



Care for Elderly

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بسم الله الرحمن الرحيم

وَقَضَىٰ رَبُّكَ أَلَّا تَعْبُدُوا إِلَّا آيَاهُ وَبِالْوَالِدَيْنِ إِحْسَانًا، أَمَا يَنبُلُغُنَّ عِنْدَكَ الْكِبَرُ أَخَذَهُمَا أَوْ
كَلَاهُمَا فَلَا تَقْل لَّهُمَا أَوْ لَا تَنْهَرْهُمَا وَقُل لَّهُمَا قَوْلًا كَرِيمًا « الإسراء 23



“You do not heal old age ,you
protect it, you promote it, you
extend it”



Objectives:

Definitions

Significance of geriatric group

Role of Family physician

Geriatric assessment

Geriatric Health hazard

Geriatric screening and prevention

Introduction



Aging is not merely the passage of time. It is the manifestation of biological events that occur over a span of time.

It is important to recognize that people age differently. The aging body does change. Some systems slow down, while others lose their "fine tuning."

As a general rule, slight, gradual changes are common, and most of these are not problems to the person who experiences them. Sudden and dramatic changes might indicate serious health problems.



Definitions

Greek:

gerus = old age

iatrea = treatment

Geriatrics: A branch of medicine that deals with the problems and diseases of old age and aging people.

Gerontology: Comprehensive study of aging and the problems of the aged people .

Aging: Period of life when impairment of physical and mental functions becomes increasingly manifested in comparison to the previous years of life.



Who Is Old person

Although there are commonly definitions used of old age, there is **NO general agreement** on the age at which a person become old.

Lacking an accepted definition of old person , in many instances , the **age at which a person become eligible for statutory and occupational retirement pensions** has become the default definition .

The ages of **60 and 65 years** are often used .



Significance of geriatric group

Declining death rate and increasing life expectancy:

In Palestine:

MOH has reported the crud death rate in Palestine is 2.7/1000 population in 2005 (3.1 GS and 2.5 WB)

Population natural increase is 3.3%.

Life expectancy in 2005 is 71.7 years for males and 73 years for female.

60-64 years age group is 1.1% of total population in 2005, where >65 years age group is 2.6% of total population.

In Egypt:

Death rate dropped from 38.3/1000 population in 1931 to 8.6/1000 in 1988 then 6.3/1000 in 1997.

Life expectancy : male/female ratio increase from 41.4/47 in 1947 to 54/56.8 in 1980 then 62.9/66 in 1996.



Significance of geriatric group

In UK:

65 age group is 15.5% of population in 1987 and reach 20% of population in 2000.

Social change with modernization.

Aging process is associated with varied hazards due to progressive impairment of physiological function and pathological change and their sequel .

Role of Family physician in geriatric care

Family physicians are responsible for the care of increasing numbers of elderly patients and their unique and complex primary care needs.

Older patients often have comorbidities; “polypharmacy”; and psychological, social, and functional impairments.

These can lead to variability in presentation of health problems and make diagnosis and treatment challenging for the family physician.

Primary care physician can identify specific problem that are common in elderly and shift their focus from disease specific intervention to preventive care management.





**As well as adding years to life, it is also
important to add life to years**



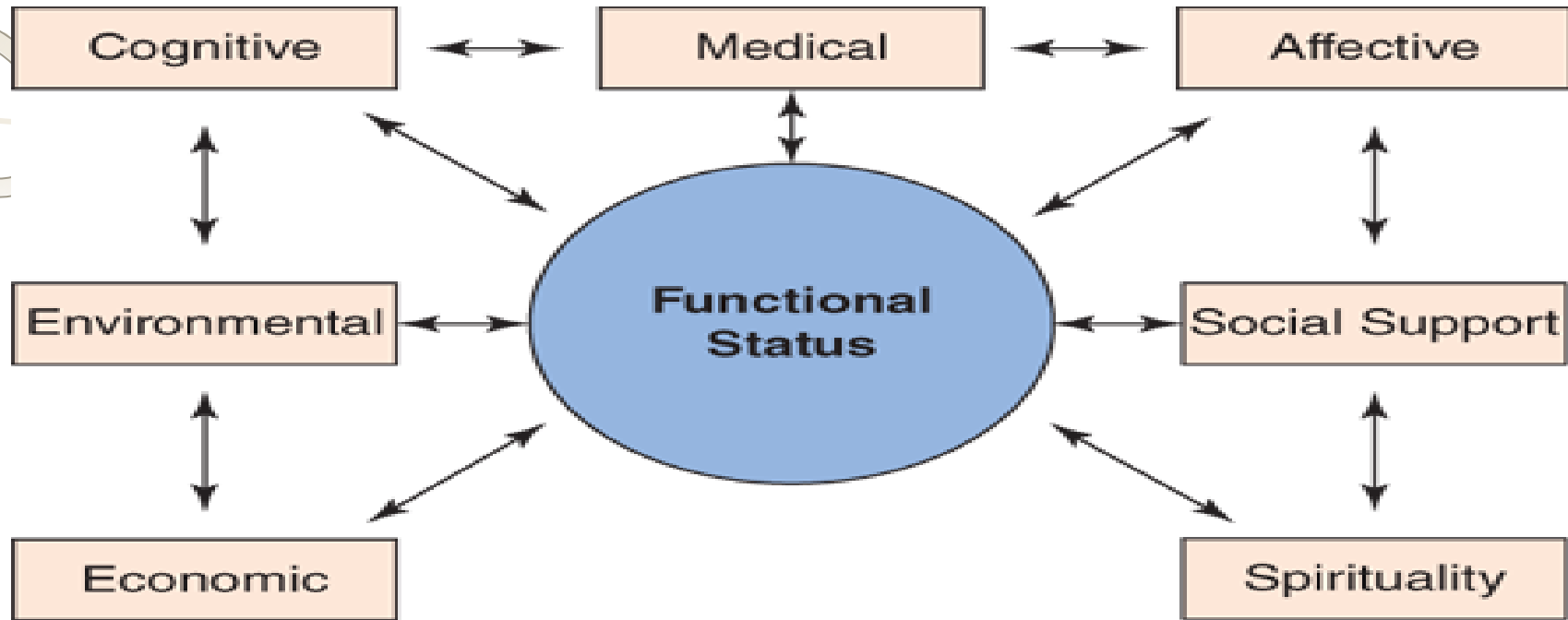
Geriatric Assessment

A comprehensive geriatric assessment is defined as a multidisciplinary process that identifies medical, psychosocial, and functional limitations of a frail older person in order to develop a coordinated plan to maximize overall health with aging.

CGA is a systematic approach to the collection of patient data.

Individualized approach

The first step is **Establishing rapport** with the elderly patient





Behaviors and situations that can irritate and confuse elderly patients :

Having a consulting room with slippery steps, poor lighting and inadequate handrails.

keeping them waiting

Having low soft chairs in the waiting room and surgery

Being overfamiliar, with addresses such as 'Pop' or first names for elderly females

Shouting at them on the assumption that they are deaf.

Appearing rushed and keen to get the consultation over quickly

Forgetting their psychosocial problems and concentrating only on their physical problems (i.e. not treating the whole person)



Forgetting that they have several things wrong with them and using a different priority list from theirs

Failing to ask patients to give their understanding of what is wrong

Omitting to give printed patient education hand-outs about their problems and medications

Omitting to explain how the medication will work

Treating them as though they would have little comprehension of their health and treatment.

Failing to respect their privacy, such as not knocking before entering the examination room

Failing to re-evaluate carefully their health and medication.



Goals of Geriatric assessment

1. Focus on preventive medicine rather than acute medicine.
2. Focus on improving or maintaining functional ability and not necessarily a "cure."
3. Provide a long-term solution for "difficult to manage" patients with multiple physicians, recurrent emergency department visits, and hospital admissions with poor follow-up.
4. Aid in the diagnosis of health-related problems.
5. Develop plans for treatment and follow-up care.
6. Establish plans for coordination of care.
7. Determine the need and site of long-term care as appropriate.
8. Determine optimal use of health care resources.
9. Prevent readmission into the hospital.



The geriatric assessment can be divided into four categories :

Medical

Functional

Psychological

and social.

Within each of these categories are a number of approaches, including use of office-based instruments that can aid in the collection of information and streamline the plan of care.



FUNCTIONAL ASSESSMENT

Functional status refers to a **person ability to perform tasks that are required for living** .

Age in and of itself is never criterion for medical decisions but function is.

The functional assessment focuses on **activities of daily living (ADLs)** and **risk screening for falls** .

Activity of daily living is divided into three levels “ **Basic** , **Instrumental** and **Advanced** .



The basic ADL activities are typically listed as :

Self-feeding

Functional Mobility

(moving while performing activities, getting in and out of bed, in and out of a chair)

Dressing

Bathing or Showering

Personal Hygiene

(includes brushing/styling hair, shaving, grooming activities)

Toilet Hygiene

(includes getting to the toilet, self-cleaning, getting up from the toilet)



IADLs most often refer to the following types of activities with long-term care :

Cooking and Preparing Meals

Cleaning and Maintaining the Home

Shopping and Buying Necessities

Managing Money and Paying Bills

Speaking or Communicating on the Phone or Through Other
Devices

Taking Prescribed Medications



The **advances activity of daily living(AADLs)** such as practicing a profession , or trade and contributing to society in other ways.

TYPES OF ACTIVITIES OF DAILY LIVING (ADLs)

Basic ADLs

consists of
self-care tasks



Personal Hygiene



**Continence
Management**



Dressing



Feeding



Ambulating



Toileting

Instrumental ADLs

not necessary for fundamental
functioning, but they let an
individual live independently
in a community



**Companionship &
Mental Support**



**Transportation
& Shopping**



Preparing Meals



Managing Household



**Managing Medications
& Finances**



**Communicating
with Others**



ADL impairment is a **stronger predictor** of hospital outcomes (functional decline, length of stay, institutionalization, and death) than admitting diagnoses.

ADL impairment is also **a risk factor** for nursing home placement, emergency room visits, and death among community-dwelling adults.

Approximately **25% to 35% of older patients** admitted to the hospital for treatment of acute medical illness **lose independence in one or more ADL** .



GERIATRIC SYNDROMES

- 1) **Falls**
- 2) **Urinary Incontinence**
- 3) Elder abuse
- 4) Pressure ulcers
- 5) **Rational Drug Prescribing for elderly patients**



Geriatric health hazards

Morbidity diseases:

1. **Cardiovascular (the most common):**

Atherosclerosis.

Hypertension and complication.

Varicosity.

2. **Nervous:**

Cerebrovasclar disease: due to thrombosis, embolism hemorrhage.
involved in sensory and motor nerves.

Neuritis, paralysis and defective sphincter control.

Dementia, psychoneurosis.

3. **Dental problems**

Interfere with proper Feeding.



Geriatric health hazards

4. Bone and joints

Osteoarthritis.

Osteoporosis.

5. Malnutrition and deficiency

6. Respiratory

Chronic bronchitis

emphysema

7. Disorders of special sense

Presbycusis : impaired hearing with aging and deafness.

Diminished speech discrimination.

8. Others :

Diabetes mellitus

neoplasia



Geriatric health hazards

Injuries: The elderly are exposed to accident that cause injury of varied severity.

Disability: Morbidity of aging and injuries may interfere with physical activity and/or mental and psychological behavior.

Mortality:

Cardiovascular disease, special CHD and cancer cause up to 75% of total death.

Cerebrovascular disease: causing around 15% of death.

Respiratory disease, infection and others.



RISK OF GERIATRICS

Prone for infections

Prone for injuries

Need special assistance

Prone for psychological problems

Prone for degenerative disorders

Increased risk for disease

Increased risk of disability

Increased risk of death



Geriatric services

1. Adequate nourishment

Nutrition education for elderly and family.

Dietary supplementation.

Management of morbidity, including :

Anorexia that may contribute to nutrition deficiency .

Rationing of subsidized food and geriatric food if needed.

2. Social welfare:

To have convenient living accommodation either with the family or geriatric home or special sanatorium according to circumstance .



Geriatric services

3. Health education :Teaching and counseling the elderly for principle healthful lifestyle.

4. Socioeconomic promotion

Satisfactory income and social study to solve problems and provide support when needed.

Convenient living condition at home or geriatric home.

5. Health appraisal

Periodic medical examination for early case finding and management.

Screening test (glaucoma, malignancy, hearing loss...etc)

Survey studies: to identify and investigate geriatric problems and morbidity.

6. Curative service :

Diagnosis and management of disease of elderly.

Home visit :may be needed for medical care, social service and health education.



PREVENTION

Primordial prevention

Pre geriatric care

Primary prevention

Health education

Exercise

Secondary prevention

Annual medical check-up

Early detection (Universal approach, Selective approach)

Treatment

Tertiary prevention

Counseling and Rehabilitation

Welfare activities

Chiropody services

Screening of elderly



Screening of elderly

For the elderly screening programme to succeed you will need the following:

1. An up to date age sex register.
2. An enthusiastic primary health team (practically the practice nurse).
3. A good referral system (chiropodists, dietitian, occupational therapist's).

The screening protocol:

4. Sensory function, assessment of hearing and vision.
5. Mobility(arthritis, Parkinson's, any recent fall) consider also her any specific aids required.
6. Mental condition :depressed, confused.
(score by asking specific question: time, date, address...)



Screening of elderly

4. **Physical condition :**

Appearance, weight, anemia, hypothyroidism, basal cell carcinoma.

Current medical problems.

Smoking and alcohol.

Continence urinary and fecal.

Assessment of cardiovascular system.

Urine tests for protein and sugar.

5. **Social environment :**

Accommodation (warm, telephone available)

Cares/contact with others

Need for help e.g (bath nurse, home help, meal on wheel)

6. **Use of medicines: the observation made must be noted in patient medical record.**

