CERTIFICATE IN GERIATRIC CARE (CGC)

For Academic Session 2016-17

BASIC GERIATRIC PRACTICAL MANUAL

ACTIVITY-I: PSYCHO SOCIAL STUDY

ASSESSMENT OF PSYCHOSOCIAL AND PHYSICAL ENVIRONMENT OF ELDERLY

The social evaluation covers a vast area of information ranging from a patient's level of education to their views on terminal care. In fact, the terrain is so vast and complex that epidemiologists and clinicians alike have yet to fully embrace its tremendous impact on health. Nevertheless, an impressive and growing body of research demonstrates a consistent association between social exposures, such as income gradients and interpersonal isolation, with a number of significant health outcomes, including mortality. Translating this evidence into effective patient care is enormously challenging and, in most clinical settings, physicians do not make the attempt.

One exception to this is lifestyle modification. Many physicians routinely ask their patients about personal behaviours that may place them "at risk" of harm. Although such lifestyle "choices" are always influenced by society, most clinicians view them as attributes of the patient, largely independent of her social environment. Nevertheless, practitioners typically place "habits" information under the social history, unless the specific behaviours have particular relevance to the chief complaint, in which case they include it in the present illness.

Definitive research literature on the social determinants of health applies to all populations. Understandably, however, the well-being of physically dependent populations, like the elderly, is affected more by prevailing social conditions than most other populations. Living arrangements, financial security, transportation, crime, and access to medical services all have a demonstrably direct impact on health outcomes in older adults. Less obvious, though, are the equally significant health effects of interpersonal conditions, usually falling under the rubric of "psychosocial" influences. The death of a spouse or detachment from a community is clearly associated with higher rates of morbidity and mortality in the elderly. Despite these risks, physicians operating in customary clinical settings are ill equipped to sufficiently address the social status of their elderly patients.

For this reason, the geriatric assessment must explicitly incorporate an extensive social evaluation. There is no well-recognized, formal screening tool that has been validated for social risk. As part of a typical geriatric assessment, one or several members of the team will gradually collect socially relevant information over several encounters. Although this is frequently done in the office or institutional

setting, the best place to perform a social evaluation is in the patient's own social environment.

As a supplement to the Social History, we outline below additional components relevant to geriatric assessment. The social assessment questions you will actually ask appear in the DGA.

Vocation and Education

It is important to remember that raising a family, looking for a job, going to school and enjoying retirement are all legitimate "vocations". Many older adults who have retired from their "careers" continue to work part time or volunteer. The potential benefits of working include community connections, financial independence, personal accomplishment and self-respect, all of which are potential determinants of health. For populations, there is considerable evidence that level of education varies directly with health status. Whether this applies to individual elders is less clear, but it is certainly reasonable to include academic accomplishments in the assessment.

Habits

Decades of research have firmly established the link between an individual's lifestyle and his health. An important, and often overlooked, feature of this research is the time-dependent nature of exposures and outcomes. With few exception (drug addiction and sleep being the most notable), individuals experience the health effects of their habits decades in the future. This has obvious and important ramifications for health-related activities in the elderly. Depending on the patient's age, much of the relevant exposure has already taken place and is beyond intervention.

Conversely, much of the predicted health outcomes from their current behaviour will be irrelevant; the patient having long since succumbed to the accumulated effects of youthful indiscretion. Still, where the activity has relatively swift consequences or the patient can expect to be around for another two or three decades, it is reasonable to screen for certain behaviours, particular those with convincing evidence in support of their effects on health and modifiability.

Exercise.

The numerous and beneficial health effects of regular exercise in the elderly operate in both the short and long-term. Exercise decreases blood pressure, weight, cardiovascular and cerebrovascular risk, osteoarthritic joint pain and stiffness, osteoporosis and overall mortality. It improves glucose tolerance, strength, cardiopulmonary fitness, agility and flexibility, balance, sleep, mood and cognition. It is hard to come up with a compelling argument against some form of exercise,

even in the frailest elderly. Information obtained in the assessment ought to include the frequency and duration of aerobic and non-aerobic exercise, the type of activity (walking, swimming, gardening, heavy housework), method of monitoring intensity (heart rate, fatigue, pain), presence of orthopaedic and or cardiovascular diagnoses or symptoms, and the occurrence and nature of injuries.

Sleep.

Sleep physiology changes dramatically with age. Older adults tend to sleep fewer hours and often find it difficult to fall asleep (sleep latency) or stay asleep. A poor night sleep may have a range of health effects including mood disorders, cognitive impairment and even immunologic dysfunction. Plus, the pharmacologic treatment of sleep disorders in the elderly is fraught with iatrogenic hazards. Practitioners need to carefully assess the sleep quantity (night time duration frequency and duration of daytime naps), sleep quality (sleep latency and ability to stay asleep, vigilance on waking, and presence of nightmares), sleep environment, bedtime habits, and medical conditions affecting sleep (depression, congestive heart failure, and carpal tunnel syndrome).

Sexual Activity.

Elders have sex. Although pregnancy is not an issue, sexually transmitted diseases are not irrelevant to geriatrics, and physicians often make incorrect assumptions regarding monogamy and safe sexual practices. Although a minority of elderly patients may be at risk from sexual indiscretion, most are far more concerned about the opposite problem, sexual dysfunction. Even though impotence, diminished libido and dyspareunia (pain with intercourse, usually related to vaginal dryness) are extremely common in older adults, they are uncommonly the topic of conversation in their doctors' offices. Since all three conditions are potentially treatable (more so recently with the introduction of Viagra), it is crucial that practitioners obtain such information, despite their own misgivings about broaching the subject, especially when a generation or two separates them from their patients. Asking straightforward, close-ended questions in a non-judgmental fashion ("Are you currently sexually active?" as opposed to "Are you still sexually active after all these years?), usually works well.

Recreational Activity:

How a person spends his or her leisure time may influence their health in three major ways.

(1) To the extent that the activity involves consistent exercise, the participant is bound to experience an overall health benefit.

(2) To the extent that the activity is harmful or dangerous (cruising bars, for example, with its associated binge drinking and driving), it will increase the risk of disease, injury and premature mortality. And

(3) Most recreational activities are designed to relieve stress (golf notwithstanding). Experimental evidence linking strain (an individual's response to stress) with disease, suggests a mechanisms for the protective health effects of activities mitigating stress.

Substance Use:

Although the prevalence of illicit drug use in the geriatric population is relatively low, older adults do not lose interest in most other substances. It is extremely rare for anyone to take up smoking late in life, so the vast majority of elders who smoke have been doing so for decades. Similarly, elders who have no prior history of alcoholism, or other addictive behaviour, do not suddenly develop a pattern of addictive behaviour in their seventies and eighties. Elderly alcoholics almost always have a history of substance abuse or misuse, of one form or another, dating back to their youth. Medically relevant addictive behaviour can be divided into two categories based on their associated psychosocial harm. The abuse of alcohol and other drugs (most notably prescription hypnotics in the elderly) are often far more psychosocially devastating than the effects of tobacco use and the over-consumption of saturated fats. It is more sensible, therefore, to save the evaluation of alcohol and drug abuse for the Neuropsychiatric section of the assessment. Dietary fat consumption appears in the Nutritional Evaluation above, leaving tobacco use for this section

Although the prevalence of smokers has declined since the mid-1960, about 25% of continue to smoke. This drops to about 19% in persons 65 to 74 year old and 9% in those over 75 years (at least partially due to their smoking attributable premature mortality). Smoking accounts for about one out of every five deaths in the United States making it the most important modifiable cause of death. Many older smokers reasonably assume that the damage from years of smoking has been done; the common refrain being "If it hasn't killed them yet, why quit?" While this mindset is difficult to overcome, there is considerable evidence that mortality is significant postponed even in smokers who quit after the age of 70. Smoking cessation is worth pursuing in the elderly. Useful assessment questions include: Is the patient a current or former smoker? What does he smoke (or chew) and how much (recorded in pack-years)? Have there been attempts to quit and were they successful? Is there any exposure to environmental (second-hand) tobacco smoke?

Mood Assessment

Although it is true that the entire spectrum of mood disorders is represented among the elderly, overwhelmingly the problem in this population is that of major depression. As you will learn in lecture, undiagnosed and untreated major depression is one of the most significant contributors to excess morbidity and mortality in geriatrics. Physicians who see elderly patients are well advised to be aggressive in seeking out and treating this condition, since it has an impact on all aspects of medical and surgical care.

Major depression is diagnosed using the core criteria of the Diagnostic & Statistical Manual of Mental Disorders, 4th Ed (DSM-IV). These criteria can be recalled using the mnemonic, "Depressed? SIG E CAPS". The acronym stands for depressed mood, sleep, interests, guilt, energy, concentration, appetite, psychomotor abnormality, and suicidal ideation. Medical illnesses common in the elderly population can greatly affect functions such as sleep and appetite, however, and so confound this assessment. It is often useful in these patients to take a closer look at attitudes and feelings that could indicate the presence of depression. For this purpose, an instrument such as the Geriatric Depression Scale (GDS) can be used.The depression assessment is made as part of the mental status exam, before the (A)MMSE is administered. The patient or an interviewer may fill out the GDS. Yes or no answers are recorded to each of 15 questions. Hits are scored as shown on the form ,and one point is assigned for each hit. Major depression should be suspected in any patient with a score of 5 or more points.

Living Arrangements and Services

According to the U.S. Census Bureau, of the non-institutionalized adults over 65 years and older, approximately 70% live with a spouse or extended family and 30% live alone. As we've discussed earlier, due to their relative longevity, considerably more women than men live alone, while conversely, more men than women live with their spouse. Whereas only about one percent of Americans between 65 and 74 live in nursing homes, about one-fourth of those 85 and older are institutionalized. The determination of appropriate living arrangements for elderly patients is one of the assessment's most significant functions. Although options for elder housing vary widely, there are three basic types: private homes in the community, assisting living residences, and skilled nursing facilities (rehabilitation hospitals and nursing homes). Ideally, the most highly functioning elders remain in their homes as long as possible, frequently with the aid of a personal caregiver, usually a spouse or other close relative. It is always important to ask about co-dwellers, both to determine the level of interpersonal support (see below) and to evaluate for the possibility of caregiver stress, a relatively common phenomenon, particularly among elderly spouses.

Security:

As elders become more dependent, their vulnerability to intentional injury and loss of property increases. For this reason, the social assessment must include an evaluation of security risks experienced by patients living in the community. Has the apartment building hired a doorman? Is the home equipped with security alarms and fire detectors? Is there a working telephone? Are trustworthy neighbours easily accessible?

Injury Risk:

Of all the possible sources of harm that may come their way, falls are among the most common and serious. They occur in both community and institutional settings. One in four elders living in the community will suffer a fall, and on an average, a resident in a long-term care facility will fall one to two times per year. About one in forty falls results in hospitalizations. About half of hospitalized fallers are institutionalized, and up to 20% of them are dead within the year. The reason for most falls is complex, having to do with an aggregation of medical factors including drugs and alcohol, dementia, depression, visual impairment and dysmobility. All of these potential aetiologies, covered elsewhere in the assessment, combine with a patient's environment to pose a significant risk of unintentional injury. At this point in the assessment, the focus is on the patient's physical surroundings at home and his or her history of falling. How adequate is the ambient lighting? How many levels must occupants traverse over stairs? Is the house or apartment fully accessible by wheelchair? Where are the bathroom, kitchen and bedroom in relation to one another? Are there throw rugs and other trip hazards? Are there grab bars and mats in the tubs? How many times has the patient fallen in the past year? What were the circumstances and consequences of the falls? Has the patient developed a fear of falling out of proportion to the physical risks?

Community Services:

Although family members and other non-professionals provide upwards of 80% of the care received by non-institutionalized elders, there is a long list of community-based services. Largely due to interest in cost-containment and recent advancements in technology, the home healthcare industry has boomed in recent years. In addition to selected hospital-based services (like dialysis and intravenous antibiotic treatment), in-home support includes hospice care, physician house calls, visiting nurses, home health aides, Meals on Wheels, and hired homemakers to name of few. Group counselling, adult day centres, congregate meals and respite-care are examples of out-of-home support. Community-based health care services include a designated primary care physician, ambulatory care centre, acute and rehabilitative facilities, mental health providers and provision of pharmaceuticals.

Long-term Care:

Elders who cannot manage alone at home and do not have family members able or available to provide adequate support may take advantage of various long-term care settings. Assisted living residences provide various levels of services for elderly adults who do not require skilled nursing care but whom, nonetheless, cannot continue to safely live at home. Although some assisted living residents have mild to moderate dementia, they tend not to have seriously disabling conditions. Assisted living is truly a long-term care option. Most residents do not return to their original homes, and many go onto more intensive settings, like nursing homes. Skilled nursing facilities include nursing homes and similar long-term care institutions employing skilled medical professionals. Most residents of nursing homes suffer from chronic disabled conditions requiring 24-hour nursing care for the indefinite future. A smaller percentage of residents at some facilities receive rehabilitative services after an acute event (such as a fall or stroke) during a relatively short, well-defined admission. Short-term (usually about two weeks) respite stays are a third type of admission in which elders living at home occupies a nursing home bed in order to provide their caregivers with a much needed break.

Social Networks

Social networks may take the form of intimate, tightly knit relationships or broad-based community affiliations. Interestingly, studies suggest that the health of elder women benefits more from group relationships, as opposed to elder men who thrive better on close personal relationships with family members, particularly a spouse. The assessment of social networks involves collecting information on:

(1) Marital status,
(2) Number of children and the frequency of their visits,
(3) Existence and involvement of other close relatives or close friends, and
(4) Frequency of attendance at religious and secular meetings or events.

Supportive arrangements within a patient's network include

(1) Practical assistance with daily tasks (such as transportation, shopping and cooking), and

(2) Emotional assistance from family members, friends, or community groups. Conversely, questions about abusive behaviour directed at the patient are a critical to the social assessment. Elder abuse may take the form of direct physical harm, neglect, or emotional harassment.

The assessment concludes with self-perceptive questions regarding a patient's sense of isolation or association.

Caregivers:

Since, as mentioned above, family members meet the great majority of disabled elders' needs, the patient of interest is frequently also a caregiver. If this is the case, assessment questions turn to the beneficiary of such care and its affect on the patient. Who is she caring for and how ill or disabled is this person? How often and for how long does she provide care, and what exactly is involved? Is her responsibilities causes stress and exhaustion, ill health, or an unacceptable loss of independence?

Financial Security

If we see the world statistics, according to the American Association of Retired Persons, about one in five older Americans live below 125% of the poverty line. Compared to elderly men, the poverty rate is almost double for women such that roughly the same proportion of older women lives in poverty as do children in this country. Since income level is clearly associated with health at all ages, financial security is an essential component of the geriatric assessment. Nevertheless, many physicians are uncomfortable about discussing their patients' assets, viewing the topic as outside their professional jurisdiction. To obtain this information, it is usually unnecessary to discuss a patient's annual gross income or estate plan in any detail. Inquiring in general terms about current sources of income and ability to meet expenses now and in the future is usually sufficient.

Health care coverage

An especially important assessment topic is health care coverage, both public entitlement programs (Medicare and Medicaid) and private insurance plans. Most elders use a combination of Medicare benefits and private supplemental insurance to pay for acute hospital services and physician visits. They rely on Medicaid and out-of-pocket resources for nursing home care. Although most practitioners are abundantly aware of their patient's coverage, they do not routinely explore its adequacy, except as part of a thorough geriatric assessment.

Transportation

An important objective of the geriatric assessment is to make decisions that maximizes an elder's independence and minimizes risk to his safety and the safety of others. Physicians frequently find themselves in the unenviable position of deciding when it is time for older drivers to give up their licenses. According to the AAA Foundation for Traffic Safety, more than one in four drivers will be 65 ; over by the year 2000. Although older drivers are on the road for fewer miles than their younger counterparts, the number of crash-related injuries and deaths per million drivers increases after age 60. Among other things, these accidents seem to reflect errors of inattention, failure to yield, a difficult time manoeuvring and driving too slowly. As

was the case with falls above, there are multiple risk factors for motor vehicle accidents in the elderly, all of which are evaluated elsewhere in the assessment. These include cognitive impairment, vision and hearing loss, psychomotor slowing, decreased musculoskeletal endurance and coordination poly pharmacy, and attention deficits due to any number of chronic medical problems. This part of the assessment focuses on the patient's transportation requirements, driving habits, and accident history. How does the patient get around (own car, public transportation, private livery service)? Is this acceptable? What are the typical destinations and what is the frequency of travel? If the patient drives, what type of vehicle? Does she possess a valid driver's license? Is a seatbelt routinely used (of course, this applies to all patient populations)? How many traffic violations have there been in the past year? How many accidents, including related injuries and hospitalizations?

Adaptation

Emotional adaptability and fortitude provide considerable protection against declining health in elderly patients. Disease, illness, disability and loss are inevitable challenges faced by everyone with the good fortune to live long enough. A patient's resilience in the face of adversity is often a better predictor of health outcomes than the specific nature of that adversity. Even though it is difficult to reliably measure anyone's ability to favourably confront his destiny, given the relevance of such a confrontation with advancing age, the geriatric assessment is an important place to try. Two approaches that may help gauge a patient's adaptability include assessing

(1) Stability during extreme change or adversity and

(2) Self-perception.

What was the nature of the event (loss of a spouse or institutionalization, for instance)? What was the patient's response (worsening cognition, depression or decompensation from a chronic medical condition)? How long did it take to recover? How does the patient feel about any impending changes? Evaluating self-perception, of course, requires a certain minimal level of cognition. Has the patient achieved his life's goals? How content is he with his current situation? Does he look forward to any future prospects? A number of studies support the contention that an affirmative answer to at least this last question predicts longevity.

Values

An individual's moral philosophy may or may not affect her health, but it certainly affects her health care. This is especially true for older adults who are routinely confronted with enormous ethical decisions. As part of every geriatric assessment, practitioners must therefore have an open and honest discussion with patients and families about their views on therapeutic interventions and terminal care. Well before an elderly patient's life is immediately threatened, she should have some kind of

advanced directive in place (such as identification of a healthcare proxy) to guide the future decisions of her physicians and family members. And, in the face of imminent death, the physician should approach the patient and her family about writing a "Do-Not-Resuscitate (DNR)" order on the chart.

The geriatric assessment, part of which involves the determination of medical competency is an ideal opportunity to firmly establish the wishes of patients who may soon face the prospect of terminal illness and impending death.

ACTIVITY-II : NUTRITION

Dietary assessment, lifestyle, Anthropometry of old people

Beyond the medical and social assessments, there are four components specific to the geriatric nutritional assessment.

(1) A nutritional history performed with some version of a nutritional health checklist.

(2) A detailed dietary assessment using a 24-hour recall, "usual intake" or food record.

(3) A physical exam with particular reference to signs associated with over consumption and inadequate nutrition. And

(4), selected laboratory tests if applicable.

Nutritional Health Checklist:

The Nutritional Health Checklist was developed for the Nutrition Screening Initiative for the elderly. The patient or practitioner may complete the questionnaire. A "yes" answer for any one of the ten questions listed below is a flag for a potential nutritional problem:

- I have an illness or condition that made me change the kind and/or amount of food I eat.
- I eat fewer than two meals per day.
- I eat few fruits, vegetables or milk products.
- I have three or more drinks of beer, liquor, or wine almost every day.
- I have tooth or mouth problems that make it hard for me to eat.
- I don't always have enough money to buy the food I need.
- I eat alone most of the time.
- I take three or more different prescribed or over-the-counter drugs per day.
- Without wanting to, I have lost or gained 10 lbs. in the last six months.
- I am not always physically able to shop, cook, and/or feed myself.

Dietary Assessment:

A dietary assessment includes information about the patient's intake of food and liquids during a "usual day", preferably the previous 24 hours. This includes quantitative and qualitative questions breakfast, lunch, dinner, snacks, and vitamin/mineral supplements. Such information is generalizable since there is typically little variability in intake patterns from day to day, especially in the elderly. The practitioner can then evaluate the patient's diet in light of their medical history, medications and supplements. They can use the encounter to make specific dietary suggestions based on standardized guidelines such as the food pyramid. The areas of particular concern in this population include adequate protein intake, five or more servings of fruits and vegetables, three servings of dairy foods for adequate calcium intake, and appropriate quantity of food.

Physical Examination:

Numerous findings on physical exam may be indicators of nutritional status. The examiner must pay particular attention to the patient's general appearance, anthropometrics (height and weight), oral cavity, vision and hearing, and upper extremity mobility. In the Nutritional Appendix is a list of clinical signs and symptoms associated with specific nutritional deficiencies.

Selected Laboratory Tests: There is not a routine panel of blood tests that is appropriate to all geriatric patients, or any patients for that matter. Clinicians must carefully select each laboratory test based on the totality of the patient's clinical presentation. However, the following tests may enhance the overall nutritional assessment of elderly patients.

- Serum albumin to help determine protein and immune status.
- Serum cholesterol and homocysteine to determine risk level for CVD. (Total cholesterol levels above 240 mg/dl indicate considerable risk for CVD; levels below 160 may indicate gastrointestinal problems.)
- Blood glucose in diabetics and periodically in non-diabetic elders since glucose intolerance increases with aging.
- Haemoglobin/hematocrit to evaluate for anaemia, a prevalent condition in the elderly.
- Vitamin B12 (especially in vegans, with indications of achlorhydria and gastrointestinal problems).

Geriatric practitioners may use the accumulated data from the foregoing assessments to identify and evaluate potential nutritional problems in their elderly patients. Questions to consider include: Are there "flags" for nutritional risk? How can they

be managed? Are the patient's dietary supplements appropriate? Are there any potential nutrient-drug interactions? What nutrients are affected and are the pharmaceutical benefits worth the nutritional risk? Is the patient's dietary intake adequate, and if not, what specific changes can the patient make to optimize his or her health?

ACTIVITY-III : ROLE PLAY (MEDICATION)

ROLE PLAY

Role-playing takes place between two or more people, who act out roles to explore a particular scenario.

It's most useful to help you or your team prepare for unfamiliar or difficult situations. For example, you can use it to practice sales meetings, interviews, presentations, or emotionally difficult conversations, such as when you're resolving conflict.

By acting scenarios like these out, you can explore how other people are likely to respond to different approaches; and you can get a feel for approaches that are likely to work, and for those that might be counter-productive. You can also get a sense of what other people are likely to be thinking and feeling in the situation.

Also, by preparing for a situation using role-play, you build up experience and self-confidence with handling the situation in real life, and you can develop quick and instinctively correct reactions to situations. This means that you'll react effectively as situations evolve, rather than making mistakes or becoming overwhelmed by events.

You can also use role-play to spark brainstorming sessions, to improve communication between team members, and to see problems or situations from different perspectives.

STEPS IN ROLE PLAY

Step 1: Identify the Situation

To start the process, gather people together, introduce the problem, and encourage an open discussion to uncover all of the relevant issues. This will help people to start thinking about the problem before the role-play begins.

If you're in a group and people are unfamiliar with each other, consider doing some icebreaker exercises beforehand.

Step 2: Add Details

Next, set up a scenario in enough detail for it to feel "real." Make sure that everyone is clear about the problem that you're trying to work through, and that they know what you want to achieve by the end of the session.

Step 3: Assign Roles

Once you've set the scene, identify the various fictional characters involved in the scenario. Some of these may be people who have to deal with the situation when it actually happens (for example, salespeople). Others will represent people who are supportive or hostile, depending on the scenario (for example, an angry client).

Once you've identified these roles, allocate them to the people involved in your exercise; they should use their imagination to put themselves inside the minds of the people that they're representing. This involves trying to understand their perspectives, goals, motivations, and feelings when they enter the situation. (You may find the Perceptual Positions technique useful here.)

Step 4: Act Out the Scenario

Each person can then assume their role, and act out the situation, trying different approaches where necessary.

It can be useful if the scenarios build up in intensity. For instance, if the aim of your role-play is to practice a sales meeting, the person playing the role of the potential client could start as an ideal client, and, through a series of scenarios, could become increasingly hostile and difficult. You could then test and practice different approaches for handling situations, so that you can give participants experience in handling them.

Step 5: Discuss What You Have Learned

When you finish the role-play, discuss what you've learned, so that you or the people involved can learn from the experience.

Tips

Some people feel threatened or nervous when asked to role-play, because it involves acting. This can make them feel silly, or that they've been put on the spot.

To make role-playing less threatening, start with a demonstration. Hand two "actors" a prepared script, give them a few minutes to prepare, and have them act out the role-play in front of the rest of the group. This approach is more likely to succeed if you choose two outgoing people, or if you're one of the actors in the demonstration.

Another technique for helping people feel more comfortable is to allow them to coach you during the demonstration. For instance, if you're playing the role of a customer service representative who's dealing with an angry customer, people could suggest what you should do to make things right.

Key Points

Role-playing happens when two or more people act out roles in a particular scenario. It's most useful for helping you prepare for unfamiliar or difficult situations.

You can also use it to spark brainstorming sessions, improve communication between team members, and see problems or situations from different perspectives.

To role-play:

1. Identify the situation.
2. Add details.
3. Assign roles.
4. Act out the scenario.
5. Discuss what you have learned.

MEDICATION

Medications play an expanding role in health care as we grow older. People are more likely to develop one or more chronic illnesses with advancing age, and appropriate medication can help seniors live longer and more active lives. However, medication use in older adults is also more likely to be associated with safety concerns. In this handout, learn how to get the benefits of medicine, whether prescription or non prescription, while minimizing and managing the risks.

Seniors: Their medicines and safety

Why is medication safety a particular concern for the elderly?

- With a growing number of prescription medicines available and a growing population of older adults, the potential for medication safety problems is expanding.

- As people age, they are much more likely to be prescribed more than one kind of prescription medication, and many seniors take three or more. This increases the risk for drug interactions, mix-ups, and the potential for side effects.

The effects of aging cause older adults' bodies to process and respond to medicines differently than those of younger people. Age-related changes in the liver, kidneys, central nervous system, and heart are among the contributing factors causing elderly people to be more vulnerable to overdose and side effects.

- Age-related challenges like memory loss or poor eyesight can make it harder to follow instructions for taking medication.
- Financial issues may prevent seniors from filling some prescriptions.

On the following pages are steps you can take to reduce your risk of medication safety problems, for yourself or for an older person in your care.

Be aware that medications can interact

When you take medicine, two kinds of interactions may occur:

- Drug-drug interactions happen when two or more medicines react with each other to cause unwanted effects or make either medicine's effects more or less potent. Such interactions may also be caused by alcohol, nutritional supplements or herbal products, and non prescription medicines as well as prescription medications.
- Food-drug interactions happen when medicines react with foods or beverages. For example, grapefruit juice should not be taken with certain blood pressure−lowering medications, and dairy products should be avoided with some antibiotics and antifungal medications.

At the doctor's office

Before your visit, be prepared to take an active role in your medication treatment plan. If possible, have someone come with you to help take notes and remember questions that need to be asked. If you help care for an elderly person, ask to stay with him or her during any conversations with the doctor.

Make a list of questions you want to ask about your health and medications.

- Bring an up-to-date list of all the prescription and non prescription medications you take, including herbal or dietary supplements and topical medications (i.e., those applied to the skin), along with key facts about your medical history. This is particularly important if you are visiting a doctor, clinic, or other health care professional for the first time.

- Once a year, request a "brown-bag review" in which you bring in all your medications for your doctor's advice. When you schedule your appointment, request extra time for this service.
- If your doctor prescribes medication, make sure you understand the name of the medicine (trade name and generic); how, when, and for how long you should take it; any precautions or warnings about the medicine; side effects to watch out for, and what to do if they occur.
- Ask what the medicine is intended to do, and whether you will need any lab tests to monitor your treatment.
- Ask how long you will be taking the medicine, and whether you should stop taking it once you feel better.

Be honest about any ways in which you are having trouble managing your current medication routine: forgetting or skipping doses, not filling a prescription, experiencing side effects, having trouble affording your medication, or feeling too dependent on a medication.

- If you already take a number of medications, ask your doctor:
    - if the new medicine has any of the same actions or possible side effects (such as drowsiness or dizziness);
    - if the new medicine might interact with anything you are already taking;
    - if there are any non medicinal ways of treating your medical condition.
- Before you leave the doctor's office, speak up for yourself if:
    - you still have unanswered questions;
    - you didn't hear or understand any of the doctor's answers;
    - you are not sure if you can carry out your treatment plan (and let your doctor know what things stand in the way);
    - you felt too rushed to address your concerns.

At the pharmacy

- When you get a prescription filled, bring the list of the medicines (prescription and non prescription) that you take (including medications received by mail order). If your pharmacy keeps records on all the prescriptions you have filled there, make sure the list is up-to-date and includes medicines that you may have purchased elsewhere.
- After your prescription is filled, check that the medicine's name and directions are the same as what your doctor told you.
- Ask your pharmacist to confirm the directions that you were given for your medication, including warnings about interactions with foods or other drugs (including alcohol), possible side effects, and follow-up testing.

- Make sure medication is packaged in a way that you can access it easily (e.g., non child proof caps if you have arthritis, but be sure that such containers are kept safely out of the reach and sight of children who live in or visit your home).

At home

- Read the information packaged with your medicine for important information.
- If you experience possible side effects, call your doctor or pharmacist. It's possible that you may do better on a different dose, especially at first, or your doctor may decide to switch you to a different medicine for the same condition.
- Keep an updated list of your medical history and all medications you take—prescription medicines non-prescription, and herbal or dietary supplements. Give a copy to family member
- Use a pill organizer to track whether you have taken your pill(s). Other strategies include linking your medication routine to something you do every day (such as brushing your teeth) or using checklists.

Non prescription medicines

Non-prescription medicines are convenient because they don't require a prescription, and many of these products can help relieve temporary minor conditions like headaches, indigestion, and cold symptoms. Here are some potential problems:

- Seniors taking one or more prescription medicines may take a non-prescription medicine that causes the same effect (for example, lowering blood pressure).
- Non-prescription medicines may not be taken according to directions, or mix-ups may occur.
- Some medical conditions make certain non-prescription medicines potentially harmful, including high blood pressure and asthma.
- Age-related changes affect the body's ability to use non-prescription medicines, including those applied to the skin, just as they do for prescription medications

These steps can reduce your risks from non-prescription medications:

- Even if you have been taking a non-prescription product for years, ask your doctor or pharmacist if it's still okay for you now.
- Always read and follow the "Drug Facts" label on the non-prescription product packaging. This label tells you what the medicine is for, how and when to take it, active and inactive ingredients, and warnings. Pay special attention to the

active ingredient, and make sure you're not taking another product with the same or similar ingredient without your doctor's approval.

- Pick non-prescription medicines that treat only the symptoms you have. Avoid multi symptom cold remedies (for instance, if all you have is a stuffy nose, get a product containing only a decongestant instead of one with a pain reliever, cough suppressant, decongestant, and antihistamine). Each of those active ingredients could cause potential problems, so keep it simple.

Non-prescription medicines are usually meant only for short-term use. If your symptoms don't go away or worsen, talk to your doctor.

ACTIVITY-IV : ROLE PLAY (COMMUNICATION SKILL)

Cognitive Assessment

Cognition involves the basic processes of perception, attention, memory, reasoning, decision-making and problem solving. When these processes are disrupted, the consequences for the individual can be disastrous; unintentional overdose of prescription medication, motor vehicle accidents, and squandered life savings are only a few examples. Disease, medication, or accidents (especially those involving head injury) can disrupt cognition. Before testing cognition, it is important to know that the patient s primary sensory abilities (vision and hearing) are intact, since deficits in primary sensation could mislead you to conclude that the patient was cognitively impaired. It is for this reason that vision and hearing testing are a routine part of the geriatric assessment.

There are many ways to assess cognition, some clearly superior to others. Getting a feel for the cognitive abilities of a patient by way of the medical interview is an ill-advised strategy, since many cognitively impaired patients will be able to compensate for any deficits and appear to be intact unless individual capacities are explicitly tested. For this purpose, the best-validated and most widely used instrument is the Mini Mental State Exam (MMSE) originated by Folstein, et al. It has recently been made available in annotated form, the Annotated MMSE, or AMMSE (reproduced in the Directed Geriatric Assessment for your use).

The (A)MMSE covers the cognitive domains of orientation, memory, attention, calculation, language, and constructional ability. It involves putting a series of standardized questions directly to the patient, and recording the patient s verbatim answers. It has a total score of 30 points and a general cut-off score of <24 is abnormal. Performance on this exam depends on age and education; however, so

normative data adjusted for these variables are available in various published references.

The (A) MMSE is usually performed at the end of the interview (history) portion of the assessment, when the patient is seated in a chair and remains fully clothed. It is best introduced simply by saying, "Now I am going to ask you some questions to test your memory." (Although the (A) MMSE does go beyond memory, this is usually the quickest and least objectionable way to introduce it.)

Cognitive Stimulation Activities

ACTIVITY-1
Sorting
Size of Group: 4-8
Equipment: Multiple items of different colours (cloth, crayons, balls, paper, etc.), flash cards, baskets
Objective: Encourage residents to use cognitive thinking skills
Description: Get a basket for each resident and fill it with several different items of different colours. On the flash cards write different descriptive words (i.e. black, white, round, square, soft, hard, etc). Show the residents a card and have them select an item that matches the description. This could be used as a game by rewarding residents with points and the highest score receiving a prize.

ACTIVITY-2
Stories out of the Hat

Size: 4+

Equipment: Hat or bowl
strips of construction with descriptive questions

Objective: stimulate memory
allow staff to see clients as ""real people""
encourage communication, sharing and trust within group

Description: prior to session group leader will write out memory stimulating questions and/or phrases on the strips of paper, fold paper in half and place in hat/bowl.

Questions will reflect group objectives for session. example, favorite memory of mom? Favorite book or movie, Why? Favorite season what is your favorite thing to

do? Who were you closest to growing up? Best friend story, first drive in date, each client/staff chose a slip from the hat. Tell their story and pass the hat on.

ACTIVITY –3
Hoy Card Game

Size: small to large

Equipment: two packs of cards

Objective: to promote concentration

Description: Leader has one pack of cards. Leader gives clients for or five cards each, more or less depending on size of group.

Cards are then turned face up.

Leader holds up a card (eg, seven of diamonds) and announces it to the group. Whoever has that card turns it over. Play continues in this manner until all cards are turned over. Whoever has all their cards turned over first yells out "Hoy"

Three or four games can be played to fill a morning or afternoon session.

ACTIVITY –4
Conversation Group

Size of Group: 4-12

Equipment: Workbook: 52 Weeks: Social Themes for Language Stimulation

Objective: Conversation group to stimulate long term and short term memory, word-finding, sharing of thoughts and feelings, increase communication

Description: The workbook provides weekly lessons on topics relevant to historical events, holidays and topics of high level interest to adults. There are 52 pre-planned activities for stimulation of cognition and communication. Each unit contains paragraphs for short term memory, trivia questions, discussion questions and other miscellaneous communication activities. The material will be appropriate for the alert, older adults or those with mild-moderate communication problems.

ACTIVITY-5
Famous Faces

Size: small 3-6

Equipment: Pictures of famous people

Objective: Increase cognition, communication skills, problem solving and pragmatics.

Description: One patient is picked to be the first person to guess. Everyone else is shown the famous face. The guesser must then ask questions to find out who the famous face is.

Are they a man or woman?
Are they alive or dead?
Are they an entertainer?
Are they a politician?

ACTIVITY-6

In My Suitcase

In this activity, one client will start by stating what he or she will pack in their suitcase for their trip. The second person will state what the first person identified, and one article that they will add to the suitcase. The third person will identify what the first two added, and one article that he or she will add. By the end of the activity, the final person to take a turn will have several articles to remember. Not only do the clients have to come up with what they personally will take, their concentration level must be high enough to focus on his or her peers. This will keep the clients attention focused on the activity and prevent them from becoming bored or disinterested in the activity.

ACTIVITY-7
Product Slogans

Benefits

Mental: memory, creativity
Emotional: feelings of success, competence, challenge
Social: group interaction, conversation

Greeting Suggestions:

Have participants exchange names
Have members think of their favourite advertisements
.As a group, brainstorm to name quality products

Activity

we often identify products with the slogans used to advertise them over the years. This activity will challenge the participants to remember and connect products with the appropriate slogan.

1. Matching. Write 5-10 slogans on a large sheet of paper. Hand out Pictures of the products and have participants match each with the corresponding slogan.

2. Guessing. Read a slogan and ask participants to call out the corresponding product. This may be done in teams or individually.

3. Create a Slogan. Have individuals or small groups create their own Slogans for a number of products. See if the rest of the group can guess the right product for each slogan.

Sample Slogans

- Amul: The taste of India
- Pepsi : Yehi hain right choice baby
- Thums Up : Taste The Thunder
- Surf : Daag Acche hain
- Tata Safari : Reclaim Your Life
- Asian Paints : Har Ghar Kuchch Kahta hein
- Air Deccan : Simplifly
- Rasna : I love you Rasna
- Frooti : Fresh N Juicy
- Coca Cola : Thanda Matlab Coca Cola
- Raymond's : The Complete Man
- Bajaj: Hamara Bajaj
- Dairy Milk : Swad Zindagi Ka
- Bingo : No Confusion, Great Combination
- Boost : Boost is the secret of our energy
- Polo : The mint with a hole
- Lifebuoy : Lifebuoy hai jahan, tandrusti hai wahan
- Ceat : Born Tough
- MRF : Tyres With Muscle
- Idea : An Idea can Change your life
- Hutch : Where ever you go , our network follows
- Maggi : Taste Bhi, Health Bhi

- Onida : Neighbor's Envy , Owner's Pride
- Kingfisher : The King of Good Times
- Airtel: Express Yourself
- Fevicol: Fevicol ka mazboot jod hai Tootega nahi!
- Hero Honda: Desh ki Dhadkan
- Indian Army: Do you have it in you?
- Malaya Manorama: Nobody Delivers Kerala Better
- Tata Sky: Isko laga dala to life to life zinga lala
- LIC: Zindagi ke Saath bhi, zindagi ke baad bhi
- Nike: Bleed Blue
- Wills: made for each other
- Lux: Beauty bar of film stars
- Chlormint: Dobara mat poochna
- Tata Salt: Desh ka namak
- Big Bazar: Isse sasta aura cha kahin nahi
- The Economic Times: Journalism of Courage
- Videocon: The Indian Multinational
- Mentos: Dimag ki batti jaja de
- Kit Kat: Have a break, have a kit kat
- Red FM: Bajate raho
- Radio Mirchi: It's Hot!
- Taj Mahal: Wah Taj!
- Telegraph: The Unputdownable
- ICICI: Hum hain na
- Sprite: Bujhaye pyas, baaki all, bakwas!
- Alpenlibe: Jee lalchaye, raha na jaye
- Lays: No one can eat just one
- HDFC Std Life: Jiyo sar utha ke

Conversation Starters:

1. What products have you bought because of the advertisement?
2. What products would you never buy because of the advertisement?
3. How do you decide which products to buy?
4. Does advertising serve a useful purpose?
5. What is your favorite slogan?
6. Create a slogan to promote your talents.
7. Create a slogan for each month in the year.

8. Do you think that slogans are more effective on T.V., over the radio, Or in the paper?
9. What is the oldest slogan you can remember?

ACTIVITY-V : RISK ASSESSMENT

ASSESSMENT OF RISK OF ELDERLY

Case/risk identification

Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.

Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

Multi factorial falls risk assessment

Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multi factorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multi factorial intervention.

Multi factorial assessment may include the following:

- Identification of falls history
- Assessment of gait, balance and mobility, and muscle weakness
- Assessment of osteoporosis risk
- Assessment of the older person's perceived functional ability and fear relating to falling
- Assessment of visual impairment
- Assessment of cognitive impairment and neurological examination
- Assessment of urinary incontinence
- Assessment of home hazards
- Cardio vascular examination and medication review.

Multi factorial interventions :

All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualized multi factorial intervention.

In successful multi factorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognized risk factors):

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- Medication review with modification/withdrawal.

Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk and individualized intervention aimed at promoting independence and improving physical and psychological function.

Strength and balance training

Strength and balance training is recommended. Those most likely to benefit are older people living in the community with a history of recurrent falls and/or balance and gait deficit. A muscle-strengthening and balance programme should be offered. This should be individually prescribed and monitored by an appropriately trained professional.

Exercise in extended care settings

Multi factorial Interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling.

Home hazard and safety intervention

Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained healthcare professional. Normally this should be part of discharge planning and be carried out within a timescale agreed by the patient or carer, and appropriate members of the health care team.

Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation.

Psychotropic medications

Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling.

Cardiac pacing

Cardiac pacing should be considered for older people with cardio inhibitory carotid sinus hypersensitivity that has experienced unexplained falls.

Encouraging the participation of older people in falls prevention programmes

To promote the participation of older people in falls prevention programmes the following should be considered.

- Healthcare professionals involved in the assessment and prevention of falls should discuss what changes a person is willing to make to prevent falls.
- Information should be relevant and available in languages other than English.
- Falls prevention programmes should also address potential barriers such as low self-efficacy and fear of falling, and encourage activity change as negotiated with the participant.

Practitioners who are involved in developing falls prevention programmes should ensure that such programmes are flexible enough to accommodate participants' different needs and preferences and should promote the social value of such programmes.

Education and information giving

All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

Individuals at risk of falling, and their carers, should be offered information orally and in writing about:

- What measures they can take to prevent further falls
- How to stay motivated if referred for falls prevention strategies that include exercise or strength and balancing components
- The preventable nature of some falls
- The physical and psychological benefits of modifying falls risk

- Where they can seek further advice and assistance
- How to cope if they have a fall, including how to summon help and how to avoid a long lie.

Interventions that cannot be recommended

Brisk walking: There is no evidence that brisk walking reduces the risk of falling. One trial showed that an unsupervised brisk walking programme increased the risk of falling in postmenopausal women with an upper limb fracture in the previous year. However, there may be other health benefits of brisk walking by older people.

Interventions that cannot be recommended because of insufficient evidence

We do not recommend implementation of the following interventions at present. This is not because there is strong evidence against them, but because there is insufficient or conflicting evidence supporting them

Low intensity exercise combined with incontinence programmes. There is no evidence that low intensity exercise interventions combined with continence promotion programmes reduce the incidence of falls in older people in extended care setting

Group exercise (untargeted). Exercise in groups should not be discouraged as a means of health promotion, but there is little evidence that exercise interventions that were not individually prescribed for older people living in the community are effective in falls prevention.

Cognitive/behavioral interventions: There is no evidence that cognitive/behavioral interventions alone reduce the incidence of falls in older people living in the community who are of unknown risk status. Such interventions included risk assessment with feedback and counseling and individual education discussions. There is no evidence that complex interventions in which group activities included education, a behavior modification programme aimed at moderating risk, advice and exercise interventions are effective in falls prevention with older people living in the community.

Referral for correction of visual impairment: There is no evidence that referral for correction of vision as a single intervention for older people living in the community is effective in reducing the number of people falling. However, vision assessment and referral has been a component of successful multi factorial falls prevention programme.

Vitamin D: There is evidence that vitamin D deficiency and insufficiency are common among older people and that, when present, they impair muscle strength and possibly neuromuscular function, via CNS-mediated pathways. In addition, the use of combined calcium and vitamin D3 supplementation has been found to reduce fracture rates in older people in residential/nursing homes and sheltered accommodation. Although there is emerging evidence that correction of vitamin D deficiency or insufficiency may reduce the propensity for falling, there is uncertainty about the relative contribution to fracture reduction via this mechanism (as opposed to bone mass) and about the dose and route of administration required. No firm recommendation can therefore currently be made on its use for this indication.

Hip protectors. Reported trials that have used individual patient randomization have provided no evidence for the effectiveness of hip protectors to prevent fractures when offered to older people living in extended care settings or in their own homes. Data from cluster randomized trials provide some evidence that hip protectors are effective in the prevention of hip fractures in older people living in extended care settings who are considered at high risk.

Preventing falls in older people during a hospital stay

Predicting patients' risk of falling in hospital

Do not use fall risk prediction tools to predict inpatients' risk of falling in hospital.

Regard the following groups of inpatients as being at risk of falling in hospital and manage their care

- all patients aged 65 years or older
- Patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition.

Assessment and interventions

Ensure that aspects of the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling are systematically identified and addressed.

For patients at risk of falling in hospital, consider a multi factorial assessment intervention.

Ensure that any multi factorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay. These may include:

- cognitive impairment
- continence problems
- falls history, including causes and consequences (such as injury and fear of falling)
- footwear that is unsuitable or missing
- health problems that may increase their risk of falling
- medication
- postural instability, mobility problems and/or balance problems
- syncope syndrome
- Visual impairment.

Ensure that any multi factorial intervention:

- promptly addresses the patient's identified individual risk factors for falling in hospital **and**
- Takes into account whether the risk factors can be treated, improved or managed during the patient's expected stay.

Do not offer falls prevention interventions that are not tailored to address the patient's individual risk factors for falling.

Information and support

Provide relevant oral and written information and support for patients, and their family members and carers if the patient agrees. Take into account the patient's ability to understand and retain information. Information should include:

- explaining about the patient's individual risk factors for falling in hospital
- showing the patient how to use the nurse call system and encouraging them to use it when they need help
- informing family members and carers about when and how to raise and lower bed rails
- providing consistent messages about when a patient should ask for help before getting up or moving about

Helping the patient to engage in any multi factorial intervention aimed at addressing their individual risk factors.

ACTIVITY-VI : FIELD VISIT REPORT

VISIT DETAILS

COMPLETEDBY	
LOCATION	
DATES	
OBJECTIVES	

- **AGENDA**
- **The following activities were completed as part of monitoring the visit**

DATE	TIME	ACTIVITY	PARTICIPANTS

- **GENERAL OBSERVATIONS:**
- **SPECIFIC ACTIONS AND ISSUES:**

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