectomy

Overflow Incontinence

Symptoms of dribbling, small volume, leakage, hesitancy and weak stream

Caused by outlet obstruction or detrusor under activity or both

It is the second most common in men:

- A. Obstruction:- prosthetic hypertrophy, cancer, urethral stricture, large cystocele
- B. Neurological causes

Assessment

History

- Ask specifically whether the problem exist
- Whether recent or longstanding
- Whether both day and night or during the night only
- The frequency, timing and volume of urine (voiding record-time, volume)
- Any other urinary symptoms
- Medical conditions
- Mental state
- Bowel habits

Clinical Examination

- Alertness, cognitive function
- Functional status
- Neurological examination
- Abdominal Examination such as palpable bladder
- Gynaecological examination to exclude vaginitis or cystocoele
- Rectal examination (faecal impaction, prostate hyperthrophy, palpable masses)

Investigations

Urine analyses and microscopy

Urine culture and sensitivity

Blood tests:- glucose, renal function and electrolytes

Abdominal X-Rays to detect impaction or bladder stone

Ultra sound

Urodynamic tests to measure flow, pressure and residual urine.

Management

Treat Transient cause (infection, constipation, diabetes control)

Use of commodes

Environment

In Established

Continence Chart

Bladder re-training

Regular toileting

Pelvic floor exercises

Operation (prostate, cystocoele)

Pads, pants nappies

Catheterization always as a last remedy

Never as a first option unless retention

Potential Catheterization Problems

- Can cause trauma or urethral stricture
- Can cause infection
- Can leak, get blocked (encrustations), cause bladder contractions
- Can get stuck either on insertion or when removing
- Can fall out
- Need regular changing

Faecal Incontinence

Definition: Involuntary leakage of rectal content through the anal canal (Royal College of Physicians 1995)

Prevalence:

- | | |
|----------------------|-----------|
| a. Community | 1% - 4% |
| b. Residential homes | 10% |
| c. Long stay wards | 25% - 35% |

Causes

- Immobility
- Constipation and impaction
- Neurological (dementia, stroke, parkinson's)
- Diarrhoea
- Pathology
- Weakness of anal sphincter or pelvic floor muscles
- May be multi functional

Causes of Constipation

Diet (Lack of roughage)

Dehydration

Immobility

Carcinomas

Medicines such as anti-depressants

Neurological problems

Diarrhoea

Any condition that induces diarrhoea can lead to faecal incontinence such as:

Infective enteritis

Diverticulitis

Colitis

Carcinoma

Medication (antibiotics)

Malabsorption Syndrome

Frequent watery stools

Neurological

Causes include: Dementia

Stroke

Frequency once or twice daily

Can occur half an hour after meals (gastro-colic reflux)

Assessment

- Onset
- Stool frequency
- Stool consistency (solid, semi liquid)
- Straining hard motions (constipated)
- Rectal sensation intact? (neurological)
- Delayed defecation (Neurological)
- Other symptoms (blood, mucus, pain)
- Diet (roughage)
- Fluid intake
- Medication
- Mental state

Clinical Examination

- Abdominal masses (faecal, carcinoma)
- Rectal examination masses(blood, stool consistence, faecal loading)
- Mobility
- Hydration
- Mental state
- Neurological examination

Investigations

Plain abdominal X-Ray

Ba enema

Sigmoidoscopy or colonoscopy

Blood tests: Anaemia

Renal function

Electrolytes

Thyroid function

Management

1. Continence Chart: stool frequency, consistency, treatment effect
2. Diarrhoea: treat cause
3. Constipation / Impaction: Empty rectum (suppositories, enemas, manual evacuation)
4. Prevent recurrence (diet, fibre, hydration, mobility, laxatives)

Rehabilitation

Rehabilitation was introduced about sixty years ago around the 1940's by Marjorie Warren

Rehabilitation focuses elderly people to regain their best possible functional independence.

Rehabilitation concerns the restoration of the individual to his or her the fullest physical mental and social capabilities.

World Health Organisation 1970

It is a process aiming to restore personal autonomy in those aspects of Daily Living (A.D.L.), considered most relevant by patients or service users and their family carers.

Rehabilitation is a complete process, usually involving several professional disciplines. It is aimed at improving the quality of life of older people, facing daily living difficulties, caused by chronic disease.

Young J., B.M.J. 1996

Geriatrics is that branch of general medicine which concerns with the clinical, preventive, remedial and social aspects of illness of older people.

Their morbidity rates, different patterns of disease, presentation, slow response to treatment and requirements.

Rehabilitation Objective

The main purpose is to restore an ill and disabled old person to a level of maximum ability and possible return the person to community.

British Geriatric Society

-  Impairment
-  Disability
-  Handicapped

Impairment is loss or abnormality of anatomical, physiological structure or function.

Disability (Activity) is the restriction or lack of ability to perform a task.

Handicap (Participation) concerns the disadvantage resulting from an impairment / disability that limits or prevents the fulfilment of a Role which is normality for that age.

Rehabilitation is about the following

- A. Intervening between impairments and disabilities and handicaps
- B. Is concerned with lessening the impact of disabling conditions
- C. Is central to the management of old persons
- D. Those involved in their care is to maximise the assets and minimise the deficits of old people to promote independent community living.

Process of rehabilitation

- ✓ Is active, problem – solving and educational
- ✓ Focus is on disabilities
- ✓ Consist of the identification of problems (assessment), goal setting
- ✓ Intervention, i.e. improve and maintain
- ✓ Evaluation, i.e. effects of intervention

BED IS BAD

Bedsore
Joint stiffness
Foot drop
Contractures
Muscle wasting
Constipation
Faecal impaction and incontinence
Urine incontinence
Loss of balance
Potential hypotension
Chest infection
Deep vein thromboses
Pulmonary embolism
Dehydration
Undernutrition
Osteoporoses
Demoralisation

IT IS OF UTMOST IMPORTANCE TO GET OLDER PERSONS OUT OF BED.

The issue of rehabilitation is Holistic

WHY?

- By general definition an entire criterion is greater than the sum of its parts.
- In the medical field: Consideration of the complete person in the treatment or disease.

Factors required for successful rehabilitation

- ✚ Holistic approach
- ✚ Team working
- ✚ Positive attitude and approach
- ✚ Individual assessment of patients and carers
- ✚ Involvement of patients and carers
- ✚ Promote independence by special and general therapeutic techniques optimizing the environment.

Barriers to the rehabilitation process

- ❖ Unidentified medical problems such as side effects of drugs (postural hypotension and fatigue due to heart failure).
- ❖ Depression (unrecognised)
- ❖ Dementia (unrecognised)
- ❖ Communication problems (unrecognised)
- ❖ Teamwork problems
- ❖ Patient problems. Prefers to remain dependant because the person is afraid.

Type of practice - Inter disciplinary team

- Multi and different disciplines
- Each discipline provides specific assessment and intervention
- Formal commitment to sharing of information and assessments, common goal setting, problem solving, decision done together, coordination of approach, planning, implementing, evaluating together.
- Shared accountability for actions
- Clients usually active members

Advantages

- ✚ Diverse skills brought together
- ✚ Quality care improved
- ✚ Record for each patient
- ✚ One team leader
- ✚ Agreed set of objectives and priorities
- ✚ Operational practices and procedures govern all team members

Dilemmas

- ✚ Preparation for such interaction and practice
- ✚ Loss of freedom to make unilateral decisions and to take unilateral action
- ✚ Potential conflicts between long established disciplines and emerging disciplines
- ✚ Inexperienced or new team members 'not fitting in'
- ✚ Learning to work 'with' rather 'for' the old person and carers

Team definition

Group of workers, with agreed aims and objectives

Collaborate together

Work in a formulized manner

Have a clear understanding of each other's roles and expectations.

Each member will have

Different aims/objectives

Different members

Different mix of assessment, treatment, advice

Structure of members

- Should have relevant skills and knowledge
- Can resolve most of the problems found by the old persons
- Involve and educate common goals for each old person

Pool of members

- Nurse
- Doctor
- Physiotherapist
- Occupational therapist
- Social worker
- Pharmacist
- Carer
- Patient
- Priest

Other members

- Speech therapist
- Foot care
- Psychiatrist
- Tissue viability service
- Continence advisor

MUSTS for MEMBERS

- ❖ Must understand, accept, value and respect each other as discipline representative, as professional and as individual.
- ❖ Must trust each other
- ❖ Must communicate with each other
- ❖ Must compliment each other

Other qualities

- Be accessible
- Continually maintain morale
- Be enthusiastic
- Be interesting
- Good humoured
- LEAD BY EXAMPLE

Aims of Geriatric Services such as Hospital Based

- Improve diagnoses and treatment
- Increase patient's functional level
- Increased quality care
- Achieve appropriate placement
- Reduce use of institutions

SUCCESSFUL REHABILITATION EQUATES TO BEST DISCHARGE AND PATIENTS LEAVE BETTER.

Institutional Care

Long stay institutions started during the 1940's in U.K

Some Points

- ✚ No one should enter long term care without prior assessment, rehabilitation and treatment. This should reduce inappropriate long term care.
- ✚ Comprehensive geriatric assessment helps better transferring to long term care
- ✚ Any placement in long term care should not be final but open to review and reassessment.
- ✚ More domiciliary care Less Institutionalization

Institutional Care

- A. Hospital type wards
- B. Nursing homes
- C. Residential homes

Hospital Type Wards

- Multiple chronic problems
- Very dependent in A.D.L's
- Recurrent illness
- Continual supervision, monitoring and interventions

Nursing Homes

- Dependent
- Chronic Problems
- Stable clinical condition

Residential homes have the following factors

- A. Protected environment
- B. Need help in activities of daily living
- C. Services are run by:
 - State
 - Private sector
 - Voluntary
 - Church

Residential Homes

- Old persons unable to live independently **even** with the help of domiciliary services
- Care usually limited to what might have been provided by a competent and caring relative
- Help required in activities of daily living such as toilet needs, taking medicines and attention when sick
- People with disabilities should also be considered if they are nearly self-sufficient or require help such as wheelchair, colostomy and artificial leg.
- Intractable incontinence that cannot be managed
- Manage and help confused patients but not to behaviour problems
- Should not be used as nursing homes or extensions of hospitals
- Demands will depend on domiciliary services

Nursing homes

- Provide Nursing care
- Spectrum of care wider
- Needs of residents may alter over the time

Criteria for admission

- i. Condition/ disability/ behaviour that:- progressively deteriorating changes weekly with no set of patterns
- ii. Persistent vegetative state
- iii. Short term terminal illness
- iv. Severe behaviour problems not anticipated to improve, places individual or others at risk

Services for the elderly long stay care

- Last resort
- Strict entry criteria
- Quality care
- Quality environment
- Audit tools to measure and improve care

Implications in the U.K.

- ❖ Lack of privacy, homely surroundings and personal space
- ❖ Commodes in full **view** of others, toilets without doors or curtains
- ❖ Overcrowding
- ❖ Use of restraints
- ❖ Excessive use of pooled clothing
- ❖ Minimal medical participation
- ❖ Poor communication among professions
- ❖ Minimal ward rounds
- ❖ Poor standard ward used as punishment wards
- ❖ One prescription chart to last for a lifetime

(BMJ 1990)

Others problems

- ❖ Fixed routines and batch treatment
- ❖ Depersonalization

Threats

- ✓ Autonomy vs Depersonalization and infantilisation
- ✓ Choice vs. Rigidity of routine and structured living
- ✓ Dignity vs. Block treatment of old persons
- ✓ Individuality vs. Levels of social distance between staff and residents
- ✓ Individuality vs. Residents seen as homogenous

Principles of management in long stay institutions

1. Accommodation is acceptable environment with Maintenance of Standards
2. Maintain patient's physical and mental capabilities by appropriate stimulation and rehabilitation activity
3. Active therapy if indicated for acute illness
4. Apply principles of good terminal care
5. Encourage healthy relationships between patients, staff relatives and visitors

REMEMBER

Objectives in the care of old people are **INDEPENDENCE** and **DIGNITY**.

If not independence than **DIGNITY**