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ସମ୍ବଲପୁର
Odisha State Open University
Sambalpur

CERTIFICATE IN GERIATRIC CARE (CGC)

INTRODUCTION TO
GERONTOLOGICAL NURSING

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Geriatric Care Nursing

Block –01

Introduction to Gerontological Nursing

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UNIT – 1: CONCEPTS OF GERONTOLOGICAL NURSING

Structure

1.1 INTRODUCTION TO GERONTOLOGICAL NURSING

Aging, the normal process of time-related change, begins with birth and continues throughout life. The older segment of the population is growing more rapidly than the rest of the population: the U.S Census Bureau projects that by the year 2030, there will be more than 65 years of age than people younger than 18 years of age. As the older population increases, the number of people who live to be very old will also increase. Health professionals will be challenged to design strategies that address the higher prevalence of illness within this aging population. Many chronic conditions commonly found among older people can be managed, limited, and even prevented. Older people are more likely to maintain good health and functional independence if appropriate community-based support services are available.

1.2 HISTORY OF GERONTOLOGICAL NURSING

The history and development of gerontological nursing is rich in diversity and experiences, as is the population it serves. There has never been a more opportune time than now to be a gerontological nurse. No matter where nurses practice, they will at some time in their career care for older adults. The health care movement is constantly increasing life expectancy; therefore, nurses must expect to care for relatively larger numbers of older people over the next decades. With the increasing numbers of acute and chronic health conditions experienced by elders, nurses are in key positions to provide disease prevention and health promotion, and to promote positive aging.

The American Journal of Nursing, the American Nurses Association (ANA), and the John A. Hartford Foundation Institute for Geriatric Nursing at New York University contributed significantly to the development of the specialty of gerontological nursing. The specialty was formally recognized in the early 1960s when the ANA recommended a specialty group for geriatric nurses and the formation of a geriatric nursing division, and convened the first national nursing meeting on geriatric nursing practice. The growth of the specialty soared over the next three decades. In the early 1970s, the ANA Standards for Geriatric Practice and the Journal of Gerontological Nursing were first published (in 1970 and 1975, respectively). Following the enactment of federal programs such as Medicare and Medicaid, rapid growth in the health care industry for elders occurred. In the 1970s, the Veterans Administration funded a number of Geriatric Research Education and Clinical Centres (GRECCs) at VA medical centres across the United States.

Nurses were provided substantial educational opportunities to learn about the care of older veterans through the development of GRECCs. The Kellogg Foundation also funded numerous certificate nurse practitioner programs at colleges of nursing for nurses to become geriatric nurse practitioners. These were not master's in nursing–level programs, but provided needed nurses who were trained in geriatrics to meet the growing needs of an aging population. Terminology used to describe nurses caring for elders has included geriatric nurses, gerontic nurses, and gerontological nurses. These terms all have various meanings; however, gerontological nursing provides an encompassing view of the care of older adults. In 1976, the ANA Geriatric Nursing Division changed its name to Gerontological Nursing Division and published the Standards of Gerontological Nursing (Ebersole&Touhy, 2006; Meiner&Lueckenotte, 2006). The decade of the 1980s saw a substantial growth in gerontological nursing when the National Gerontological Nursing Association was established, along with the ANA statement on the Scope and Standards of

Gerontological Nursing Practice. Increased numbers of nurses began to obtain masters and doctoral preparation in gerontology, and higher education established programs to prepare nurses as advanced practice nurses in the field (geriatric nurse practitioners and gerontological clinical nurse specialists).

Thus, interest in theory to build nursing as a science grew and nurses were beginning to consider gerontological nursing research as an area of study. Implementation of five Robert Wood Johnson (RWJ) Foundation Teaching Nursing Homes provided the opportunity for nursing faculty and nursing homes to collaborate to enhance care to institutionalized elders. An additional eight community-based RWJ grant–funded demonstration projects enabled older adults to remain in their homes and fostered cooperation between social service and health care agencies to partner in providing in-home care.

In the 1990s, the John A. Hartford Foundation Institute for Geriatric Nursing was established at the NYU Division of Nursing. It provided unprecedented momentum to improve nursing education and practice and increase nursing research in the care of older adults. In addition, it focused on geriatric public policy and consumer education. The Nurses Improving Care for Health system Elders (NICHE) program gained a national reputation as the model of acute care for older adults. The 21st century has provided a resurgence in gerontological care, as older adults are gaining full status and recognition by society. As the baby boomers enter the older age group in 2011, this cadre of individuals will not only expect but demand excellence in geriatric care. In 2003, the collaborative efforts of the John A. Hartford Institute for Geriatric Nursing, the American Academy of Nursing, and the American Association of Colleges of Nursing (AACN) led to the development of the Hartford Geriatric Nursing Initiative (HGNI). This initiative substantially increased the number of gerontological nurse scientists and the development of evidence-based gerontological nursing practice. Today, there are multiple professional journals, books, Web sites, and organizations dedicated to the nursing care of older adults. One of the newest journals to emerge in 2008 was the Journal of Gerontological Nursing Research.

The development of gerontological nursing as a specialty is attributed to a host of nursing pioneers. The majority of these nurses were from the United States; however, two key trailblazers were from England. Florence Nightingale and Doreen Norton provided early insights into the “care of the aged.” Nightingale was truly the first geriatric nurse, because she accepted the nurse superintendent position in an English institution comparable to our current nursing homes. She cared for wealthy women’s maids and helpers in an institution called the Care of Sick Gentlewomen in

Distressed Circumstances (Wykle& McDonald, 1997). Doreen Norton summarized her thoughts on geriatric nursing in a 1956 speech at the annual conference of the Student Nurses Association in London. She later focused her career on care of the aged and wrote often about the unique and specific needs of elders and the nurses caring for them. She identified the advantages of learning geriatric care in basic nursing education as:

- Learning patience, tolerance, understanding, and basic nursing skills;
- Witnessing the terminal stages of disease and the importance of skilled nursing care at that time;
- Preparing for the future, because no matter where one works in nursing the aged will be a great part of the care;
- Recognizing the importance of appropriate rehabilitation, which calls upon all the skill that nurses possess; and
- Being aware of the need to undertake research in geriatric nursing (norton, 1956).

1.3 Landmarks in the development of Gerontological Nursing

The following is a summary of significant landmarks in the development of gerontological nursing as a specialty:

1902 American Journal of Nursing (AJN) publishes first geriatric article by an MD.

1904 AJN publishes first geriatric article by an RN.

1925 AJN considers geriatric nursing as a potential specialty Anonymous column entitled "Care of the Aged" appears in AJN.

1950 First geriatric nursing textbook, Geriatric Nursing (Newton), published First master's thesis in geriatric nursing completed by Eleanor Pingrey Geriatrics becomes a specialization in nursing.

1952 First geriatric nursing study published in Nursing Research.

1961 ANA recommends specialty group for geriatric nurses 1962 ANA holds first National Nursing Meeting on Geriatric Nursing Practice.

1966 ANA forms a geriatric nursing division First Gerontological Clinical Nurse Specialist master's program begins at Duke University 1968 First RN (Gunter) presents at the International Congress of Gerontology.

1970 ANA creates the Standards of Practice for Geriatric Nursing.

1973 ANA offers the first generalist certification in gerontological nursing (74 nurses certified).

1975 First nursing journal for the care of older adults published: Journal of Gerontological Nursing by Slack, Inc. First nursing conference held at the International Congress of Gerontology.

1976 ANA Geriatric Nursing Division changes name to Gerontological Nursing Division ANA publishes Standards of Gerontological Nursing.

1977 Kellogg Foundation funds Geriatric Nurse Practitioner certificate education First gerontological nursing track funded by the Division of Nursing at the University of Kansas.

1979 First national conference on gerontological nursing sponsored by the Journal of Gerontological Nursing.

1980 AJN publishes Geriatric Nursing journal Education for Gerontic Nurses by Gunter and Estes suggests curricula for all levels of nursing education ANA establishes Council of Long Term Care Nurses.

1980 First Robert Wood Johnson (RWJ) Foundation grants for health-impaired elders given (eight in the United States).

1981 First International Conference on Gerontological Nursing sponsored by the International Council of Nursing (Los Angeles, California) ANA Division of Gerontological Nursing publishes statement on scope of practice John A. Hartford Foundation's Hospital Outcomes Program for the Elderly (HOPE) using a geriatric resource nurse (GRN) model developed at Yale University under the direction of Terry Fulmer.

1982 Development of RWJF Teaching-Nursing Home Program (five programs in the United States).

1983 First endowed university chair in gerontological nursing (Florence Cellar Endowed Gerontological Nursing Chair) established at Case Western Reserve University.

1984 National Gerontological Nursing Association (NGNA) established ANA Division on Gerontological Nursing Practice becomes Council on Gerontological Nursing.

1986 National Association for Directors of Nursing Administration in Long Term Care established ANA publishes Survey of Gerontological Nurses in Clinical Practice.

1987 ANA revises Standards and Scope of Gerontological Nursing Practice.

1988 First PhD program in gerontological nursing established (Case Western Reserve University) 1989 ANA certification established for Clinical Specialist in Gerontological Nursing.

1990 ANA establishes Division of Long Term Care within the Council of Gerontological Nursing.

1992 Nurses Improving Care for Healthsystem Elders (NICHE) established at New York University (NYU) Division of Nursing based on the HOPE programs.

1996 John A. Hartford Foundation Institute for Geriatric Nursing established at NYU Division of Nursing NICHE administered through the John A. Hartford Foundation Institute for Geriatric Nursing 1998 ANA certification available for geriatric advanced practice nurses as geriatric nurse practitioners or gerontological clinical nurse specialists.

2000 American Academy of Nursing, the John A. Hartford Foundation, and the NYU Division of Nursing develop the Building Academic Geriatric Nursing Capacity (BAGNC) program.

2002 American Nurses Foundation (ANF) and ANA fund the Nurse Competence in Aging (NCA) joint venture with the John A. Hartford Foundation Institute for Geriatric Nursing.

2003 The John A. Hartford Foundation Institute for Geriatric Nursing, the American Academy of Nursing, and the American Association of Colleges of Nursing (AACN) combine efforts to develop the Hartford Geriatric Nursing Initiative (HGNI) John A. Hartford Foundation Institute for Geriatric Nursing at NYU awards Specialty Nursing Association Programs-in Geriatrics (SNAP-G) grants.

2004 American Nurses Credentialing Centre's first computerized generalist certification exam is for the gerontological nurse.

2005 Journal of Gerontological Nursing celebrates 30 years.

2007 NICHE program at John A. Hartford Foundation Institute for Geriatric Nursing at NYU receives additional funding from the Atlantic Philanthropies and U.S. Aging Program.

2008 Geriatric Nursing journal celebrates 30 years Journal of Gerontological Nursing Research emerges.

1.4 ATTITUDE TOWARDS AGING AND OLDER ADULTS

As a Geriatric care professional, you may have preconceived ideas about caring for older adults. Such ideas are influenced by your observations of family members, friends, neighbours, and the media, and your own experience with older adults. Perhaps you have a close relationship with your grandparents or you have noticed the aging of your own parents. For some of you, the aging process may have become noticeable when you look at yourself in the mirror. But for all of us, this universal phenomenon we call aging has some type of meaning, whether or not we have taken the time to consciously think about it.

The way you view aging and older adults is often a product of your environment and the experiences to which you have been exposed. Negative attitudes toward aging or older adults (ageism) often arise in the same way—from negative past experiences. Many of our attitudes and ideas about older adults may not be grounded in fact. Some of you may have already been exposed to ageism, which is often displayed in much the same way as sexism or racism—via attitudes and actions. This is one reason for studying the aging process—to examine the myths and realities, to separate fact from fiction, and to gain an appreciation for what older adults have to offer.

Population statistics show that the majority of your careers as Geriatric health professionals will include caring for older adults. As MathyMezey, director of the John A. Hartford Foundation Institute for Geriatric Nursing at NYU, stated, "The

population of older Americans is exploding. Geriatric patients are not one subgroup of patients but rather the core business of health systems" (Mezey, 2005). Providing high-quality care to elders requires knowledge of the intricacies of the aging process as well as the unique syndromes and disease conditions that can accompany growing older.

As you read and study this book, you are encouraged to examine your own thoughts, values, feelings, and attitudes about growing older. Perhaps you already have a positive attitude toward caring for older adults. Build on that value, and consider devoting your time and efforts to the practice of gerontological nursing. If, however, you are reading this chapter with the idea that gerontological nursing is a less desirable field of nursing, or that only those professionals who cannot find jobs elsewhere work in nursing homes, or that working with older people would be an option of last resort, then you may need to re-examine these feelings. Armed with the facts and some positive experiences with older adults, you may change your mind.

Advocates for older adults, such as Nobel laureate Elie Wiesel, feel that older adults, as repositories of our collective memories, should be appreciated and respected. As the 1997 American Psychological Association's keynote convention speaker, Wiesel said, " an old person represents wisdom and the promise of living a full life . . . the worst curse is to make him or her feel worthless" (American Psychological Association, 2008).

The older population is changing dramatically as the baby boomers (those born from 1946–1964) reach retirement age (as of 2011). Because this phenomenon is happening in many places around the globe , gerontology is the place to be! Caring for the largest number of older adults in history will present enormous opportunities. With the over-85 age group being the fastest growing, the complexity of caring for so many people with multiple physical and psychosocial changes will present a challenge for the most daring of nurses. Will you be ready?

The purpose of this chapter is to provide the essential information needed by students of gerontological nursing to provide quality care to older adults. In your study of this text, you will be presented with knowledge and insights from experienced professionals with expertise in various areas of gerontological nursing and geriatrics.

1.5 DEFINITIONS OF GERONTOLOGICAL NURSING

Gerontology is the broad term used to define the study of aging and/or the aged. This includes the biopsychosocial aspects of aging. Under the umbrella of gerontology are several subfields including geriatrics, social gerontology, geropsychology, geropharmacology, financial gerontology, gerontological nursing, and gerontological rehabilitation nursing.

Geriatrics is often used as a generic term relating to the aged, but specifically refers to medical care of the aged. For this reason, many nursing journals and texts have chosen to use the term gerontological nursing instead of geriatric nursing.

Social gerontology is concerned mainly with the social aspects of aging versus the biological or psychological. "Social gerontologists not only draw on research from all the social sciences—sociology, psychology, economics, and political science—they also seek to understand how the biological processes of aging influence the social aspects of aging".

Geropsychology is a branch of psychology concerned with helping older persons and their families maintain wellbeing, overcome problems, and achieve maximum potential during later life.

Geropharmacology is the study of pharmacology as it relates to older adults. The credential for a pharmacist certified in geropharmacology is CGP (certified geriatric pharmacist).

Financial gerontology is another emerging subfield that combines knowledge of financial planning and services with a special expertise in the needs of older adults. Cutler (2004) defines financial gerontology as "the intellectual intersection of two

fields, gerontology and finance, each of which has practitioner and academic components".

Gerontological rehabilitation nursing combines expertise in gerontological nursing with rehabilitation concepts and practice. Nurses working in gerontological rehabilitation often care for older adults with chronic illnesses and long-term functional limitations such as stroke, head injury, multiple sclerosis, Parkinson's disease, spinal cord injury, arthritis, joint replacements, and amputations. The purpose of gerontological rehabilitation nursing is to assist older adults to regain and maintain the highest level of function and independence possible while preventing complications and enhancing quality of life.

Gerontological nursing, then, falls within the discipline of nursing and the scope of nursing practice. It involves nurses advocating for the health of older persons at all levels of prevention. Gerontological nurses work with healthy elderly persons in their communities, acutely ill elders requiring hospitalization and treatment, and chronically ill or disabled elders in long-term care facilities, skilled care, home care, and hospice. The scope of practice for gerontological nursing includes all older adults from the time of "old age" until death.

1.6 CONCEPT AND SCOPE OF GERONTOLOGICAL NURSING

Gerontological nursing draws on knowledge about complex factors that affect the health of older adults. Older adults are more likely than younger adults to have one or more chronic health conditions, such as diabetes, cardiovascular disease, cancer, arthritis, hearing, impairment, or a form of dementia such as Alzheimer's disease. As well, drug metabolism changes with aging, adding to the complexity of health needs.

Gerontological nurses work in a variety of settings, including acute carehospitals, rehabilitation, nursing homes (also known as long term care homes and skilled nursing facilities), assisted living facilities, retirement homes, community health agencies, and the patient's home. Depending on the conditions of the geriatric's health determines what type of facility one should reside in. Assisted living facilities

are also known as a senior retirement home that provides care services depending on health conditions. Skilled nursing otherwise known as a nursing home is a place where they can reside and get provided with 24/7 cares.

Older adults have been referred to as "the core business of healthcare" by gerontological nursing experts. Population aging and the complexity of health care needs of some older adults means that older adults are more likely than younger people to use health care services. In many settings, the majority of patients are older adults. Thus, experts recommend that all nurses, not only those identified as gerontological nurses, need specialized knowledge about older adults. This position was endorsed by 55 US nursing specialty organizations.

1.7 PRINCIPLES OF GERONTOLOGICAL NURSING

According to Stanford School of Medicine- Ethno geriatrics, the principles of geriatric care include,

- Biopsychosocial approach: the integration of consideration of physical, psychological, and social factors in providing health care
- Use of multidisciplinary teams
- Importance of chronic illnesses and geriatric syndromes
- Importance of showing respect to older patients
- Goal of maximizing function Awareness and sensitivity to sensory changes
- Age-appropriate dosing and avoidance of interactions of multiple medications
- Continuity of care through the different components of geriatric care
    - Geriatric primary care
    - Geriatric acute care
    - Geriatric rehabilitation
    - Geriatric long-term care

- Community based

- Home care
- Adult day care/day health care
- Respite care

- Residential Services
  - Assisted living, board & care, adult care, or residential care
  - Nursing homes
  - Combinations of levels of care—Continuing care retirement communities
- Geriatric managed care: integration of primary, acute, and long term care
  - Program of All-inclusive Care for the Elderly (PACE)
  - U.S. Department of Veterans Affairs geriatric programs.

According to Emory, the basic principles of gerontological nursing are,

Principles	Descriptions
1. Aging is not a disease	➢ Aging occurs at different rates between individuals, within individuals in different organ systems. ➢ Aging alone does not generally cause symptoms. ➢ Aging increases susceptibility to many diseases and conditions ("homeostenosis"). ➢ Aging people are heterogeneous - some are very healthy, some are very ill.
2. Medical conditions in geriatric patients are commonly chronic, multiple,	➢ Older individuals commonly suffer multiple chronic conditions, making management complex and

and multifactorial	challenging. ➢ Acute illness are superimposed on chronic conditions and their management. ➢ Treatment for one chronic or acute illness can influence the management of other underlying conditions. ➢ Multiple factors are generally involved in the pathogenesis of geriatric conditions.
3. Reversible and treatable conditions are often under-diagnosed and under-treated in geriatric patients	➢ Older individuals, caregivers, and health professionals mistakenly attribute symptoms to "old age". ➢ Many conditions present atypically in the geriatric population. ➢ Systematic screening for common geriatric conditions can help avoid undiagnosed, treatable conditions. ➢ Geriatric "syndromes" are commonly undiagnosed and therefore not managed optimally, such as: delirium, gait, instability and falls, urinary incontinence, pain, and malnutrition.
4. Functional ability and quality of life are critical outcomes in the geriatric population	➢ Functional capacity, in combination with social supports, is critical in determining living situation and overall quality of life.

	➢ Small changes in functional capability (e.g., the ability to transfer) can make a critical difference for quality of life of older patients and their caregivers. ➢ Standard tools can be used to measure basic and instrumental activities of daily living and overall quality of life.
5. Social history, social support, and patient preferences are essential aspects of managing geriatric patients	➢ Understanding the patient's life history and preferences for care are critical (place of birth, education, occupation, family relationships, spirituality, resources, willingness to take risks and utilize resources for care, etc). ➢ Living circumstances are critical to managing frail older patients. ➢ Caregiver availability, health, and resources are critical determinants of care planning for frail older patients.
6. Geriatric care is multidisciplinary	➢ Interdisciplinary respect, collaboration, and communication are essential in the care of geriatric patients and their caregivers. ➢ Various disciplines play an important role in geriatric care, e.g. nursing, rehabilitation therapists, dieticians, pharmacists, social

	workers, etc.
7. Cognitive and affective disorders are prevalent and commonly undiagnosed at early stages	➢ Aging is associated with changes in cognitive function. ➢ Common causes of cognitive impairment include delirium, Alzheimer's Disease, and multi-infarct dementia. ➢ Geriatric depression is often undiagnosed. ➢ Screening tools for delirium, dementia, and depression should be used routinely.
8. Iatrogenic illnesses are common and many are preventable	➢ Polypharmacy, adverse drug reactions, drug-disease interactions, drug-drug interactions, inappropriate medications all common. ➢ Complications of hospitalization, such as falls, immobility, and deconditioning can be serious and life-threatening.
9. Geriatric care is provided in a variety of settings ranging from the home to long-term	➢ There are specific definitions and criteria for admission to different types of care settings.

care institutions	➢ Funding for care in different settings varies and depends on many factors. ➢ Transitions between care settings must be coordinated in order to avoid unnecessary duplication, medical errors, and patient injuries. ➢ Integrated, multi-level systems provide the most coordinated care for complex geriatric patients.
10. Ethical issues and end-of-life care are critical aspects of the practice of geriatrics	➢ Ethical issues arise almost every day in geriatric care. ➢ Advance directives are critical for preventing some ethical dilemmas. ➢ Principles of palliative care and end-of-life care are essential for high quality geriatric care.

1.8 SUMMARY

The older adults enjoy, good health, in national surveys as many as 40% of adults aged 65 and older report disability. Chronic diseases are the major reasons for disability, and heart diseases, cancer and stroke continued to be the three most significant causes of death in persons 65 years of age and older. Alzheimer's disease accounted for almost 44,000 deaths in 1999 (National Centre for Health statistics, 2000). It is the duty of the health professionals to coordinate with the health team members in providing care to the elderly and assist them for a better living.

1.9 CHECK YOUR PROGRESS

1.9.1 OBJECTIVE TYPE QUESTIONS

1. In humans, the time-related changes begins with birth and continues ……

2. …….contributed to development of gerontological nursing.

3. Gerontological nursing was 1st recognized in ……..…..

4. ……is the study of aged.

5. ……..refers to the study of medical care of aged.

6. Collaboration of ……..is required for care of elderly.

7. Residential services for elderly include ……..and ……

8. …….is the major chronic disease among aged population.

9. Gerontological nursing improves …….of elderly.

10. Aging is associated with changes in ……. function.

1.9.2 SHORT ANSWER QUESTIONS

1. Scope and concept of gerontological nursing?
2. Explain how the attitude of people influences the care of elderly?
3. Elaborate about the history of gerontological nursing?
4. Discuss the various landmarks in the origination of gerontological nursing?

1.9.3 ESSAY TYPE QUESTIONS

1. Define gerontological nursing? Explain in detail the various principles of gerontological nursing?

1.9.4 ANSWERS TO OBJECTIVE QUESTIONS

1. throughout life.
2. Hartford foundation institute for geriatric care
3. 1960s
4. Gerontology
5. Geriatrics
6. Health team members

7. Assisted living facilities and nursing homes.

8. Alzheimer's disease

9. Quality of life

10. Cognitive

1.10 KEY TERMS

1. **Gerontology-** is the broad term used to define the study of aging and/or the aged.
2. **Geriatrics-** is often used as a generic term relating to the aged, but specifically refers to medical care of the aged.
3. **Gerontological rehabilitation nursing-** combines expertise in gerontological nursing with rehabilitation concepts and practice.
4. **Gerontological nursing**, then, falls within the discipline of nursing and the scope of nursing practice.

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UNIT II:- APPROACH TO AN ELDERLY PATIENT

Structure

2.1 INTRODUCTION

Approach to the elderly for evaluation usually differs from a standard medical evaluation. For elderly patients, especially those who are very old or frail, history-taking and physical examination may have to be done at different times, and physical examination may require 2 sessions because patients become fatigued.

The elderly also have different, often more complicated health care problems, such as multiple disorders, which may require use of many drugs (sometimes called polypharmacy) and thus greater likelihood of a high-risk drug being prescribed. Diagnosis may be complicated, resulting in delayed, missed, or erroneous diagnoses leading to inappropriate use of drugs.

Early detection of problems results in early intervention, which can prevent deterioration and improve quality of life, often through relatively minor, inexpensive interventions (eg, lifestyle changes). Thus, some elderly patients, particularly the frail or chronically ill, are best evaluated using a comprehensive geriatric assessment, which includes evaluation of function and quality of life, best administered by an interdisciplinary team.

On average, elderly patients have 6 diagnosable disorders, and the primary care physician is often unaware of some of them. A disorder in one organ system can weaken another system, exacerbating the deterioration of both and leading to

disability, dependence, and, without intervention, death. Multiple disorders complicate diagnosis and treatment, and effects of the disorders are magnified by social disadvantage (eg, isolation) and poverty (as patients outlive their resources and supportive peers) and by functional and financial problems.

Clinicians should also pay particular attention to certain common geriatric symptoms (eg, delirium, dizziness, syncope, falling, mobility problems, weight or appetite loss, urinary incontinence) because they may result from disorders of multiple organ systems.

If patients have multiple disorders, treatments (eg, bed rest, surgery, drugs) must be well-integrated; treating one disorder without treating associated disorders may accelerate decline. Also, careful monitoring is needed to avoid iatrogenic consequences. For example, with complete bed rest, elderly patients can lose 1 to 3% of muscle mass and strength each day (causing sarcopenia), and effects of bed rest alone can ultimately result in death.

Disorders that are common among the elderly are frequently missed, or the diagnosis is delayed. Clinicians should use the history, physical examination, and simple laboratory tests to actively screen elderly patients for disorders that occur only or commonly in the elderly; when diagnosed early, these disorders can often be more easily treated. Early diagnosis frequently depends on the clinician's familiarity with the patient's behaviour and history, including mental status. Commonly, the first signs of a physical disorder are behavioural, mental, or emotional. If clinicians are unaware of this possibility and attribute these signs to dementia, diagnosis and treatment can be delayed. The elderly people must be approached by the health professionals at times of pain, cancer, psychological complications such as delirium, dementia, Alzheimer's which is already discussed in the previous chapters. A careful and detailed assessment of the elderly is required.

2.2 ASSESSMENT OF AN ELDERLY PATIENT

Often, more time is needed to interview and evaluate elderly patients, partly because they may have characteristics that interfere with the evaluation. The following should be considered:

- **Sensory deficits:** Dentures, eyeglasses, or hearing aids, if normally worn, should be worn to facilitate communication during the interview. Adequate lighting and elimination of visual or auditory distraction also helps.
- **Underreporting of symptoms:** Elderly patients may not report symptoms that they consider part of normal aging (eg, dyspnoea, hearing or vision deficits, memory problems, incontinence, gait disturbance, constipation,

dizziness, and falls). However, no symptom should be attributed to normal aging unless a thorough evaluation is done and other possible causes have been eliminated.

- **Unusual manifestations of a disorder:** In the elderly, typical manifestations of a disorder may be absent. Instead, the elderly may present with nonspecific symptoms (eg, fatigue, confusion, weight loss).
- **Functional decline as the only manifestation:** Disorders may manifest solely as functional decline. In such cases, standard questions may not apply. For example, when asked about joint symptoms, patients with severe arthritis may not report pain, swelling, or stiffness, but if asked about changes in activities, they may, for example, report that they no longer take walks or volunteer at the hospital. Questions about duration of functional decline (eg, "How long have you been unable to do your own shopping?") can elicit useful information. Identifying people when they have just started to have difficulty doing basic activities of daily living (BADLs) or instrumental activities of daily living (IADLs) may provide more opportunities for interventions to restore function or to prevent further decline and thus maintain independence.
- **Difficulty recalling:** Patients may not accurately remember past illnesses, hospitalizations, operations, and drug use; clinicians may have to obtain these data elsewhere (eg, from family members, a home health aide, or medical records).
- **Fear:** The elderly may be reluctant to report symptoms because they fear hospitalization, which they may associate with dying.
- **Age-related disorders and problems:** Depression (common among elderly who are vulnerable and sick), the cumulative losses of old age, and discomfort due to a disorder may make the elderly less apt to provide health-related information to clinicians. Patients with impaired cognition may have difficulty describing problems, impeding the physician's evaluation.

2.2.1 Interview

A clinician's knowledge of an elderly patient's everyday concerns, social circumstances, mental function, emotional state, and sense of well-being helps orient and guide the interview. Asking patients to describe a typical day elicits information about their quality of life and mental and physical function. This approach is especially useful during the first meeting. Patients should be given time to speak about things of personal importance. Clinicians should also ask whether patients have specific concerns, such as fear of falling. The resulting rapport can help the clinician communicate better with patients and their family members.

A mental status examination may be necessary early in the interview to determine the patient's reliability; this examination should be conducted tactfully so that the patient does not become embarrassed, offended, or defensive. Routine screening for physical and psychologicdisorders should be done annually, beginning at age 70.

Often, verbal and nonverbal clues (eg, the way the story is told, tempo of speech, tone of voice, eye contact) can provide information, as for the following:

- **Depression:** Elderly patients may omit or deny symptoms of anxiety or depression but betray them by a lowered voice, subdued enthusiasm, or even tears.
- **Physical and mental health:** What patients say about sleep and appetite may be revealing.
- **Weight gain or loss:** Clinicians should note any change in the fit of clothing or dentures.

Unless mental status is impaired, a patient should be interviewed alone to encourage the discussion of personal matters. Clinicians may also need to speak with a relative or caregiver, who often gives a different perspective on function, mental status, and emotional state. These interviews may be done with the patient absent or present.

The clinician should ask the patient's permission before inviting a relative or caregiver to be present and should explain that such interviews are routine. If the caregiver is interviewed alone, the patient should be kept usefully occupied (eg, filling out a standardized assessment questionnaire, being interviewed by another member of the interdisciplinary team).

If indicated, clinicians should consider the possibility of drug abuse by the patient and patient abuse by the caregiver.

2.2.2 Medical history

When asking patients about their past medical history, a clinician should ask about disorders that used to be more common (eg, rheumatic fever, poliomyelitis) and about outdated treatments (eg, pneumothorax therapy for TB, mercury for syphilis). A history of immunizations (eg, tetanus, influenza, pneumococcal), adverse reactions to immunizations, and skin test results for TB is needed. If patients recall having surgery but do not remember the procedure or its purpose, surgical records should be obtained if possible.

Clinicians should ask questions designed to systematically review each body area or system (review of systems) to check for other disorders and common problems that patients may have forgotten to mention.

2.2.3 Drug history

The drug history should be recorded, and a copy should be given to patients or their caregiver. It should contain

- Drugs used
- Dose
- Dosing schedule
- Prescriber
- Reason for prescribing the drugs
- Precise nature of any drug allergies

All drugs used should be recorded, including

- Topical drugs (which may be absorbed systemically)
- OTC drugs (which can have serious consequences if overused and may interact with prescription drugs)
- Dietary supplements
- Medicinal herb preparations (because many can interact adversely with prescription and OTC drugs)

Patients or family members should be asked to bring in all of the above drugs and supplements at the initial visit and periodically thereafter. Clinicians can make sure patients have the prescribed drugs, but possession of these drugs does not guarantee adherence. Counting the number of tablets in each vial during the first and subsequent visits may be necessary. If someone other than a patient administers the drugs, that person is interviewed.

Patients should be asked to demonstrate their ability to read labels (often printed in small type), open containers (especially the child-resistant type), and recognize drugs. Patients should be advised not to put their drugs into one container.

2.2.4 Alcohol, tobacco, and recreational drug use history

Patients who smoke should be counseled to stop and, if they continue, not to smoke in bed because the elderly are more likely to fall asleep while doing so.

Patients should be checked for signs of alcohol use disorders, which are underdiagnosed in the elderly. Such signs include confusion, anger, hostility, alcohol

odor on the breath, impaired balance and gait, tremors, peripheral neuropathy, and nutritional deficiencies. Screening questionnaires and questions about quantity and frequency of alcohol consumption can help. The 4 CAGE questions are quick and straightforward, the clinician asks if the patient has ever felt.

- Need to *C*ut down drinking
- *A*nnoyed by criticism about drinking
- *G*uilty about drinking
- Need for a morning "*E*ye-opener"

Two or more positive responses to the CAGE questions suggest the possibility of alcohol abuse. Questions about use of other recreational drugs or substances of abuse also are appropriate.

2.2.5 Nutrition history

Type, quantity, and frequency of food eaten are determined. Patients who eat ≤ 2 meals a day are at risk of undernutrition. Clinicians should ask about the following:

- Any special diets (eg, low-salt, low-carbohydrate) or self-prescribed fat diets
- Intake of dietary fiber and prescribed or OTC vitamins
- Weight loss and change of fit in clothing
- Amount of money patients have to spend on food
- Accessibility of food stores and suitable kitchen facilities
- Variety and freshness of foods

The ability to eat (e.g., to chew and swallow) is evaluated. It may be impaired by xerostomia and/or dental problems, which are common among the elderly. Decreased taste or smell may reduce the pleasure of eating, so patients may eat less. Patients with decreased vision, arthritis, immobility, or tremors may have difficulty preparing meals and may injure or burn themselves when cooking. Patients who are worried about urinary incontinence may reduce their fluid intake; as a result, they may eat less food.

2.2.6 Mental health history

Mental health problems may not be detected easily in elderly patients. Symptoms that may indicate a mental health disorder in younger patients (eg, insomnia, changes in sleep patterns, constipation, cognitive dysfunction, anorexia, weight loss, fatigue, preoccupation with bodily functions, increased alcohol consumption) may have another cause in the elderly. Sadness, hopelessness, and crying episodes may indicate depression. Irritability may be the primary affective

symptom of depression, or patients may present with cognitive dysfunction. Generalized anxiety is the most common mental disorder encountered in elderly patients and often is accompanied by depression.

Patients should be asked about delusions and hallucinations, past mental health care (including psychotherapy, institutionalization, and electroconvulsive therapy), use of psychoactive drugs, and recent changes in circumstances. Many circumstances (eg, recent loss of a loved one, hearing loss, a change in residence or living situation, loss of independence) may contribute to depression.

Patients' spiritual and religious preferences, including their personal interpretation of aging, declining health, and death, should be clarified.

2.2.7 Functional status

Whether patients can function independently, need some help with basic activities of daily living (BADLs) or instrumental activities of daily living (IADLs), or need total assistance is determined as part of comprehensive geriatric assessment. Patients may be asked open-ended questions about their ability to do activities, or they may be asked to fill out a standardized assessment instrument with questions about specific ADLs and IADLs.

2.2.8 Social history

Clinicians should obtain information about patients' living arrangements, particularly where and with whom they live (e.g., alone in an isolated house, in a busy apartment building), accessibility of their residence (e.g., upstairs or a hill), and what modes of transportation are available to them. Such factors affect the ability of the elderly to obtain food, health care, and other important resources. A home visit, although difficult to arrange, can provide critical information. For example, clinicians can gain insight about nutrition from the refrigerator's contents and about multiple ADLs from the bathroom's condition.

The number of rooms, number and type of phones, presence of smoke and carbon monoxide detectors, and condition of plumbing and heating system are determined, as is the availability of elevators, stairs, and air conditioning. Home safety evaluations can identify home features that can lead to falls (e.g., poor lighting, slippery bathtubs, unanchored rugs), and solutions can be suggested.

Having patients describe a typical day, including activities such as reading, television viewing, work, exercise, hobbies, and interactions with other people, provides valuable information.

Clinicians should ask about the following:

- Frequency and nature of social contacts (eg, friends, senior citizens' groups), family visits, and religious or spiritual participation)
- Driving and availability of other forms of transportation
- Caregivers and support systems (eg, church, senior citizens' groups, friends, neighbors) that are available to the patient
- The ability of family members to help the patient (eg, their employment status, their health, traveling time to the patient's home)
- The patient's attitude toward family members and their attitude toward the patient (including their level of interest in helping and willingness to help)

Marital status of patients is noted. Questions about sexual practices and satisfaction must be sensitive and tactful but thorough. The number and sex of sex partners are determined, and risk of sexually transmitted diseases (STDs) is evaluated. Many sexually active elderly people are not aware of the increasing incidence of STDs in the elderly and do not follow or even know about safe sex practices.

Patients should be asked about educational level, jobs held, known exposures to radioactivity or asbestos, and current and past hobbies. Economic difficulties due to retirement, a fixed income, or death of a spouse or partner are discussed. Financial or health problems may result in loss of a home, social status, or independence. Patients should be asked about past relationships with physicians; a long-time relationship with a physician may have been lost because the physician retired or died or because the patient relocated.

2.2.8 Advance directives

Patient wishes regarding measures for prolonging life must be documented. Patients are asked what provisions for surrogate decision making (advance directives) have been made in case they become incapacitated, and if none have been made, patients are encouraged to make them. Getting patients and their surrogates accustomed to discussing goals of care is important; then when circumstances require medical decisions and prior documentation is unavailable or not relevant to the circumstance (which is very common), appropriate decisions can be made.

LAWTON INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE

Activity	Description	Score
Using the telephone	Uses a telephone, including looking up and dialling numbers.	1
	Dials a few familiar numbers.	1
	Answers the telephone but does not dial.	1
	Does not use the telephone.	0
Shopping	Does all the shopping without help.	1
	Shops for small items without help.	0
	Shops for small items without help.	0
	Cannot do any shopping.	0
Preparing food	Plans, prepares, and serves adequate meals without help.	1
	If given the ingredients, prepares adequate meals.	0
	Heat and serves prepared meals or prepares meals but ones that are nutritionally inadequate.	0
	Needs someone to prepare and serve meals.	0
Doing household tasks	Does household tasks without help or occasionally with help for physically demanding tasks (eg, washing windows).	1
	Does light housework (eg, dish washing, dusting).	1
	Does light housework but does not keep the house adequately clean.	1
	Needs help with all household tasks.	1
	Does not do any household tasks.	0
Doing laundry	Does laundry without help.	1

	Washes small items (e.g., stockings).	1
	Needs someone to do all laundry.	0
Traveling other than by walking	Uses public transportation without help or drives a car.	1
	Calls for taxis but does not use other public transportation.	1
	Uses public transportation if accompanied by someone to help.	1
	Travels only by taxi or car and only if helped by someone.	0
	Does not travel.	0
Taking prescription drugs as directed.	Takes the correct doses of prescribed drugs at the correct time without help.	1
	Takes prescribed drugs if they are prepared in advance in separate dosage.	0
	Cannot dispense the prescribed drugs.	0
Managing money.	Manages finances (eg, making a budget, writing checks, paying rent, keeping track of income) without help.	1
	Buys small items needed on a daily basis but requires help with banking and major purchases.	1
	Cannot manage money.	0

2.3 APPROACHES TO AN ELDERLY PATIENT

2.3.1 Preliminary Steps (Before you walk into the room)

- Acuity increases with age, so beware of the under-triaged older adult based on
    - Atypical presentations of common complaints
    - **Stoicism or minimization of problem.**
- Review medical records (if available)
    - Does the patient have a history of dementia, delirium or other cognitive deficit? If so, verify (corroborate) any history
    - Is there **a pattern of ED(Emergency Department) visits to suggest unmet social needs** (e.g. caregiver fatigue; unsafe home environment; poor access to care)
    - Are there patterns of injuries to raise suspicion of elder abuse?
- Code status and goals of care.
    - If unclear, ask for this information and find out sooner than later.

2.3.2 Recommended Approach and Assessment

2.3.2.1 Subjective Assessment:

- Older adults may minimize complaints, conditions, and symptoms.
- Over **40% of older adults in ED have a cognitive deficit which may affect history-taking** (37% dementia; 5% delirium), corroborate history with family/caregiver/companion whenever feasible to not miss anything.
- Atypical chief complaints are common.
- "Confusion" – Is it dementia, delirium or an intracranial lesion?
    - **If they have dementia, how is this episode DIFFERENT FROM BASELINE?**
    - A "new" psychiatric problem (e.g. "psychosis" or "mania" or "aggressive behaviour" is RARELY a de novo psychiatric problem – think medical (organic) etiology first, then think medications, then think something else OTHER than.
    - Common medical problems can cause change in mutation: UTI; AMI; pain; thyroid dysfunction.

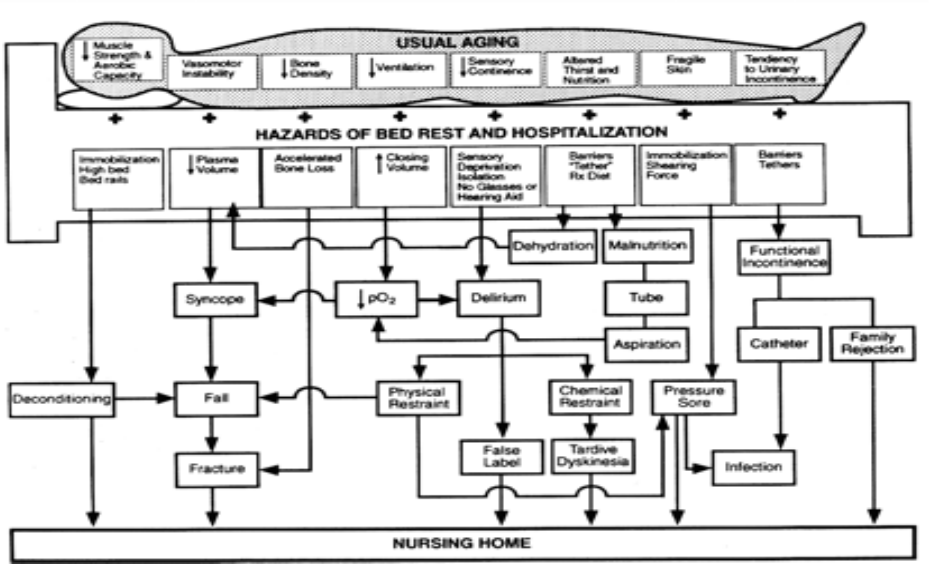
2.3.2.2 Objective Assessment:

- **Mental Status or "Confusion"** – Is it dementia, delirium or an intracranial lesion?
    - Not everyone needs a head CT: **anyone on anticoagulants MUST get a head CT, EVERYTIME**

- If they have dementia, how is this episode DIFFERENT FROM BASELINE?
    - If you suspect undocumented dementia, the Short Blessed Test is a good cognitive function screen for ED use that is most sensitive/specific
- **A "new" psychiatric problem (e.g. "psychosis" or "mania" or "aggressive behaviour" is RARELY a de novo psychiatric problem –** think medical (organic) etiology first, then think medications, then think something else OTHER than psychiatric
- Delirium
    - Richmond Agitation Sedation Scale (RASS) is a quick delirium screen for ED use with very good sensitivity/specificity; RASS >+1 or <-1 is nearly diagnostic
- **Intracranial**
    - Older adults, particularly those on anticoagulants, may be at higher risk for delayed bleeds. However, there is NO widely accepted consensus guidelines on screening for delayed bleeds if the initial CT is negative.
    - A compromise strategy may be to screen (e.g. by telephone follow-up for signs/symptoms within 24 hours) to decide need for repeat head CT within 24 hours of a negative study; if follow-up cannot be guaranteed, admission for observation may be necessary.
- **Dizziness**
    - 15% of older adults presenting to ED for dizziness have serious etiologies; 4-6% are stroke-related and sensitivity of CT for identifying stroke or intracranial lesion in dizziness is poor (16%), so if CNS etiology suspected, seek neuro consult or MRI (83% sensitivity).
- **Skeletal Injury**
    - C-spine injuries may result from seemingly benign trauma/falls.
    - Compression fractures of vertebral column can result from relatively little trauma.
    - Given high prevalence of osteopenia/osteoporosis, **X-ray imaging can have reduced sensitivity, consider CT studies for fractures,** especially vertebral fractures
    - Knee pain? May be referred pain from occult hip fracture
- **Cardiopulmonary**

- AMI presents with atypical complaints in older adults (e.g., "indigestion", "dizziness", "tired")
    - The HEART score assigns maximal points to anyone ≥65y (2 points) but the mean age (±SD) of participants used to derive and validate the HEART score was 61 ±15y, thus unclear how valid the score is for the very old.
- Heart failure (HF): ~70% of patients ≥65y with HF have normal EF of >50%(18), and **BNP (**B-type Natriuretic Peptide**)underestimates degree of decompensation due to thicker heart** (thicker heart, less stretch, smaller rise in BNP); consider BNP difference from last hospital discharge to help determine severity and disposition.

- **Abdominal pain**
    - Visceral pain is modified in older adult; exam can underestimate severity.
    - Constipation and urinary retention are common but often overlooked causes of abdominal pain.
    - Risk of ischemic bowel is higher in older adults.
    - Acute abdominal series provides quick screen for perforation or SBO (Small Bowel Obstruction) and balances benefit of CT against higher risk of contrast-induced nephropathy in older adults.
- **Falls**
    - Rule-out medical/surgical or medication-related reasons for the fall; check orthostatic vital signs
    - One mechanical fall in a given year –no unequivocal need for further ED testing unless clinical suspicion
    - **Two falls in a given year is a red flag** and requires a comprehensive evaluation (in the outpatient setting; ideally by a geriatrician).



2.3.3 Clinical Decision Making and ED Management:

- Screening for geriatric syndromes is critical
    - **polypharmacy**
    - **delirium/dementia**
    - **fall risk**
    - **function (independence) and mobility**
    - **abuse and neglect**
- Geriatric syndromes are individually associated with ED returns and adverse outcomes (e.g. hospitalization, death at 30 days) and must be addressed, not necessarily in the ED if prompt and reliable outpatient follow-up with their PCP(Primary Care Physician) can be arranged
- Beware that screening for adverse outcomes is complicated by scarcity of reliable instruments (results vary across populations)
- Managing the agitated older adult
    - Try to avoid use of restraints (if patient has dementia or is delirious, restraints worsen the situation)
    - Is agitation related to pain? Agitation is often secondary to pain: Start with low dose opioid, and titrate up (start low and go slow) – why? You can reverse it
    - Avoid benzodiazepines with delirium, they can paradoxically worsen it – UNLESS patient is on chronic benzodiazepines (make sure it's for a good reason), then consider use as it could be benzo withdrawal
    - Avoid Haldol – Haldol can lead to fatal reactions in Parkinson's disease and prolonged QT interval; if neither condition is present (once you're sure), then use a LOW dose. AVOID Haldol 5mg in anyone over 55. Use magnesium sulphate to treat long QT interval

- **Antipsychotics help manage the behaviour but will NOT treat the underlying cause** – you still need to evaluate for the medical cause(s) of the agitation

- After any diagnostic study with IV contrast, give fluids
  - Older adults are at higher risk of contrast-induced nephropathy; IV saline is recommended.
- IV fluid resuscitation
  - Unless patient is in shock, **steady IV infusion is preferred over a rapid bolus**, particularly if heart failure present
- Medications
- Do not assume what is listed in the computer accurately reflects the patient's medication regimen
- Always confirm medication regimen with patient, family, or pharmacy/home health if patient/family not able to tell
- Potentially Inappropriate Medications (PIM). Older adults have greater susceptibility to adverse effects of particular medications.
- New symptoms may be due to a medication side effect.
- New medications for common complaints could be a source of adverse outcomes.
- PIMs may be indicated and necessary in specific ED situations (e.g. diphenhydramine for acute allergic reactions) but be cautious regarding duration/course when prescribing for post-discharge use.

2.3.3.1 Disposition:

- Precautionary steps at time of discharge
  - Ability to understand and follow discharge instructions (consider degree of patient and caregiver health literacy, low vision, cognitive impairment, logistics of clinician follow-up)
- If all work-ups are negative but clinical suspicion persists
  - Pursue rapid (24-48 hours) outpatient follow-up with PCP (if available and if patient logistically can go to PCP)
  - Consider the 48-hour ED return
- CAUTION: **Hospitalization worsens function, mobility, and morbidity**which in turn lead to ED returns and hospitalization.
  - Hospitalize only if clinically indicated (ideally)
  - If social issues exist – can ED social worker or case manager find a sufficiently safe disposition for patient and avoid hospitalization?
  - If social needs cannot be met, or if safety is a concern, then admit to hospital but ensure that inpatient service understands the problem (and document this need for transitions of care)

2.3.3.2 Pitfalls

- Look for **atypical presentations of common medical conditions.**
- **Avoid admitting to hospital simply because of their age**, as unwarranted hospitalization can be harmful to the patient's subsequent function, mobility, and quality of life.
    - Know your own biases: older adults are a source of stress in EPs; >75% recognize the need to improve quality of care.
    - 22% of ED admits are potentially avoidable.
    - 50% of ED admits are for non-clinical reasons.
- **Address unmet social needs** as these are highly responsible for ED returns– ask ED social worker or case manager for help.
- Screen for geriatric syndromes to identify older adults at high risk for adverse events
    - **Delirium** (abnormal RASS score) predicts increased mortality at 6 months.
    - **Dementia** is unrecognized in the ED up to 70% of the time.
    - **Elder abuse and neglect** may have subtle signs/symptoms.
    - **Two mechanical falls in a given year** indicates an increased risk of adverse events.
    - **Declines in mobility** (e.g. walking speed) are associated with increased hospitalization or mortality.
- **Potentially Inappropriate Medications** (PIMs)

2.4 SUMMARY

Assessment can have the following benefits:

- Improved care and clinical outcomes
- Greater diagnostic accuracy
- Improved functional and mental status
- Reduced mortality
- Decreased use of nursing homes and acute care hospitals
- Greater satisfaction with care

If elderly patients are relatively healthy, a standard medical evaluation may be appropriate. Comprehensive geriatric assessment and the necessary approach is most successful when done by a geriatric interdisciplinary team (typically, a geriatrician, nurse, social worker, and pharmacist). Usually, assessments are done in an outpatient setting. However, patients with physical or mental impairments and chronically ill patients may require inpatient assessment.

2.5 CHECK YOUR PROGRESS

2.5.1 OBJECTIVE TYPE QUESTIONS

1.Approach to the elderly for evaluation usually depends on …….
2. Early detection of problems results in …….
3. Disorders may manifest solely as ……
4. Older adults, particularly those on anticoagulants, may be at higher risk for ……
5. Risk of ……..is higher in older adults.

2.5.2 SHORT ANSWER QUESTIONS

1. Geriatric assessment?
2. Management of falls in elderly?
3. Effect of medications on elderly?

2.5.3 ESSAY QUESTION

1. Define geriatric assessment? Explain in detail about the various approaches for assessment of the elderly?

2.5.4 KEY FOR OBJECTIVE TYPE QUESTIONS

1. Medical evaluation
2. Early intervention
3. Functional decline
4. Delayed bleeds
5. Ischemic bowel

2.6 KEY TERMS

1. Delirium- an acutely disturbed state of mind characterized by restlessness, illusions, and incoherence, occurring in intoxication, fever, and other disorders.
2. Sensory deficit- a defect in the function of one or more of the senses.
3. Pit falls- a hidden or unsuspected danger or difficulty.
4. Dizziness- a sensation of spinning around and losing one's balance.
5. Advanced directives- a living will which gives durable power of attorney to a surrogate decision-maker, remaining in effect during the incompetency of the person making it.

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UNIT -III: LEVELS OF GERIATRIC CARE AND ROLE OF NURSE

Structure

3.1 INTRODUCTION TO GERIATRIC CARE

Gerontology (from the Greek geron, "old man" and logia, "study of"; coined by IlyaIlyichMechnikov in 1903) is the study of the social, cultural, psychological, cognitive, and biological aspects of aging. It is distinguished from geriatrics, which is the branch of medicine that specializes in the treatment of existing disease in older adults. Gerontologists include researchers and practitioners in the fields of biology, nursing, medicine, criminology, dentistry, social work, physical and occupational therapy, psychology, psychiatry, sociology, economics, political science, architecture, geography, pharmacy, public health, housing, and anthropology.

Gerontology encompasses the following:

- Studying physical, mental, and social changes in people as they age
- Investigating the biological aging process itself including aging's causes, effects and mechanisms (bio gerontology)

- Investigating the social and psycho-social impacts of aging (sociogerontology)
- Investigating the psychological effects on aging (psycho gerontology)
- Investigating the interface of biological aging with aging-related diseases (geroscience)
- Investigating the effects of an ageing population on society (demography)
- Exploring the relationship between the aging and their environment (environmental gerontology)
- Applying this knowledge to policies and programs, including the macroscopic (for example, government planning) and microscopic (for example, running a nursing home) perspectives.

The multidisciplinary nature of gerontology means that there are a number of sub-fields, as well as associated fields such as physiology, anthropology, social work, public health, psychology and sociology that overlap with gerontology.

Geriatric care management (also known as "elder care management", "senior health care management" and "professional care management") is the process of planning and coordinating care of the elderly and others with physical and/or mental impairments to meet their long term careneeds, improve their quality of life, and maintain their independence for as long as possible. It entails working with persons of old age and their families in managing, rendering and referringvarious types of health and social care services. Geriatric care managers accomplish this by combining a working knowledge of health and psychology, human development, family dynamics, public and private resources and funding sources, while advocating for their clients throughout the continuum of care. For example, they may assist families of older adults and others with chronic needs such as those suffering from Alzheimer's disease or other dementia.

3.2 DEFINITIONS OF GERIATRIC CARE

Elderly care, or simply elder care (also known in parts of the English speaking world as aged care), is the fulfilment of the special needs and requirements that are unique to senior citizens. This broad term encompasses such services as assisted living, adult day care, long term care, nursing homes (often referred to as residential care), hospice care, and home care.

Geriatrics is the branch of medicine that focuses on health care of the elderly. It aims to promote health and to prevent and treat diseases and disabilities in older adults.

Gerontological nursing is the specialty of nursing pertaining to older adults. Gerontological nurses work in collaboration with older adults, their families, and communities to support healthy aging, maximum functioning, and quality of life. The term gerontological nursing, which replaced the term geriatric nursing in the 1970s, is seen as being more consistent with the specialty's broader focus on healthand wellness, in addition to illness.

3.3 OVERVIEW OF GERIATRIC CARE

Geriatric care management integrates health care and psychological care with other needed services such as: housing, home care services, nutritional services, assistance with activities of daily living, socialization programs, as well as financial and legal planning (e.g. banking, trusts). A care plan tailored for specific circumstances is prepared after a comprehensive assessment has taken place, and is continuously monitored and modified as needed. A comprehensive geriatric care assessment is thorough and can take anywhere from 2 to 5 hours in length, this of course is broken down into 2 or 3 assessment visits with the patient/family members. The comprehensive assessment is really a compilation of smaller individual assessments with the first one being a primary intake assessment which includes demographic type data as well as a health history, social history, and legal/financial history. From there, a medication profile assessment is included, as well as an assessment of ADLs (Activities of Daily Living) and IADLs (Instrumental Activities of Daily Living). In addition other assessments may include; Falls risk assessment, Home safety assessment, Nutritional assessment, Depression assessment, Pain assessment, Mini Mental State Exam (MMSE), MiniCog Clock Drawing Exam (Cognitive Assessment), Balance assessment, and Gait assessment (ability to walk). If the comprehensive geriatric care management assessment is being conducted by a Registered Health Care Proffessional, then a physical assessment can be included such as vital signs recording temperature, pulse, respirations, blood pressure, oxygen saturation, and sometimes FBS or RBS (Fasting or Random Blood Sugar) checks for diabetics. In addition, physical assessments in areas such as cardiopulmonary, gastrointestinal, musculoskeletal, genitourinary, eyes/ears/nose/throat, integumentary (skin), lower extremities inspection, as well as a modified neuro assessment and medication compliance assessment.

Because older adults tend to have multiple disorders and may have social or functional problems, they use a disproportionately large amount of health care resources. In the US, people ≥ 65 account for,

- > 40% of acute hospital bed days
- > 30% of prescription and OTC drug purchases
- $329 billion or almost 44% of the national health budget
- > 75% of the federal health budget

The elderly are likely to see several health care practitioners and to move from one health care setting to another. Providing consistent, integrated care across specific care settings, sometimes called continuity of care, is thus particularly important for elderly patients. Communication among primary care physicians, specialists, other health care practitioners, and patients and their family members, particularly when patients are transferred between settings, is critical to ensuring that patients receive appropriate care in all settings. Electronic health records may help facilitate communication.

3.4 HEALTH CARE SETTINGS FOR PROVIDING GERIATRIC CARE

Geriatric care may be delivered in the following settings:

- **Physician's office:** The most common reasons for visits are routine diagnosis and management of acute and chronic problems, health promotion and disease prevention, and pre surgical or postsurgical evaluation.
- **Patient's home:** Home care (see Home Health Care) is most commonly used after hospital discharge, but hospitalization is not a prerequisite. Also, a small but growing number of health care practitioners deliver care for acute and chronic problems and sometimes end-of-life care in a patient's home.
- **Long-term care facilities:** These facilities include assisted-living facilities, board-and-care facilities, nursing homes, and life-care communities. Whether patients require care in a long-term care facility depends partly on the patient's wishes and needs and on the family's ability to meet the patient's needs.
- **Day care facilities:** These facilities provide medical, rehabilitative, cognitive, and social services several hours a day for several days a week.
- **Hospitals:** Only seriously ill elderly patients should be hospitalized. Hospitalization itself poses risks to elderly patients because of confinement, immobility, diagnostic testing, and treatments.
- **Hospice:** Hospices provide care for the dying. The goal is to alleviate symptoms and keep people comfortable rather than to cure a disorder. Hospice care can be provided in the home, a nursing home, or an inpatient facility.
- **Senior Communities:** Senior housing is designed for high-functioning elders, defined as those not requiring assistance with ADLs. Senior communities are usually neighborhoods or towns (consider Sun City, the nation's "first and

finest" senior community) that are limited to people of a minimum age. They are designed for active seniors and have a variety of social clubs such as golf, arts and crafts and cards. While some senior communities offer additional levels of care, many are not equipped for individuals who require assistance with ADLs. Some senior communities require the resident move on, should they require this level of care.

- **Continuing Care:** Continuing care communities are sometimes called "step care" or "progressive" care facilities. They offer a wide range of options, all the way from independent living to special care. Residents are usually admitted when they live independently. As their needs increase, they are guaranteed vacancies in the lower level of care. An entry fee is often required, making this option quite expensive.
- **Assisted Living:** Assisted living offers the elderly a place to live outside of their own home, where they can receive basic assistance in one or more of the following areas: housekeeping, meal preparation, 24/7 monitoring, shower assistance, toileting, medication assistance or reminders, transportation, eating, dressing, activities or socialization. In assisted living, your loved one will likely have their own apartment, unless you or your loved one consents to sharing a room with someone. A private bathroom is most often in the apartment to allow for privacy and dignity. Most facilities will have a kitchenette in the apartment with a sink, microwave, refrigerator, and cupboard space. Each apartment will likely be climate controlled individually. There will be access to common areas such as a TV room, an activity room, dining room, library, and communal sitting areas. Assisted living facilities are designed for people who need help with complex ADLs on a daily basis. Basic ADLs include eating, bathing, dressing and hygiene. More complex ADLs include cooking, shopping and money management. Assisted living aims to be the mid- point between independent living and long-term care. Most assisted living facilities have a dining room decorated like a restaurant as well as a variety of activities. Most assisted living facilities are not licensed to administer IVs, requiring patients who need IVs to temporarily relocate to a skilled nursing facility.
- **Board and Care:** Board and care is similar to assisted living in terms of care, although some group homes work with lower functionality seniors than those found in assisted living. This is usually a single-family dwelling which has been converted into a residence for elderly and disabled residents. The monthly rent paid commonly includes room, three meals a day, laundry services, and some transportation – in addition to a 24-hour staff person. While basic medical care can be attended to, residents who have serious medical conditions will be expected to move into a more suitable facility.

- **Skilled Nursing:** Skilled nursing (also called SNF or "sniff") is the first level of care that is licensed to administer medical treatment with nurses. In fact, there are strict regulations that require nurses to be on duty and to regulation the nurse-patient ration. As the name denotes, such a facility offers extensive nursing services for the residents. Admission must be initiated by a person's physician, who recommends that a patient enter either 'rehab care' or a 'special care' facility.
  - ✓ Rehab care: Located in hospitals or nursing homes, rehab care programs are sometimes called "Level 1" or transitional care. They provide intensive medical care for patients who are expected to regain functional capacity and return home in a relatively short time.
  - ✓ Special care: There are two types of special care facilities: those involved with unique medical issues (sometimes called "Level 2" care), and those which manage behavioural problems that may arise from dementia.

(not appropriately framed)Many patients are admitted to skilled nursing to address an acute condition such as rehabilitating a broken hip, or treating an infection with IV antibiotics. Many skilled nursing facilities have a portion of their residents who are long- term care patients. These are patients who require the treatment capabilities of a SNF, yet their condition requires that level of care permanently. Long-term care includes nursing supervision, but it is custodial in nature – focused on maintenance as opposed to curative care. Here the condition is not expected to improve, and the nursing activities are focused on keeping the person healthy and safe.

3.5 PRINCIPLES OF GERIATRIC CARE

- Clinical judgement should be used to determine which level of care would be most appropriate based on the criteria below.
- Although a lower level of care will usually require a lower nurse to patient ratio or reduced critical care support, this may not apply in all circumstances and the aim should be to be flexible in the provision of staff resources to meet the needs of the patient. The level of care assigned to a patient will influence, but not determine, staffing requirements.
- The location of patients does not determine their level of care.
- Patients who have „not for resuscitation" orders written or who are receiving palliative care may also fulfill the criteria listed below. It may be appropriate to modify the actual level of critical care delivered to these patients whilst enhancing their palliative care.

3.6 SERVICES OF GERIATRIC CARE

- **Home health**
  - ✓ Services must be ordered by a doctor.
  - ✓ Services may include nurse, home health aide, therapies (ot, speech, pt).
  - ✓ Services are provided in the patient's place of residence.
  - ✓ Services may include assistance with all or some of ADLs
  - ✓ Services may be long or short term.
  - ✓ Patient may be dependent, semi-independent, and have acute or chronic health status.
  - ✓ Services are on an intermittent basis, not 24 hours a day
  - ✓ Patient participates in a plan of care developed by a RN.
  - ✓ Personal care services (ADLs) provided according to R432-700-30, which include dressing, eating, grooming, bathing, toileting, ambulation, transferring, and self-administration of medications.
- **Assisted living facility type I**
  - ✓ Resident lives in a licensed facility that provides safe and clean living accommodations and three meals a day.
  - ✓ Resident may require minimal assistance with ADLs, including significant assistance with up to two ADLs.
  - ✓ Resident must be able to evacuate the facility under his own power (be mobile).
  - ✓ Resident must have stable health and free from any communicable disease.
  - ✓ Resident may receive assistance with medications or have medications administered by a nurse.
  - ✓ Resident may receive home health services through individual contract with home health agency.
  - ✓ Resident receives 24-hour general monitoring, 7 days a week.
  - ✓ Resident may receive general nursing care according to facility policy.
  - ✓ Resident participates in developing a service plan
- **Assisted living facility type II**
  - ✓ Resident lives in a licensed facility, permits aging in place.
  - ✓ Resident may receive full assistance with ADLs.
  - ✓ Resident may be semi-independent and may require the assist of one person for transfers or to evacuate the facility.
  - ✓ Resident may receive assistance with medication or have medications administered by a nurse.
  - ✓ Resident receives general nursing care from facility staff.

- ✓ Resident must be free of communicable diseases that could be transmitted to others through the normal course of activities.
- ✓ Resident receives 24 hour individualized personal and health-related services, 7 days a week.
- ✓ Resident may receive home health services through individual contract with a home health agency.
- ✓ Resident participates in developing a service plan

❖ **Small health care facility - type n - (limited to three persons)**

- ✓ Resident lives in a licensed home occupied by the owner or operator.
- ✓ Resident receives supervised nursing care on a daily basis from a written plan of care.
- ✓ Resident receives assistance with medications or receives medication administration by a nurse.
- ✓ Resident must be free of communicable diseases and does not require 24 hour nursing care or inpatient

❖ **Hospital care**

- ✓ Resident may be dependent.
- ✓ Resident may receive total assist with ADLs.
- ✓ Resident receives 24 hour direct care staff for monitoring and assistance.
- ✓ Resident may receive rehabilitative services through individual contract with a home health agency.

❖ **Intermediate care facilities/nursing facilities**

- ✓ Resident lives in a licensed facility that provides 24 hour inpatient care to residents who need licensed
- ✓ Nursing supervision and supportive care, but do not require continuous nursing care.
- ✓ Resident may be semi-independent or dependent.
- ✓ Resident may receive full assist with ADL.
- ✓ Resident may receive full assist with transfers.
- ✓ Resident receives medications from a nurse following a doctor's order.
- ✓ Resident may receive outpatient rehab services.
- ✓ Facility provides licensed nursing coverage 8 hours a day for facilities with less than 35 beds and 16
- ✓ Hours for facilities with 35 or more beds. Facilities have run as consultant.
- ✓ Resident receives periodic assessments by a licensed practitioner.

❖ **Skilled nursing facility**

- ✓ Resident lives in a licensed facility that provides 24 hour licensed nursing services, eight hour of which is rn coverage.
- ✓ Resident may be dependent and require total assistance with ADLS

- ✓ Resident receives medications by a nurse according to a licensed practitioners order.
- ✓ Resident receives required rehab services by the facility.

❖ **Hospital**

- ✓ Patient is admitted to a licensed facility for a short term for a condition that requires treatment.
- ✓ Patient receives 24 hour RN care.
- ✓ Patient may receive rehab services either inpatient or outpatient.
- ✓ Patient may be dependent and require full assist with ADLs.
- ✓ Patient receives medications by an RN according to licensed practitioner's orders.

❖ **Hospice**

- ✓ The hospice program is a health care agency or facility that offers palliative and supportive services providing physical, psychological, social and spiritual care for dying persons and their families.
- ✓ Patient may receive services in their place of residence or an inpatient setting.
- ✓ Family and patient participates in a plan of care developed by an interdisciplinary team which includes at least the patient and the patient's family or primary care giver, nurse, social worker, volunteer, and clergy.
- ✓ Services must be ordered by a physician.
- ✓ Services may include nurse, social worker, clergy, volunteer, physical therapy, occupational therapy,
- ✓ Speech therapy, nutritional therapy, and home health aides.

3.7 GERIATRIC INTERDISCIPLINARY TEAM

Geriatric interdisciplinary teams consist of practitioners from different disciplines who provide coordinated, integrated care with collectively set goals and shared resources and responsibilities. Not all elderly patients need a formal geriatric interdisciplinary team. However, if patients have complex medical, psychologic, and social needs, such teams are more effective in assessing patient needs and creating an effective care plan than are practitioners working alone. If interdisciplinary care is not available, an alternative is management by a geriatrician or a primary care physician with experience and interest in geriatric medicine.

Interdisciplinary teams aim to ensure the following:

- That patients move safely and easily from one care setting to another and from one practitioner to another
- That the most qualified practitioner provides care for each problem

- That care is not duplicated

To create, monitor, or revise the care plan, interdisciplinary teams must communicate openly, freely, and regularly. Core team members must collaborate, with trust and respect for the contributions of others, and coordinate the care plan (eg, by delegating, sharing accountability, jointly implementing it). Team members may work together at the same site, making communication informal and expeditious.

A team typically includes physicians, nurses, pharmacists, social workers, and sometimes a dietitian, physical and occupational therapists, an ethicist, or a hospice physician. Team members should have knowledge of geriatric medicine, familiarity with the patient, dedication to the team process, and good communication skills.

To function effectively, teams need a formal structure. Teams should set deadlines for reaching their goals, have regular meetings (to discuss team structure, process, and communication), and continuously monitor their progress (using quality improvement measures). In general, team leadership should rotate, depending on the needs of the patient; the key provider of care reports on the patient's progress. For example, if the main concern is the patient's medical condition, a physician leads the meeting and introduces the team to the patient and family members. The physician determines what medical conditions a patient has, informs the team (including differential diagnoses), and explains how these conditions affect care. The team's input is incorporated into medical orders. The physician must write medical orders agreed on through the team process and discusses team decisions with the patient, family members, and caregivers.

If a formally structured interdisciplinary team is not available or practical, a virtual team can be used. Such teams are usually led by the primary care physician but can be organized and managed by an advanced practice nurse, a care coordinator, or a case manager. The virtual team uses information technologies (eg, handheld devices, email, video conferencing, teleconferencing) to communicate and collaborate with team members in the community or within a health care system.

3.7.1 Patient and caregiver participation

Practitioner team members must treat patients and caregivers as active members of the team in the following ways:

- Patients and caregivers should be included in team meetings when appropriate.
- Patients should be asked to help the team set goals (eg, advance directives, end-of-life care).

- Patients and caregivers should be included in discussions of drug treatment, rehabilitation, dietary plans, and other therapies.
- Patients should be asked what their ideas and preferences are; thus, if patients will not take a particular drug or change certain dietary habits, care can be modified accordingly.

Patients and practitioners must communicate honestly to prevent patients from suppressing an opinion and agreeing to every suggestion. Cognitively impaired patients should be included in decision making provided that practitioners adjust their communication to a level that patients can understand. Capacity to make health care decisions is specific to each particular decision; patients who are not capable of making complex decisions may still be able to decide less complicated issues.

Caregivers, including family members, can help by identifying realistic and unrealistic expectations based on the patient's habits and lifestyle. Caregivers should also indicate what kind of support they can provide.

Geriatric care managers typically have prior training in nursing, social work, gerontology or other health service areas. They are expected to have extensive knowledge about the costs, quality, and availability of services in their communities. In some countries and jurisdictions, they may obtain certification from various professional associations, such as the *National Association of Professional Geriatric Care Managers* in the United States.

Professional care managers help individuals, families and other caregivers adjust and cope with the challenges of aging or disability by:

- Conducting care-planning assessments to identify needs, problems and eligibility for assistance;
- Screening, arranging, and monitoring in-home help and other services;
- Reviewing financial, legal, or medical issues;
- Offering referrals to specialists to avoid future problems and to conserve assets;
- Providing crisis intervention;
- Acting as a liaison to families at a distance;
- Making sure things are going well and alerting families of problems;
- Assisting with moving their clients to or from a retirement complex, assisted living facility, rehabilitation facility or nursing home;
- Providing client and family education and advocacy
- Offering counselling and support.

Depending on the country and health care organization, professional fees for the services of geriatric care managers may be billed privately on a fee-for-service basis. In the United States, they are not covered by Medicaid, Medicare nor by most private health insurance policies. However, clients may be able to bill some services to long term care insurance, depending on the history of the individual case.

3.8 LEVELS OF GERIATRIC CARE

LEVEL	EXAMPLE
LEVEL 0: Requires hospitalization. Needs can be met through normal ward care.	○ Intravenous therapy. ○ Observations required less frequently than 4 hourly.
LEVEL 1: Patients recently discharged from a higher level of care. Patients in need of additional monitoring/clinical interventions, clinical input or advice.	○ Patients requiring a minimum of 4 hourly observations. ○ Requiring a minimum of 4 hourly observation on the basis of clinical need. ○ Requiring continuous oxygen therapy. ○ Boluses of intravenous fluid (need not determined by CVP). ○ Epidural analgesia or Patient Controlled Analgesia in use. ○ Parenteral nutrition. ○ Postoperative surgical patients who are still requiring 4 hourly observations. ○ Requiring administration of bolus intravenous drugs through a Central Venous Catheter. ○ With a tracheostomy. ○ With a chest drain in situ. ○ Requiring a minimum of 4 hourly GCS assessment. ○ With diabetes receiving a continuous infusion of insulin. ○ Who are at risk of aspiration pneumonia?

Patients requiring critical care Outreach service support.	○ On established intermittent renal support. ○ Requiring respiratory physiotherapy to treat or prevent respiratory failure. ○ Requiring frequent (> 2x day) Peak Expiratory Flow rate measurement for clinical reasons. ○ Abnormal vital signs but not requiring a higher level of critical care. ○ Risk of clinical deterioration and potential need to step up to level 2 care.
LEVEL 2: Patients needing pre-operative optimization.	○ Cardiovascular, renal or respiratory optimization required prior to surgery. ○ (Invasive monitoring inserted to assist optimization (arterial line, and CVP as a minimum).
Patients needing extended postoperative care	○ Immediate care following major elective surgery. ○ Emergency surgery in unstable or high risk patients.
Patients stepping down to Level 2 care from Level 3.	○ Where there is a risk of postoperative complications or a need for enhanced interventions and monitoring. ○ Requiring a minimum of hourly observations. ○ At risk of deterioration and requiring level 3 care again.
Patients receiving Basic Respiratory Support.	Indicated by one or more of the following: ○ Mask / hood CPAP or mask /

Patients receiving Advanced Cardiovascular Support.	hood Bi-level positive airway pressure (non-invasive ventilation) o Patients who are Intubated to protect the airway but needing no ventilator support o CPAP via a tracheostomy o More than 50% oxygen delivered by face mask. (Note, more than 50% has been chosen to identify the more seriously ill patients in a hospital). Short-term increases in FiO2 to facilitate procedures such as transfers or physiotherapy do not qualify. o Close observation due to the potential for acute deterioration to the point of needing advanced respiratory support. (e.g. severely compromised airway or deteriorating respiratory muscle function). o Physiotherapy or suction to clear secretions at least two hourly, whether via tracheostomy, minitracheostomy, or in the absence of an artificial airway. o Patients who are recently (within 24 hours) extubated after a period (greater than 24 hours) of mechanical ventilation via an endotracheal tube. Indicated by one or more of the following: o Use of a CVP line for monitoring of central venous pressure and /or provision of central venous access to deliver titrated fluids to treat hypovolemia.

Patients receiving Renal Support.	○ Use of an arterial line for monitoring the arterial pressure and/or sampling of arterial blood. ○ Single intravenous vasoactive drug used to support or control arterial pressure, cardiac output or organ perfusion. ○ Single/multiple intravenous rhythm controlling drug(s) to support or control cardiac arrhythmias Indicated by one or more of the following: ○ Multiple intravenous vasoactive and/or rhythm controlling drugs when used simultaneously to support or control arterial pressure, cardiac output or organ / tissue perfusion, (e.g. inotropes, amiodarone, nitrates). To qualify for advanced support status, at least one drug needs to be vasoactive. ○ Continuous observation of cardiac output and derived indices (e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, esophageal Doppler, impedance and conductance methods). ○ Intra-aortic balloon pumping and other assist devices. ○ Insertion of a temporary cardiac pacemaker (criteria valid for each day of therapeutic connection to a functioning external pacemaker unit).
Patients receiving Neurological Support.	Indicated by: ○ Acute renal replacement therapy (e.g.haemodialysis, hemofiltration

Patients receiving Dermatological Support	etc.) or o Provision of renal replacement therapy to a chronic renal failure patient who is requiring other acute organ support in a critical care bed. Indicated by one or more of the following: o Central nervous system depression sufficient to prejudice the airway and protective reflexes, excluding that caused by sedation prescribed to facilitate mechanical ventilation or poisoning (e.g. deliberate or accidental overdose, alcohol, drugs etc.). o Invasive neurological monitoring or treatment e.g. ICP, jugular bulb sampling, external ventricular drain. o Continuous intravenous medication to control seizures and / or continuous cerebral monitoring. o Therapeutic hypothermia using cooling protocols or devices. Indicated by one or more of the following o Patients with major skin rashes, exfoliation or burns. (e.g. greater than 30% body surface area affected). o Use of complex dressings (e.g. large skin area greater than 30% of body surface area, open abdomen, vacuum dressings or, large trauma such as multiple limb or limb and head dressings).

LEVEL 3: Patients receiving Advanced Respiratory Support alone.	Indicated by one of the following: o Invasive mechanical ventilator support applied via a trans-laryngeal tracheal tube or applied via a tracheostomy. o Bi-level positive airway pressure applied via a trans-laryngeal tracheal tube or applied via a tracheostomy o CPAP via a trans-laryngeal tracheal tube. o Extracorporeal respiratory support.

3.8 ROLE OF A NURSE IN GERIATRIC CARE

Nursing interventions are aimed at maintaining the patient's physical safety., reducing anxiety and agitation., improving communication., promoting independence in self-care activities., providing for the patient's needs for socialization, self-esteem, and intimacy., maintaining adequate nutrition., managing sleep pattern disturbances., and supporting and educating family care givers. Research has demonstrated that when the nurse can provide such support, older adults are able to maintain higher levels of perceived and actual health.

3.8.1Supporting cognitive function: As the patient's cognitive ability declines, the nurse provides a calm predictable environment that helps the person interpret his or her surroundings and activities. Environmental stimuli are limited, and a regular routine is followed. A quite, pleasant manner of speaking, clear and simple explanations, and use of memory aids and ques help to minimize confusion and disorientation and give the patient a sense of security. Prominently displayed clocks and calendars may enhance orientation to time. Colour coding the door may help the patient who has difficulty locating his or her room. Active participation may help the patient to maintain cognitive, functional and social interaction abilities for a longer period. Physical activity and communication have also been demonstrated to slow some of the cognitive decline.

3.8.2 Promoting physical safety: A safe environment allows the patient to move about as freely as possible and relieves the family of constant worry about safety. To

prevent falls and other injuries, all obvious hazards are removed. Nightlights are helpful. The patient's intake of medications and food is monitored. Smoking is allowed only with supervision. A hazard-free environment allows the patient maximum independence and a sense of autonomy. Because of a short attention span and forgetfulness, wondering behaviour can often be reduced by gently persuading or distracting the patient. Restraints are avoided because they may increase agitation. Doors leading from the house must be secured. Outside the home, all activities must be supervised to protect the patient, and the patient should wear an identification bracelet or neck chain in case he or she becomes separated from the care giver.

3.8.3 Reducing anxiety and agitation: Despite profound cognitive losses, the patient will, at times, be aware of his or her rapidly diminishing abilities. The patient still need constant emotional support that reinforces a positive self-image. When losses of skills occur, goals are adjusted to fit the patient's declining ability. The environment should be kept uncluttered, familiar, and noise free. Excitement and confusion can be upsetting and may precipitate and combative, agitated state known as a catastrophic reaction (over reaction to excessive stimulation). During such a reaction, the patient responds by screaming, crying or becoming abusive (physically or verbally). This may be the patient's only way of expressing an inability to cope with the environment. When this occurs it is important to remain and unhurried. Measures such as listening to music, stroking, rocking or distraction may quite the patient. Frequently, the patient forgets what triggered the reaction. Structuring of activities is also helpful. Becoming familiar with the patient's predicted responses to certain stressors helps care givers to avoid similar situations.

By the time older persons with dementia have progressed to the late stage of the disease, they typically reside in nursing homes and are predominantly cared for by nurse's aids. Dementia education for care givers is imperative to minimize patient agitation and is very effectively taught by advanced practice nurse specialists.

3.8.4 Improving communication: To promote the patient's interpretation of messages, the nurse should remain unhurried and reduce noises and distractions. Use of clear, easy to understand sentences to convey messages is essential because patients frequently forget the meaning of words or have difficulty organizing and expressing thoughts. In the early stage, lists and simple written instructions may be helpful. In the later stage, the patient may be able to point out at objects or use non-verbal language to communicate. Tactile stimuli such as hugs and hand pats are usually interpreted as signs of affection, concern and security.

3.8.5 Providing for socialization and intimacy needs: Because socialization with friends and family can be comforting, visits, letters and phone calls are encouraged. Visits should be brief and non stressful; limiting visitors to one or two at a time helps reduce overstimulation. Recreation is important, and people are encouraged to participate in simple activities. Realistic goals for activities that provide satisfaction are appropriate. Hobbies and activities such as walking, exercising and socializing can improve quality of life. The non-judgemental friendliness of a pet can stimulate comfort and provide contentment. Care of plants and pets can be satisfying and an outlet for energy.

Elderly with their spouses can continue their sexual activity. They must be encouraged to talk regarding any sexual concerns. Simple expressions of love such as holding, touching are often meaningful.

3.8.6 Providing adequate nutrition: mealtime can be pleasant social occasion or a time of upset and distress, and it should be kept simple, calm without confrontations. People prefer foods that are appetizing and tastes good. To avoid playing with food, serve one dish at a time. Food is cut into small pieces to avoid choking. Liquids may be easier to swallow if they are converted to gelatine. Hot foods and beverages are served warm to prevent burns.

3.8.7 Promoting balanced activity and rest: Many people complain with sleep disturbances and wandering behaviours that may be inappropriate. These behaviours are most likely to occur when there are unmet physical or psychological needs. Caregivers must identify the needs of the patient who are exhibiting these behaviours because further health decline may occur if these are not corrected. During the day time physical activity can be encouraged and long durations of sleep during the day time are discouraged.

3.8.8 Supporting home and community based care: The emotional burden on the families of elderly are enormous. The physical health is often stable and mental degeneration is gradual. Family members may be faced with difficult decisions. Anger and agitation exhibited by the older adults are often misunderstood by the family members. Abuse and neglect of the older adults must be avoided and they have to be constantly supervised on the minor and major ailments for immediate medical help is mandatory

3.9 SUMMARY

The older adults being more vulnerable to many health issues constitute the higher vulnerable group. They must be constantly supervised and taken care of the

minor ailments and approach immediately for medical help in cases of emergency. The nurses must coordinate with the other health team members to provide comprehensive and holistic care considering all the needs and domains of a human being. Assisting in their daily activities and encourage them to perform minimum physical activity as tolerated which improves self-esteem and enhances self-image of the older adult.

3.10 CHECK YOUR PROGRESS

3.10.1 OBJECTIVE TYPE QUESTIONS

1. Gerontology is the study of social, ……,….and biological aspects of aging.
2. Environmental gerontology is relationship between ……. and ……
3. ADL refers to ……..
4. Skilled nursing facilities is a …… care facility.
5. Day care facilities provide …….. , …….. And …….. Services.
6. Hospice care refers to providing care to …… patients.
7. Physical activities must be encouraged as they promote ……
8. Serve …….. And …… food to avoid rejection.
9. Reduce ……. to avoid miscommunication.
10. …….. Promotes comfort among older adults.

3.10.2 SHORT ANSWERS QUESTIONS

1. Outline the various health care settings for providing geriatric care?
2. Principles of geriatric care?
3. Services of geriatric care?
4. List the various team members in a geriatric care setting?

3.10.3 ESSAY QUESTIONS

1. Define geriatric care? Explain in detail the various levels of geriatric care with examples?

3.10.4 ANSWERS TO OBJECTIVE QUESTIONS

1. Psychological and cognitive

2. Aging, environment
3. Instrumental activities of daily living.
4. Long term
5. Cognitive
6. Dying
7. Independence.
8. Appetizing and tasty
9. Distractions
10. Socialization

3.11 KEY TERMS

1. Geriatric care- is a specialty that focuses on health **care** of **elderly** people
2. Socialization- the process of learning to behave in a way that is acceptable to society.
3. Self-independence- Not relying on others for support, cares, or funds; **self**-supporting.
4. Self-esteem- confidence in one's own worth or abilities; self-respect.
5. Self-image- the idea one has of one's abilities, appearance, and personality.
6. Agitation- a state of anxiety or nervous excitement.
7. Distractions- a thing that prevents someone from concentrating on something else.

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