NPHCDA

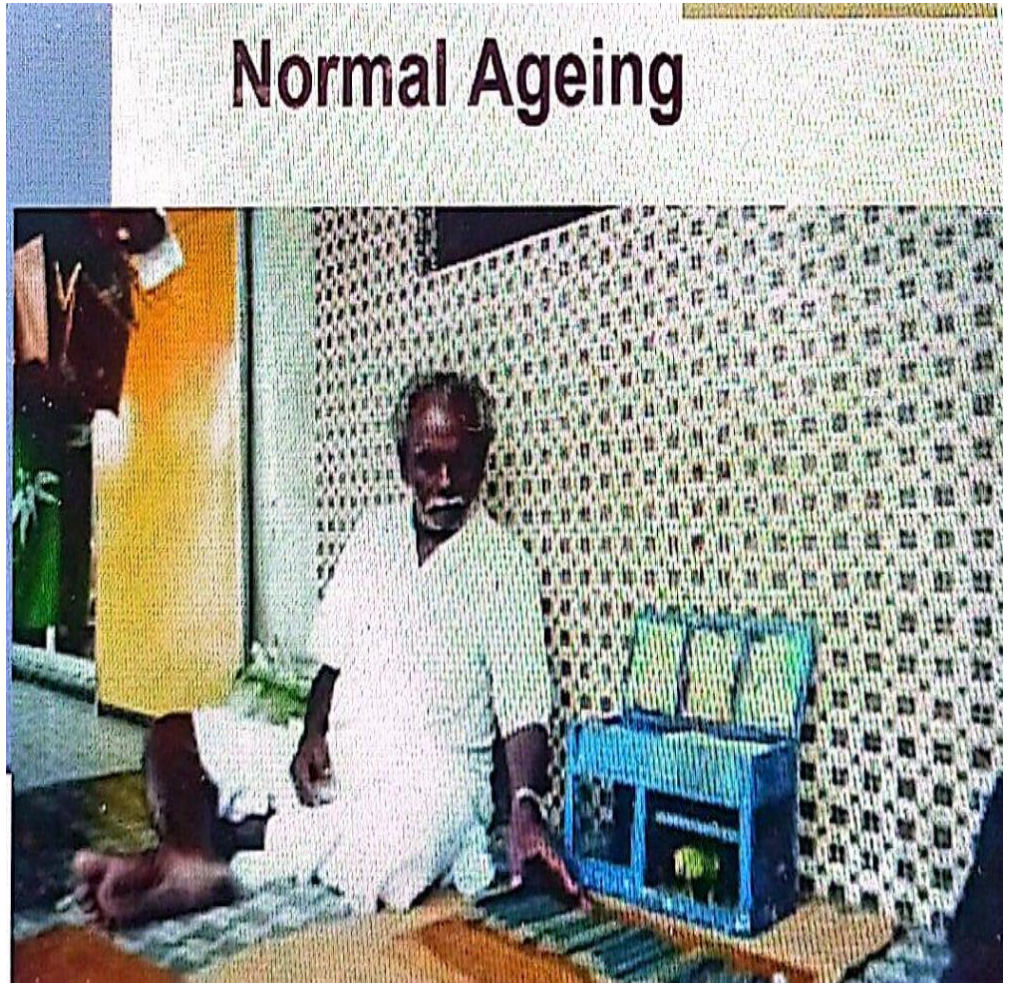
MODULE 11: CARE OF THE ELDERLY IN PRIMARY HEALTH CARE

February 2024

Overview of Care of the Elderly in Primary Health Care

Sessions	Components
11.1	Communicating with and counselling of the Elderly
11.2	Clinical Assessment and Management of Geriatrics

Normal Ageing



Ageing is NOT a disease. Ageing is a Developmental Process

A joke / ice breaker:

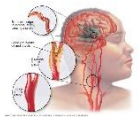
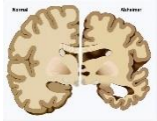
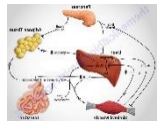
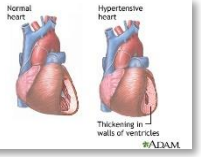
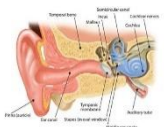
People across all ages have certain beliefs about ageing. Did you hear the story about the 85 year old woman who went to the doctor because of pain in her right knee?

The Doctor responded:

"What do you expect, you're 85 years old. Of course, it hurts!" The lady looked at him and said, "But doctor, my other knee is 85 years old too but it doesn't hurt!"



Common Causes of Mortality in the Elderly

1. Heart Disease 
2. Malignancy 
3. Stroke 
4. Dementia 
5. COPD 
6. Pneumonia 
7. Accidents 
8. Diabetes Mellitus 
9. Arthritis 
10. Hypertension 
11. Hearing Impairment 
12. Heart Disease 

Common Problems



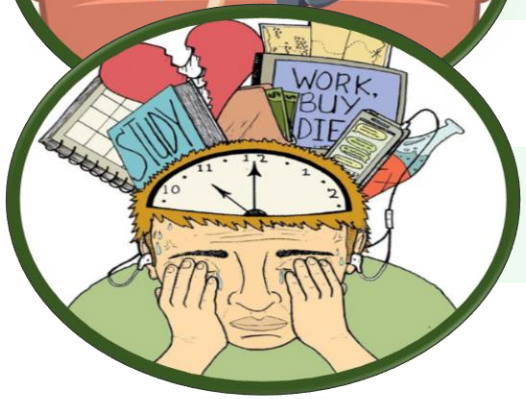
Falls



Confusion



Tiredness



Not coping



Hearing and vision



Depression



Sexual problems

Overview of Care of the Elderly in Primary Health Care

Sessions	Components
11.1	Communicating with and counselling of the Elderly
11.2	Clinical Assessment and Management of Geriatrics

Learning Objectives

At the end of this session, Participants will be able to;

1. Know the role that Primary Health Care (PHC) plays in the health of Elderly persons
2. Clinically counsel elderly individuals in a primary health care setting

Session Overview

The following content will be discussed in this session:

1. Role Of Primary Health Care (PHC) In the Health of the Elderly
2. Communication with the Elderly
3. Clinical Counselling of the Elderly

Role of Primary Health Care (PHC) in the Health of Older Persons

- All primary health care workers should be well versed in the diagnosis and management of the chronic diseases and the four giants of geriatrics: memory loss, urinary incontinence, depression and falls/immobility that often impact people as they age
- These PHC centres should facilitate an environment where Elderly people can move around independently, actively, safely and securely
- The following services are also essential for PHC centres for Elderly people:
  - Accessible transport
  - Assistive devices – mostly wheelchairs
  - Personal assistance



Brainstorming: Communication with the elderly

What is communication?

Why communication



Communication with Elderly Persons

What is communication?



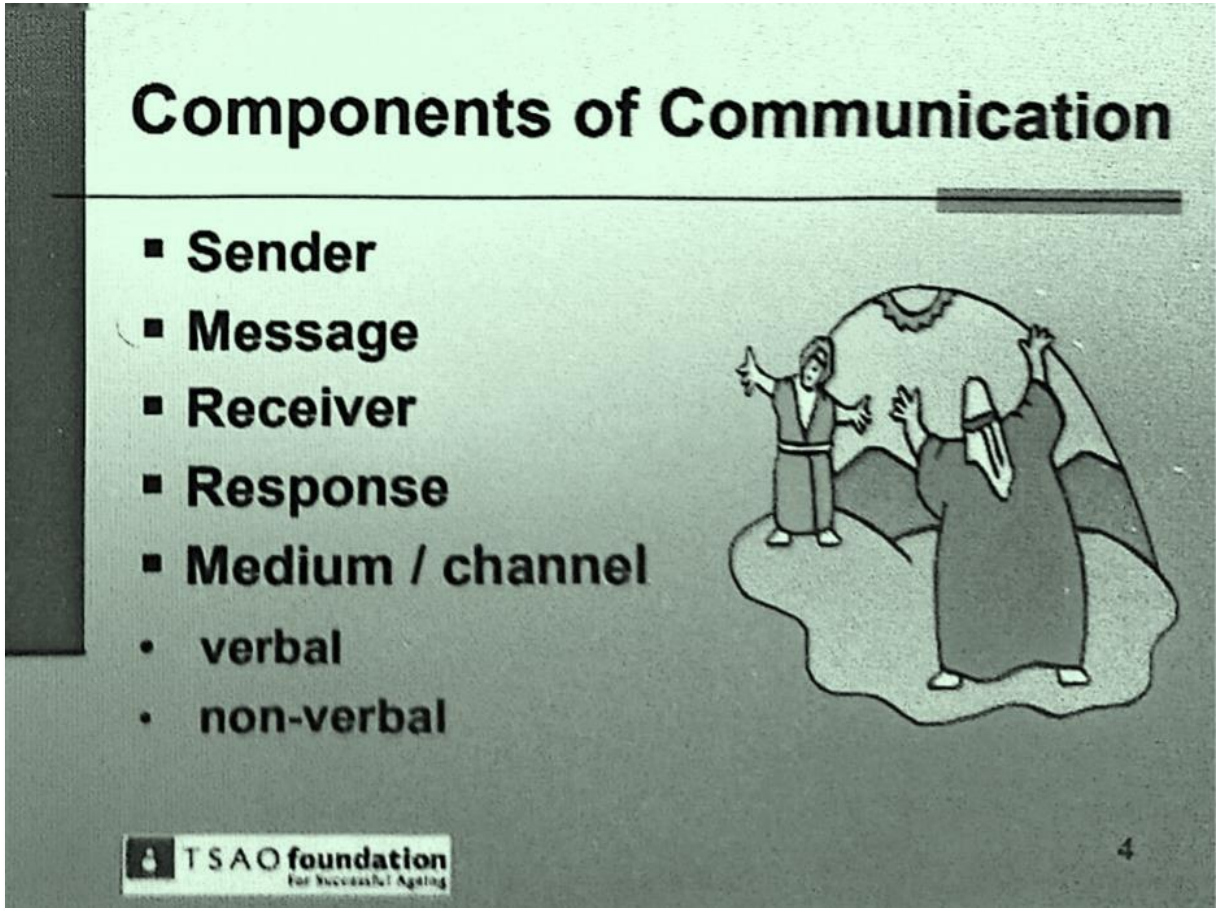
Communication is a process by which information is exchanged between individuals through speaking, writing, or using some other medium, such as common system of symbols, signs or behaviour

Why communication?



To improve all staff's awareness, knowledge and skills concerning communication with an elderly person

Components of Communication



- There is a **sender**, **message** and **receiver** – we often forget the **RESPONSE**
- There are two major components of communication: Verbal communication and Non-verbal communication
  - Verbal communication is the actual words that are said or the content (accounts for 7% of communication)

A message is not just information, advice or instructions but also feelings, encouragement, understanding and praise.

Practical Session: Non-Verbal Communication

Non-verbal communication is basically everything else (accounts for 93%) and includes our tone of voice and facial expression.

Example: Frown, furrow your eyebrows and speak in a sharp tone of voice as if you were scolding someone. Do it in such a way that participants know how you feel when they look at you. Ask for the participants' responses.







Hand gestures and posture, for example, if I were standing here slumped over, looking at the floor with a frown (do this posture) it would communicate one message in contrast to if I stand up straight, look you in the eye and smile (do this posture)!

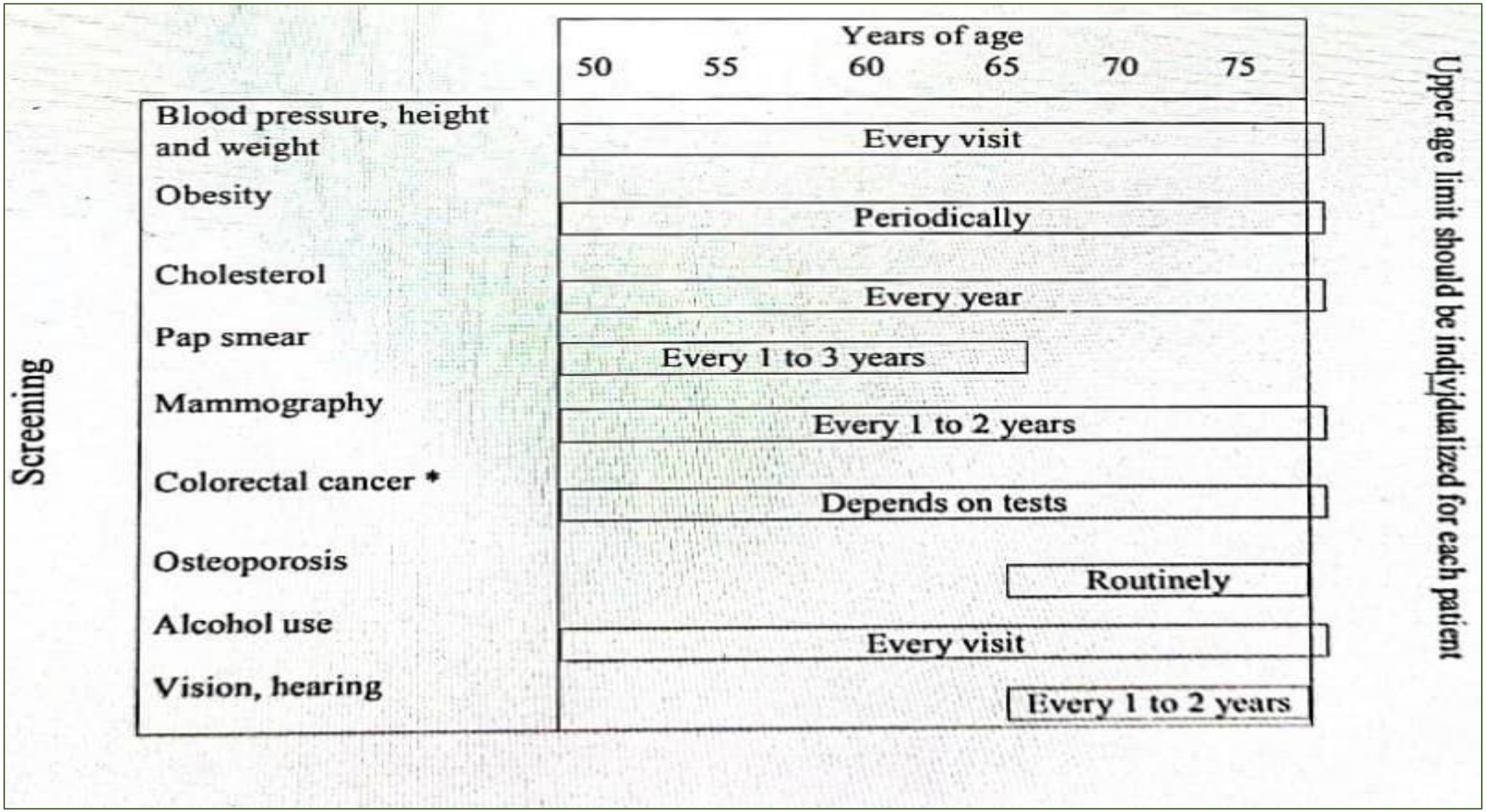
PRACTICAL SESSION:

Non-verbal communication also has to do with the general tone or presence of the person – the feeling you get when you talk to him

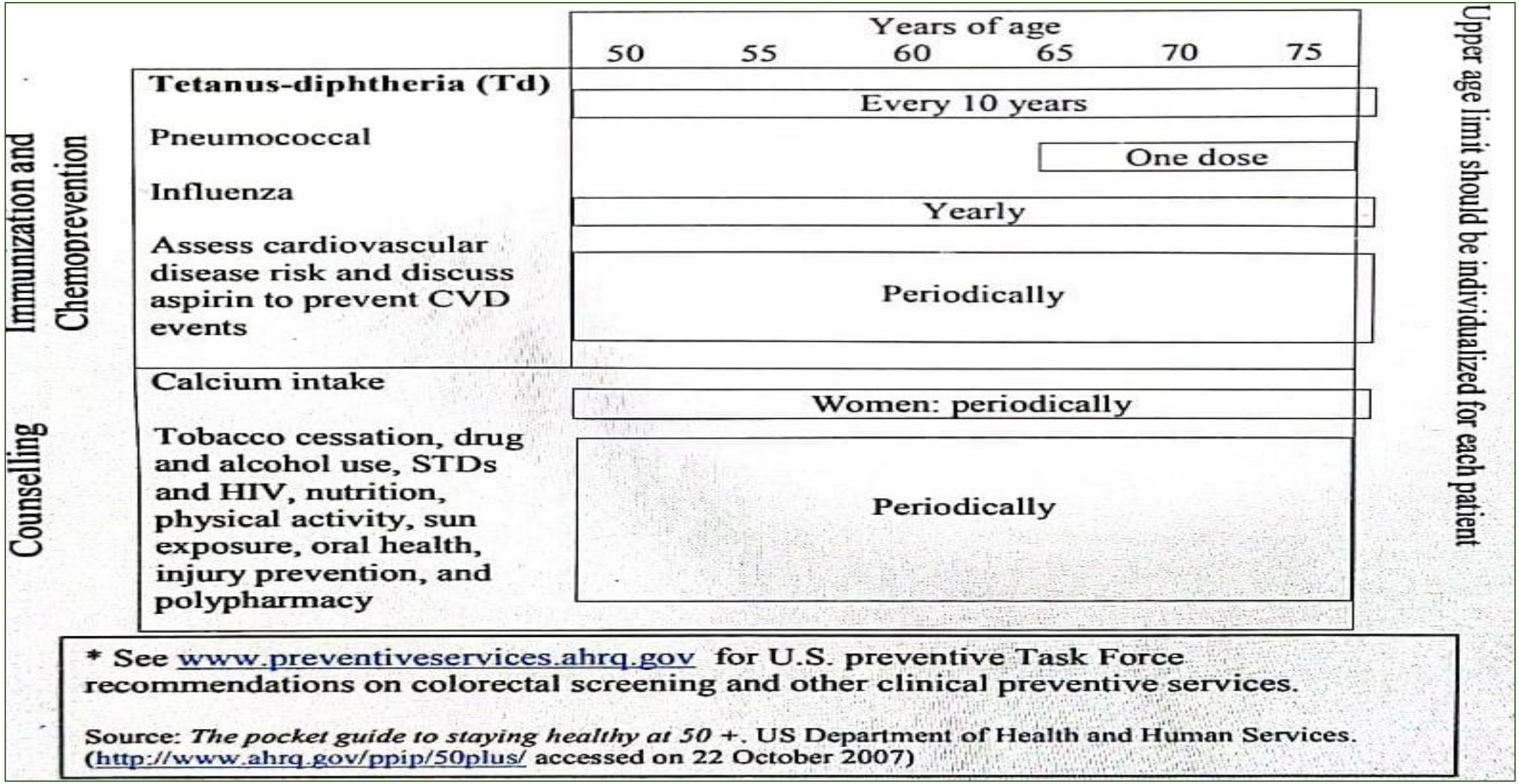
A Role Play of Good and Effective communication as well as bad communication



Screening services for the elderly



Screening services for the elderly cont.



Brainstorming: Clinical counselling of the elderly





WHAT IS COUNSELLING?



Clinical Counselling of the Elderly



Counselling is ***talking therapy*** and this involves a trained therapist or counsellor listening to your challenges and issues and ***helping you*** to find your own ***internal resources*** to deal with your emotional/psychological/health-related issues

General guidelines to consider when providing clinical counselling



Counselling should be culturally appropriate. Present information and services in a style and format that is sensitive to the culture, values, and traditions of the patient.

Several measures may be taken to improve delivery of counselling

Use a variety of resources to reinforce healthy behaviors

Display pamphlets, posters and other materials in a range of common languages conspicuously so that they are readily available

Clinical Counselling of the Elderly

Counselling is a goal-oriented process: apply your expertise to benefit each recipient, directing them to use information in a way that serves best in everyday life



- Short questionnaires to quickly assess patient's needs for counselling (can be done by non-clinical staff or volunteers)
- A team approach to provide counseling is preferable
- Provide repeated messages to patients

Eleven (11) strategies for patient education and counselling for PHC providers

1. Frame the teaching to match the patient's perceptions.
2. Fully inform patients of the purposes and expected effects of interventions and when to expect these effects
3. Suggest small changes rather than large ones
4. Be specific
5. It is sometimes easier to add new behaviours than to eliminate established behaviours.
6. Link new behaviours to old behaviors
7. Use the authority of the profession in a sensitive way
8. Get explicit commitments from the patient
9. Use a combination of strategies
10. Involve office staff
11. Monitor progress through follow-up contact

A. Basics of physical activity counselling (1/3)

Evaluation of patients' usual physical activity

- Ask all patients about their physical activity habits. Include organized activities, general activities and occupational activities.
- Determine if the patient's level of activity is sufficient using the following physical activity pyramid.



Experts agree that physical activity that is at least of moderate intensity, for 30 minutes or longer, and performed on most days of the week is sufficient to confer health benefits.

NB: Tell patients, as doing the moderate-intensity physical activity, they will feel faster heart rate, faster breathing and slightly warmer

A. Basics of physical activity counselling (2/3)



Assist patients who lack sufficient physical activity for health benefits and/or wish to improve physical activity habits in planning a programme that should be:

- **Medically Safe:** Existing heart disease presents the biggest risk.
  - Medical Evaluation: recommended prior to embarking on a vigorous exercise programme for the following individuals:
    - Persons with cardiovascular disease (CVD);
    - Men over 40 years and women over 50 years of age with multiple CVD risk factors – hypertension, diabetes, elevated cholesterol, current smoker, or obesity.

This is particularly important for older adults and those who have not been physically active recently

A. Basics of physical activity counselling (3/3)

Additional advice to promote medically safe physical activity includes:

- Increase the level of exercise gradually rather than abruptly,
- Decrease the risk of musculoskeletal injuries by performing alternate-day exercises and using stretching exercises in the warm-up and cool-down phases of exercise sessions.



This is particularly important for older adults and those who have not been physically active recently.

Overcoming barriers to exercise

Complain	Response
Exercise is hard work	Start with ordinary walking or an exercise that is not work
I don't have the time	That may be true but you never know for sure unless you try to make it
I am usually too tired for exercise	Tell yourself, "this activity will give me energy" see if it doesn't happen
I hate to fail so I will not start	Physical activity is not a test. You will not fail if you choose what you like
I do not have anyone to work with	Maybe you have not asked. A neighbor or a coworker may be a willing partner. Or you can choose an activity you can do alone
There is no convenient place	Pick an activity you can do in convenient place
I am afraid of being injured	Walking is a safe and excellent exercise. Choose a safe and well-lit area
The weather is too bad	There are many activities that you can do in your home
Exercise id boring	Some ways to it are – by listening to music, working with a companion etc.

Basics of physical activity counselling

1. Encourage participation in activities that can be enjoyed with a minimum of special preparation, ideally those that fit into daily activities

2. A too difficult programme in terms of goals and integration with other daily activities will lead to disappointment. Gradual change leads to permanent change; therefore, stress the importance of gradually increasing the intensity, frequency and duration of exercise.
   - Having defined activities, goals for performance and a set schedule and location may help improve some patients' compliance. Signing a physical activity "contract"/"action plan" may be helpful

3. Encourage patients who are unwilling or unable to participate in a regular exercise programme to increase the amount of physical activity in their daily lives:
   - Taking the stairs rather than the elevator when possible,
   - Leaving the subway or bus one or two stops early and walking the rest of the way
   - Doing household chores and yard work on a regular basis







Basics of physical activity counselling contd.

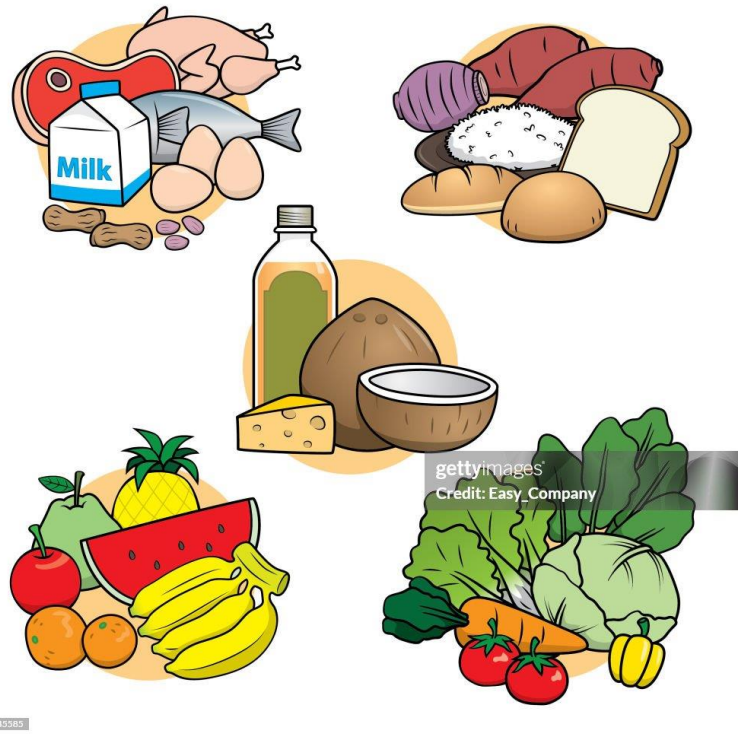
4	Involve nursing and office staff in monitoring patient progress and providing information and support to patients. Some form of routine follow-up with patients about their progress is very helpful
5	Convey positive messages about exercise and physical activity using posters, displays, videotapes, and other resources in offices or clinics.
6	Providers should try to engage in adequate physical activity themselves. Studies show that providers who exercise regularly are significantly better at providing exercise counselling to their patients than those who do not.







B. Basics of nutrition counselling:



1. Regularly weight and measure every patient. Advise them on their healthy weight range based on age, gender and distribution of body fat.

2. Talk with all patients about their dietary habits, including use of dietary supplements. Use a brief nutritional screening questionnaire accepted in your country if available to identify nutritional vulnerability, or consider an evidence-based tool.

3. Provide basic information about managing a healthy diet. Use dietary guidelines of your country if available

While nutritional vulnerability is often associated with under nutrition, the prevalence of obesity is increasing among older persons, with potential health risks.

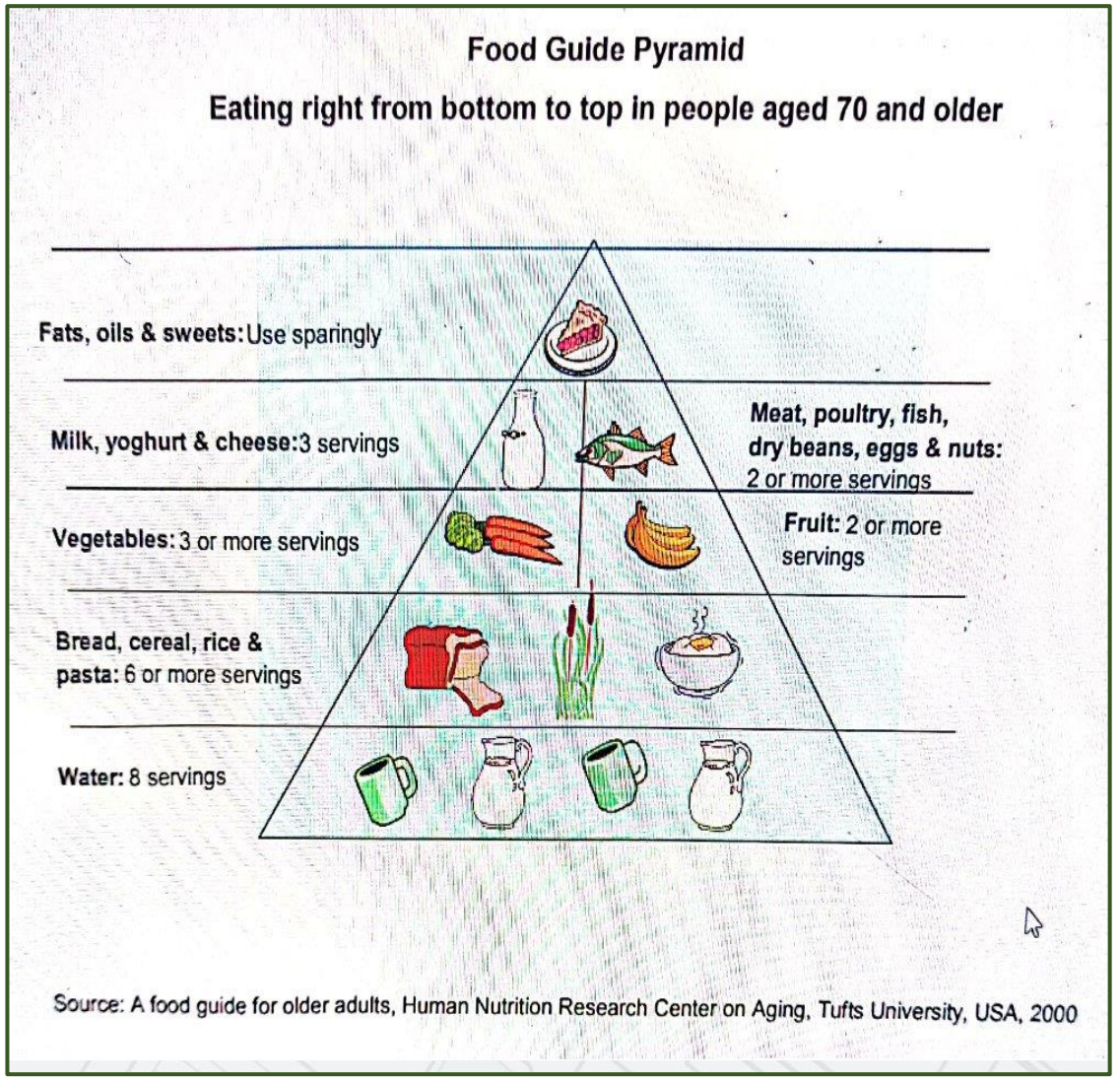
Basics of nutrition counselling CONTD.

4 Use the following Food Guide Pyramid as an educational tool for planning a healthful diet.

5 For women, recommend special dietarian particularly for calcium. Counsel older women to consume adequate calcium, which helps in:

- Building optimal bone after menopause,
- Controlling bone loss and delay development of osteoporosis.

Dairy products are major sources of calcium. Other sources of calcium are canned fish with soft bones, vegetables such as broccoli and spinach, and fortified cereals and grains



Basics of nutrition counselling CONTD.

6	For overweight patients, recommend: ○ a diet with fewer total calories from fat, ○ a modest increase in physical activity.	See information on physical activity counselling. In general, the goal should be a weight loss of 1 / 2 to 1 pound per week. Behavior therapy and physical activity have been shown to help maintain weight loss.
7	Ongoing support and reinforcement to patients undertaking significant dietary changes. This support can take several forms, including: ○ follow-up visits, ○ telephone calls and postcards.	Recommend making changes gradually, in small, achievable steps over time. Encourage patients through the plateaus and regressions that occur as a normal part of efforts at long-term change.
8	Refer if necessary: patients with multiple or severe nutritional problems should benefit from a nutrition professional counselling as possible.	Source: Optimal Calcium Intake: National Institute of Health Consensus Statement. National Institutes of Health. Bethesda MD, 1994.

B. Basics of nutrition counselling:

USA Dietary Guideline

- Eat a variety of foods.
- Balance the food you eat with physical activity; maintain or improve your weight.
- Choose a diet with plenty of grain products, vegetables, and fruits.
- Choose a diet low in fat (less than 30% of calories), saturated fat (less than 10% of calories), and cholesterol (300 mg or less per day).
- Choose a diet moderate in sugars.
- Choose a diet moderate in salt and sodium (less than 2400 mg per day).
- If you drink alcoholic beverages, do so only in moderation (no more than one drink daily for women or 2 drinks daily for men). One drink is 12 oz of regular beer, 5 oz of wine, or 1.5 oz of 80-proof distilled spirits.

KEY MESSAGES

1. Ageing is NOT a Disease. It is a physiological and developmental process

2. Counselling on physical activity, nutrition and behavioral issues is key to improving the health of the Elderly

3. Primary Health Care (PHC) plays a critical role in the health of the Elderly in all countries. It should be accessible and adapted to the needs of older population

Overview of Care of the Elderly in Primary Health Care

Sessions	Components
11.1	Communicating with and counselling of the Elderly
11.2	**Clinical Assessment and Management of Geriatrics**

Learning Objectives

At the end of this session, Participants will be able to;

Diagnose and manage chronic diseases (hypertension and diabetes) and the so-called four giants of geriatrics: memory loss, urinary incontinence, depression and falls/immobility that often impact people as they age.

Session Overview

The following content will be discussed in this session:

1. Geriatric Clinical Assessment
2. Management Approaches for the four geriatric giants

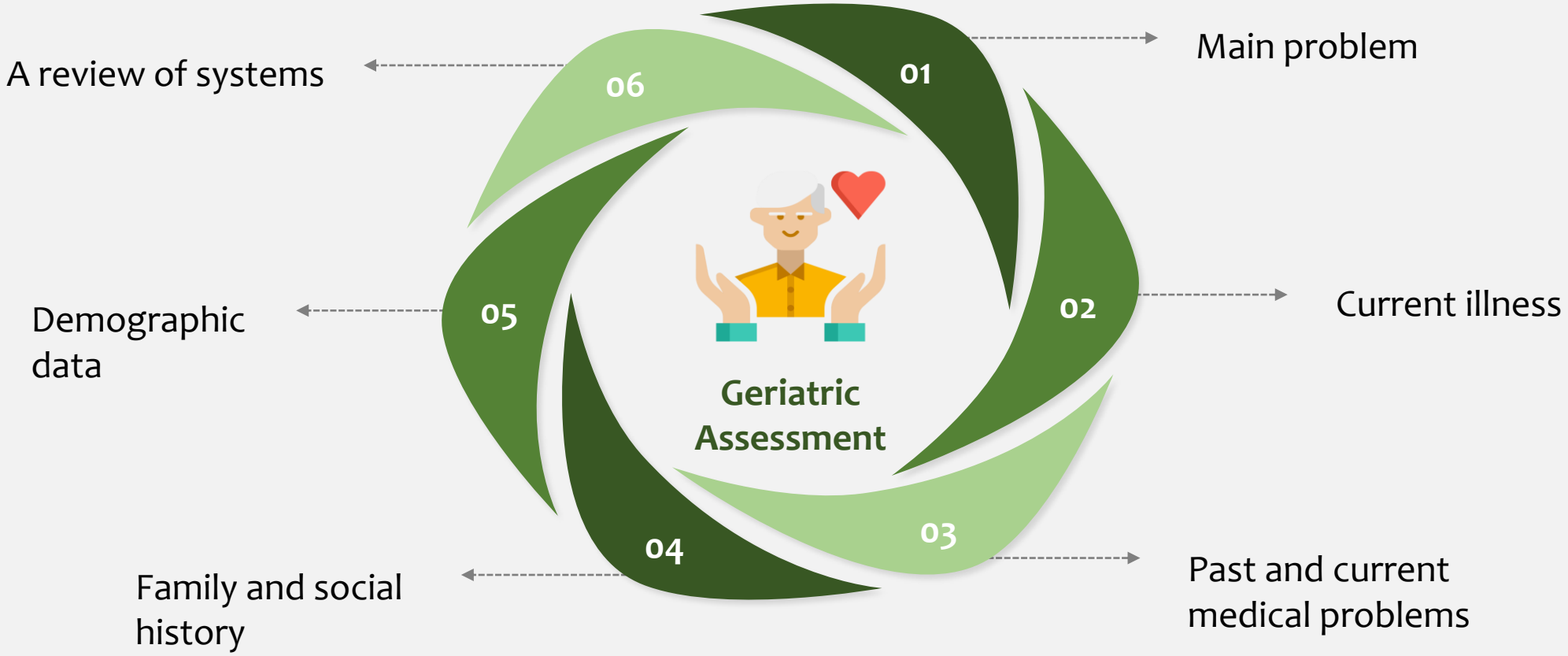
Geriatric Clinical Assessment

- Older people often have multiple complex health and social conditions and may also present with vague complaints such as dizziness
- These intertwining symptoms are difficult to diagnose and treat in the limited time available at most primary care settings
- Many of these conditions are chronic and must be screened, early detected and managed to prevent avoidable complications and disability such as amputation from diabetes



Geriatric Assessment

The geriatric assessment incorporates all facets of a conventional medical history, including



In particular, topics such as **nutrition, vision, hearing, faecal and urinary continence, balance and fall prevention, osteoporosis, and poly pharmacy** should be included in the evaluation.

Geriatric Assessment History

History of Present Illness

- Often multiple issues and non-specific symptoms
- One decompensating factor may have many manifestations
- Determine impact on function



Past Medical History

- Obtain past medical records for comparison
- Note impact of past illnesses on patient's overall function



Some Common Medical Problems/Challenges in the Elderly

FALLS
aetiology

Extrinsic

- **Environment:** ground surfaces, lighting, stairs, furniture, footwear
- **Medications:** sedatives, anticholinergics, neuroleptics, antihypertensives, diuretics, alcohol, subtherapeutic levels of anti-convulsants



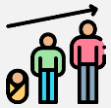
Medications Associated with an Increased Risk of Falls in the Elderly

1. Antiarrhythmics
2. Antihistamines
3. Antihypertensives
4. Antipsychotics
5. Benzodiazepines and other sedative-hypnotics
6. Digoxin (Lanoxin)
7. Accidents
8. Diuretics
9. Laxatives
10. Monoamine oxidase inhibitors
11. Muscle relaxants
12. Tricyclic antidepressants and selective serotonin reuptake inhibitors
13. Vasodilators

FALLS

INTRINSIC causes of falls	
Cardiovascular	MI, arrhythmia, orthostatic hypotension
Neurologic	Sensory impairment (visual, auditory, vesticular and proprioceptive function), stroke, TIA, dementia, Parkinson's, seizures
Gastrointestinal	Bleeding, diarrheoa
Metabolic	Hypoglycaemia, anaemia, dehydration, electrolyte imbalance
Musculoskeletal	Myositis, muscle weakness, arthritis, osteoporosis
Genitourinary	Incontinence, micturition syncope
Psychological	Depression, anxiety

Risk Factors for Osteoporosis in the Elderly (Intrinsic Factor for Falls)

1. Increasing age 
2. Female gender 
3. Early menopause 
4. Low body weight 
5. Small stature 
6. White or Asian race 
7. Family history 
8. Drug use (e.g., steroids, heparin) 
9. Low calcium intake 
10. Excessive alcohol intake 
11. Smoking 
12. Physical inactivity 
13. Conditions that impair calcium absorption 
14. High caffeine intake 

Examination can be tailored to the History but will usefully include:

1. Cardiovascular assessment
2. Selective neurological assessment
3. Functional assessment (of for example gait and transferring)
4. MMSE score
5. Vision testing

Investigation for Falls

Basic blood tests including:

- ❑ **Full blood count** (macrocytosis may indicate alcohol abuse)
- ❑ **Urea and electrolytes**
- ❑ **Liver function tests (LFTs)** - abnormal LFTs may indicate alcohol abuse, especially gamma GT
- ❑ **Thyroid function tests**
- ❑ **Vitamin B12**
- ❑ **Random blood glucose**
- ❑ **Urinalysis** may reveal unsuspected diabetes to account for vascular disease, neuropathy and poor vision

ECG to confirm or suggest:

- ❑ Atrial fibrillation, Conduction defects where there is a prolonged PR interval, inferior ischemia or bundle branch block
- ❑ Ambulatory ECG may be required to discover episodes of bradycardia with possible heart block or even tachyarrhythmia
- ❑ **Echocardiography**
- ❑ **Visual assessment**
- ❑ Syncope or TIAs require additional investigations including neuroimaging

Complications of Falls

1. Head injury resulting in subdural hematoma 
2. Fractures (hip, Colles', compression) 
3. Soft tissue injuries with a decrease in function 
4. More falls 
5. Anxiety about falling resulting in self-protective immobility 

Management of Patients with Falls

Multidisciplinary

1. Treat underlying cause(s) and any known complications
2. **Modify risk factors:** reassess medications, need for mobility aids
3. Environmental factors
4. Educate patient about nutrition
5. Exercises to improve balance and gait

Interventions to Reduce the Risk of Falling in the Elderly Risk

Risk Factor	Intervention
Postural hypotension: a drop in systolic blood pressure of ≥20 mm Hg or to < 90 mm Hg on standing	Behavioral recommendations, such as ankle pumps or hand clenching, and elevating the head of the bed
	Decrease in the dosage of a medication that may contribute to hypotension; if necessary, discontinuation of the drug or substitution of another medication
	Pressure stockings
	Midodrine (ProAmatine), 2.5 to 5 mg three times daily
	Fludrocortisone (Florinef), 0.1 mg two or three times daily, if indicated
Environmental hazards for falling or tripping	Home safety assessment with appropriate changes, such as removal of hazards, selection of safer furniture (correct height, more stability) and installation of structures such as grab bars or handrails on stairs.
Any impairment in gait	Gait training
	Use of an appropriate assistive device
	Balance or strengthening exercises if indicated

Common Medical Problems of the Elderly (Immobility)

COMPLICATIONS ASSOCIATED WITH IMMOBILITY

1. DVT, pulmonary embolus, pneumonia
2. Pressure ulcers
3. Muscle deconditioning and atrophy, contractures
4. Loss of coordinated balance and righting reflexes
5. Dehydration, malnutrition
6. Constipation, faecal impaction, urinary incontinence
7. Depression, delirium, loss of confidence

Management of Immobility

1	**Prevention:** reposition patient periodically, inspect the skin frequently, active and passive range of motion exercises
2	**Treat the underlying cause**
3	**Environmental factors:** handrails, lower the bed, chairs at proper height with arms and skid guards, assistive devices to maintain and improve function and independence
4	A **multidisciplinary team** sees patients either at home or on site

Urinary Incontinence

- A common problem in the care of the elderly, frequently accepted, under-reported and under-treated, can lead to isolation
- many causes of incontinence are treatable

Mnemonic for causes of incontinence:

Delirium/ Diabetes/ Drugs –(long-acting sedatives, anticholinergics, diuretics)	D
Restricted mobility/ Retention (neurogenic detrusor impairment)	R
Infections (UTIs)/ Impaction of stool	I
Psychological/ Post-menopausal effects (prolapse)/ Prostate	P

Urinary Care

1. Increase fluid intake



2. Decrease before bedtime



3. Regular trips to bathroom



4. Easy to remove clothing



5. Absorbent pads



Hypertension and Diabetes

These are two of the most common illnesses in older persons and is treated under Non communicable diseases (NCDs)



Management Approaches for the four geriatric giants

1	The organized clinical approach is an efficient way to identify, assess and manage patient care. It is a stepwise flow from the 10-minute comprehensive screening through identification of health problems; assessment; management and follow-up.
2	Patients who come to the PHC center for health care will be screened by a trained community health aid in the waiting room (Step 1).
3	If the screening is positive for any of the four geriatric giants, steps 2,3 and 4 as specified below will be followed.

Assessment Pictures





KEY MESSAGES

1. PHC workers need to be well versed in the diagnosis & management of chronic diseases and the so called FOUR giants of Geriatrics
2. If a nutritional problem is identified, the patient should be referred to the doctor.
3. If a hearing or vision problem is identified, the patient should be referred to the doctor for an appropriate action


Thank
you