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Older Person Assessment in the Community

When an older person walks through the doors of your clinic what do you need to watch out for?

Introduction

As the worlds demographics continue to change and as the life expectancy levels continue to rise, it is clear that as healthcare professionals we will be faced with meeting the needs of more and more over 65year olds who account for 11.3% of the population of Ireland (C.S.O., 2004) and therefore will need to keep ourselves up-to-date with older person issues and health concerns. New Zealand's domains of assessment for older people (2003) are identified as the issues of most importance to older people. These domains are as follows: *personal care, safety, food, social participation, daily life and acute episodes*. These will now be dealt with individually thus providing the practitioner with a sound evidence base from which to practice. It is recognized that each one of these domains deserves a paper of its own however the aim of this paper is to provide a brief overview and a checklist for the busy practice nurse.

Personal Care

The area of personal care pertains to the individual's ability to maintain their health and hygiene needs. The first assessment performed by the practice nurse will no doubt take place immediately as he/she observes the dress, presentation and outer cleanliness of the older person. In ascertaining the level of ability to attend to personal care it is important to ask if any assistance is required in order for the person to maintain their personal hygiene standards. Knowing the person from past visitations is always a good indicator as to whether or not this standard has indeed decreased or is still the same. It is also important for the practitioner to be aware of both normal and abnormal physiological changes as a result of ageing.

Skin	**Musculo-Skeletal**	**Circulatory**	**Sensory**
Epidermis thickens & dermis shrinks (dermal cells replaced more slowly)	Loss of bone mineral density: observe for osteoporosis	Heart decreases in weight due to increase of lipofuscin in the myocardial fibres	Decreased taste, saliva production, sight & hearing
Decline in collagen & elastin levels	Less exercise gives rise to bone loss	Usually normal red cells	Progressive loss of higher sound frequency
Decline in subcutaneous fat	Joint structures & ligaments increase in calcification & decrease in elasticity	White cell count tends to decrease	Memory disturbances
Blood vessels become more fragile		Clot reaction time may diminish in the platelets	
Sweat output decreases		Rise in ESR	
Hair loss from head & body but may increase in men in ears & nasal cavities		Blood viscosity may increase without change in plasma	
Dry due to reduced activity of skin cells which produce natural oils			
Continent/incontinent			
Sensory receptors in the skin transmit sensations less rapidly			

Equipped with an assessment of the persons ability to manage their personal care the practice nurse must now look to the person's safety needs.

Safety

Assessing an older person's safety may be dependent on the relationship which you may or may not have with the person. Trust will be an integral ingredient in eliciting much of this information. Both personal and home safety are major causes of concern for older people. Elder abuse has largely been a taboo subject within the Irish healthcare setting and thus the HSE – Western Area (2005) has just launched guidelines on elder abuse. It advises that there are 8 types of abuse which the health care practitioner should be aware of and these include: physical, sexual, psychological, financial or material, neglect & acts of omission, discriminatory, social and emotional. Lachs & Pilemer (2004: 1264)) define elder abuse as that where "intentional actions that cause harm or create serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver, or other person who stands in a trust relationship to the elder". The HSE – Western Area outline the indicators of the various types of abuse:

Physical	**Sexual**	**Psychological**	**Financial**	**Neglect**
Bruises, lacerations, abrasions, scratches, burns, sprains, fractures, dislocations, marks left from a gag, hair loss, missing teeth & eye injuries	Trauma to genitals, breasts, rectum, mouth. Injury to face & neck, chest, abdomen, thighs and buttocks. STD's or bite marks. Change in behaviour, social reluctance, nightmares, depression, sexually	Demoralisation, depression, feelings of hopelessness/helplessness, tearfulness, agitation, resignation, confusion, unexplained paranoia.	Sudden inability to pay bills, sudden withdrawal of money from accounts, funds diverted for someone else's use, damage to property, disappearance of possessions, no funds for clothes, food or services, refusal to	Dehydration, malnutrition, inappropriate clothing, poor hygiene, unkempt appearance, unattended medical needs, absence of required aids eg. Glasses or dentures, pressure sores.

	aggressive, inappropriate seductive behaviour, fear of being left alone with a particular person		spend money, making dramatic financial decisions,.	

Further to abuse the older person's safety is also reduced by their increasing fraility and their decreasing sensory ability. Frequent vision and hearing tests are advised even if there are no complaints of deficits to either. Liaising with the Public Health Care Nurse or the Community Occupational health professionals can enable a thorough risk assessment of the older person's home. Reduction of hazards at the primary point of care can clearly reduce accidents thus preventing the need for secondary and tertiary care while simultaneously maintaining the person's independence for longer. McInnes (2005) further advise that safety assessment includes assessment of gait, mobility, muscle weakness, osteoporosis risk, the older person's perceived functional ability and fear in relation to falling, cognitive impairment, continence and cardiovascular status. The National Council for Ageing and Older People (2001) advise that accidents and falls continue to be relatively common causes of death and injury among older people, often resulting in serious long-term difficulties and even premature death. Some 58% of all accidents reported of older people happen in the home (HeSSOP, 2001). Accidents from falls account for almost one third of older person deaths with 65% among the age of 75years (CSO, 2000). As well as being a danger to themselves, older people may be in danger from others.

Evanson et al (2004) reported that there is a considerable concern amongst the general population in Northern Ireland about crime against older people. In the Republic the NCAOP (2001) offer that the level of crime against older people remains low in comparison to other countries. Crime against the older person's property was reported as being higher than crime to the older person. A survey commissioned by the NCAOP in 1994 revealed that 6.6% of older people had been burgled, 4.6% had experienced vandalism and 1.3% were assaulted or mugged. The practice nurse may be the only person whom the older person has to confide their worries in and thus eliciting this information is an integral part of the nursing assessment and contributes to providing high quality holistic care. Worries and fears may have a profound affect on the older person's appetite thus this leads to the next domain of assessment.

Food

Nutritional status may drop considerably as the person ages. Eating and drinking is an integral part of human existence and an adequate intake of food and water is required to maintain physiological function, to allow for growth and maintenance of tissues and to provide energy to meet the demands of daily living. The six main nutrient groups are: proteins, carbohydrates, lipids, vitamins, minerals and water. Carbohydrates are required for energy, glucose energy for the brain and fibre production. Proteins are required for structure, movement, transport, immunity, acid-base regulation and osmotic pressure. Lipids are required for storing and providing energy, insulating beneath the skin and supporting and cushioning the organs.

The food pyramid has been re-released and now equates food intake with exercise (www.mypyramid.gov).There are several factors involved in altering an older person's nutritional status and these include: socio-economic (reduced income due to retirement), disease processes associated with ageing, oral factors (reduced saliva production &/or weight loss causing dentures to become loose), reduced manual dexterity for preparing food, malabsorption and diminished sensory ability (reduced levels of hunger and thirst, sight, sound and smell impairment). In summary a nutritional assessment of an older person should involve the assessment of their:

Normal eating habits
Weight/BMI
Known medical conditions
Dental
Medications
Activity levels
Appetite
Gastrointestinal factors
Bladder/Bowel habit
Economic
Physical/Sensory/Cognitive

Greeley (1990) reminds us that weight loss, lethargy, lightheadedness, disorientation and loss of appetite are often viewed as being symptoms of disease rather than malnutrition.

It is important for the practice to nurse to be aware of community schemes available such as meals on wheels, day care centers and the rural transport initiative scheme (which would transport the older person to the shops etc.) which can aid in maintaining the older persons nutritional status. Yet again linking with the public health nurse will

be invaluable in this process. Prevention of malnutrition can aid the prevention of secondary diseases and/or disease progression.

Social Participation/Daily Life

As an older person moves into retirement they face the loss of social connections and relationships which they have had throughout their working lives. As time goes on the older person may also experience the death of a spouse, relatives or friends. All of this contributes to a change in the older person's ability to participate socially. When older people realise that they are no longer part of their human world, they experience despair (RCN, 1993). It was highlighted by the NCAOP (2005) that there is a need to socially include older people in our communities. Recommendations include an awareness-raising programme for positive ageing, capacity building for older people and including older people in the development of policies which directly affect them. The author offers that the practice nurses waiting room is an ideal area to exhibt examples of positive ageing eg. awareness posters, art exhibitions, creative writing exhibitions etc. assessing the older person thus includes their physical health and their social health.

Checklist
Family/Friends/Visitors
Telephone/TV/Radio/Communication skills
Nearest Shop/House/Church
Transport
Hobbies/Interests
Member of any groups/Committees
Health professional involvement

Acute Episodes

Acute episodes in an older person's life can take many shapes and can stem from a failure to address some of the previously mentioned issues. These can include both physical and psychological health problems. The author believes that the best method for prevention of these problems is through health promotion. The Department of Health (1998) launched a health promotion strategy for older people entitled "Adding years to life - life to years". It advised that health promotion programmes for older people and the settings in which they are provided must take account of the physiological, social and economic changes which are associated with ageing and which are beyond the control of older people themselves. Its rationales for health promotion relies on the underlying assumptions that health is essentially a resource for everyday living, lifestyles are key determinants of health, lifestyles are themselves determined by the individual's social, economic, cultural, physical and ethical environment and that lifestyles are also determined by the amount of information and the level of skill that the individual possesses in relation to his/her own health. The strategy offers that health promotion can contribute to a good quality of life for older people, that the effects of illness or disability in older people will be lessened, the contribution of older people to society will be maximized and that escalating health care costs associated with an ageing population will be partly offset.

Conclusion

While this paper does not have the scope to deal fully with each of the relevant domains, it does serve to provide a brief overview of the important issues in older person assessment. It aims to highlight the move from the medical model of care to the social

model of care in the approach to older person care - taking the time to see the whole person and not just the illness which may be presented to us. Assessment of older people should be comprehensive and multidimensional (NZGG, 2003).

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