Contents

2
Understanding Ageing

INTRODUCTION

This chapter explores the concept of ageing and the potential to promote healthy ageing through good care supporting individuals across all the dimensions of health. Attitudes to ageing will be explored and holistic ways to enhance the quality of life of older people will be considered. Throughout the text, you will discover ways to implement best practice in your care setting.

KEY TERMS

- advocacy
- cognitive
- empathy
- empowerment
- health promotion
- HIQA
- impaired
- independence
- mobility
- multidisciplinary
- sensory

UNDERSTANDING AGEING

According to the World Health Organisation (WHO), in the next few years there will be more people in the world aged over 60 than children aged less than five for the first time. At its World Heath Day in 2012, the WHO called for 'urgent action to ensure that, at a time when the world's population is ageing rapidly, people reach old age in the best possible health'.

Our first objective is to define 'age'. The ageing process is, of course, a biological reality with its own dynamic; this is largely beyond human control.

However, it is also subject to the constructions through which each society makes sense of age. In developed nations, for example, chronological time plays a paramount role and age 60 to 65 is considered to be the beginning of old age. It must be borne in mind that this is a social construct. In other words, we as a society 'construct' how we view ageing. It is important to differentiate between ageing and healthy ageing because, as with younger people, the ageing person's health and welfare will be affected by illness, whether it is physical, psychological or social in nature.

Task

Can you think of reasons why countries need to balance their birth rate with their ageing population?

We face a major challenge in society today. Our rapidly ageing society will bring with it difficulties associated with ageing, such as physical infirmity, nervous system disorders and sensory loss, which all increase with age. On the other hand, there has never been a better time to be old. People are experiencing healthy longevity as never before in the history of mankind.

AGEING IN IRELAND

We have one of the lowest proportions of population aged over 65 in the European Union. The 2011 census shows Ireland's population of older people aged 65 and over to be at 535,393. Our population is slowly ageing and it is estimated that by 2041, 22% of the population will be over the age of 65 years. In Ireland we are fortunate that we also have one of the highest birth rates in the European Union.

Services for older people in Ireland

The Health Service Executive (HSE) provides a wide range of services for people growing older in Ireland. Supports are also available from other agencies, such as the Department of Social Protection, local authorities and voluntary organisations.

The Nursing Homes Support Scheme can support older people who require long-term nursing home care. This scheme is better known as the 'Fair Deal'. Under this scheme the person will make a contribution towards the cost of care and the state will meet the cost of the balance. This scheme is available to use in public, private and voluntary nursing homes.

Older people in Ireland are entitled to a range of benefits and schemes to help with medical costs and daily living. Everyone over the age of 66 in Ireland is entitled to a state pension, either contributory or non-contributory. Currently, every person aged over 70 is entitled to a Medical Card and will benefit from the Drug Payment Scheme. All individuals are entitled to be assessed to avail of Home Care Packages. Other benefits include optical benefits, hearing aid grants, respite care grants and the Community Support for Older People Scheme. The HSE has responsibility for the protection of older people from elder abuse.

Older people in Ireland are also supported through voluntary agencies, such as Age Action, that offer a range of information services and supports to older people. Agencies such as the Alzheimer's Society of Ireland offer support to people who suffer from this disease and their families. People with this illness are increasingly being supported through private home care provision.

The Health Information and Equality Authority (HIQA) was established as a result of the implementation of the Health Act 2007. Its remit is to drive improvements in the quality and safety of health care on behalf of patients. HIQA began inspecting residential services for older people in 2009. It makes recommendations following inspection, where necessary, and all reports are available on its website (www.hiqa.ie). According to HIQA:

> *These quality standards were developed based on legislation, research findings and best practice. They were developed in partnership with service users, service providers, health care professionals, older people's representative groups, the Department of Health and Children and the Health Service Executive.*

Currently, older people in Ireland avail of health services through their GP and public health nurse. It has been proposed for some years that primary care services would be supported by a primary care team. The objective of primary care teams is to circumvent hospital admission (known as 'secondary

care') through the primary supports offered through a multidisciplinary team. Unfortunately, the roll-out of this service has been poor and patchy. Additionally, many posts are vacant due to the HSE's moratorium on recruitment. It is hoped that in the future these teams will fully develop, creating stronger supports for older people living in the community.

A multidisciplinary team (MDT) should consist of a:

- GP
- Public health nurse
- Occupational therapist
- Physiotherapist
- Psychologist
- Social worker
- Home care team

THE AGEING PROCESS

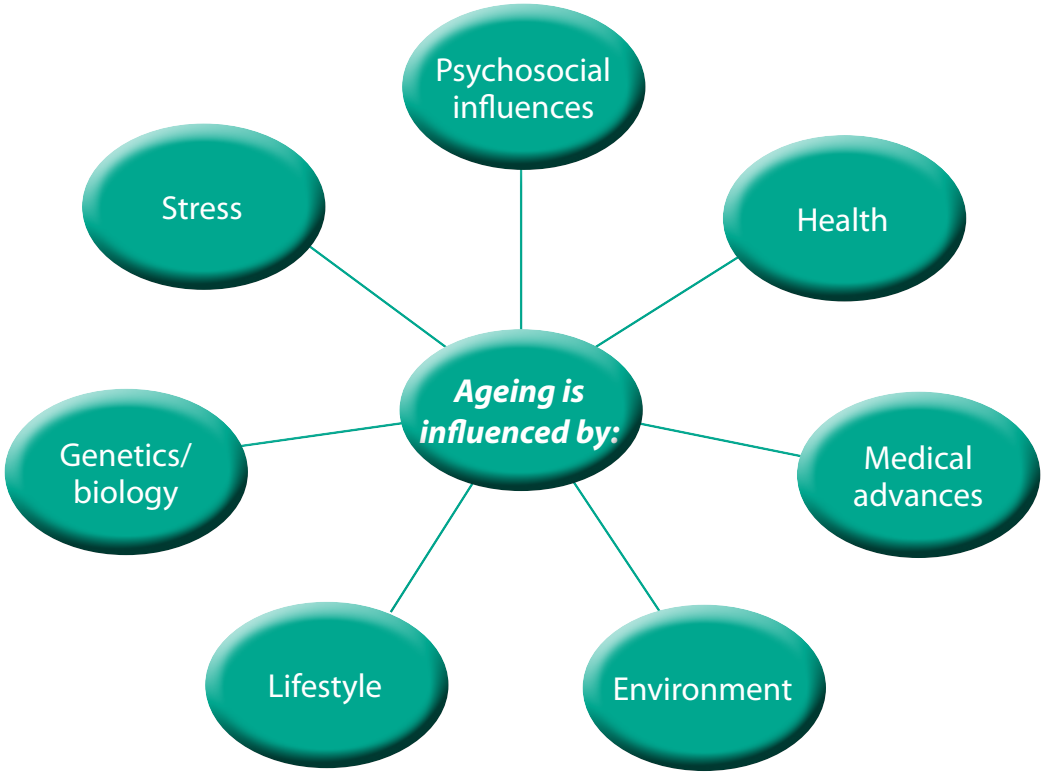
There are some biological changes that can occur as we get older. However, these are individualised and differ from person to person according to lifestyle and history. Growing old is something that happens to us all. Although we may not all experience disease or chronic illness as we age, almost all of us will lose some form of 'function' as we age.

Task

How do you think positive, healthy ageing can be promoted?

Ageing is influenced by all of the following.

Figure 2.1: Influences on ageing



Task

Referring to the previous headings, consider how you think these factors influence ageing.

According to Tyas et al (2007), 'Healthy ageing encompasses health in its broadest sense, with the quality of life maintained or enhanced into older age.' In our advancing years it is important to remain engaged and active in society. Organisations such as Age Action Ireland play a pivotal role in supporting the ageing population through the organisation of activities. As we live in a work-orientated society, retirement may mean people experience:

- Loss of social contact through work
- Loss of their 'sense of purpose'
- Loss of status.

The process of engaging older people as they age can become more difficult due to the development of age-related disabilities. Individual, community, public and private sector approaches are required to promote the health of individuals in the ageing population. Such approaches will aim to maintain and improve the physical, emotional and social well-being of older people. HIQA standard 12 requires that all residential services for older people will promote the health of those in their care.

It is important that society can support individuals in preparing for retirement so that the mental, physical and social changes are experienced gradually. Planning for life on a fixed income is essential, as low income has an impact on the overall health and well-being of all individuals in society, affecting everything from physical health status to social and emotional well-being.

As we age, changes may occur in our body. Below is a list of some of the common areas of decline as we age.

Body appearance

- **Skin:** Skin is the largest organ in the body, protecting the body from disease and infection. The skin loses some of its elasticity as we age, which makes it more vulnerable to damage. Ageing skin can also make an older person more vulnerable to pressure ulcers. As we age, there may be reduced blood flow to the skin and the amount of fat under the skin tends to decrease as people get older.
- **Nails:** Nails grow more slowly and can become thicker and more difficult to cut and maintain.
- **Hair:** Both men and women may suffer from hair loss and hair may turn grey. Some women grow facial hair after the menopause due to a change in hormone levels.

Body movement

- **Muscles:** Older people are at particular risk of muscle weakness and a reduction in mobility. It is very important to remain active in order to maximise muscle strength, maintain co-ordination and reduce the risk of falls.

- **Joints and bones:** Osteoarthritis is characterised by the destruction of cartilage, which usually affects weight-bearing joints, e.g. knees and hips. It commonly occurs in older people as joints wear out. Osteoarthritis is more common in females and obesity increases the risk. Joints affected can include shoulder, hip, knees, hands and spine. Cartilage between joints becomes worn away, making movements painful and difficult (Byrnes 2011). Older people may develop a stoop caused by a curve in the spine, which may reduce the person's height by several centimetres. Osteoporosis is caused by a lack of calcium, making bones light and brittle. It affects one in two women and one in five men. People who develop osteoporosis fracture their bones very easily. Twenty per cent of people over the age of 60 who fracture a hip can die within six to 12 months. It is essential to protect older people from falls through careful management and monitoring of their environment, particularly if they suffer from osteoarthritis or osteoporosis.

The circulatory system

Cardiovascular disease can occur as a result of diseased arteries, which supply blood to the heart and other parts of the body. They become blocked and eventually the blood supply is cut off, which can lead to a heart attack or stroke. Cardiovascular disease can be due to genetics and is more common in men. People with higher risk factors include those who smoke, have high blood pressure, have higher levels of cholesterol, have diabetes, have a poor diet, are obese or lead an inactive lifestyle. Bacterial and viral infections can play a role in the development of cardiovascular disease, which is the leading cause of death worldwide (Byrnes 2011: 76).

Older people may develop heart failure. This can be for a range of reasons, but again, the risk factors for this disease are linked to lifestyle. Heart failure occurs when the heart cannot pump as it should to meet the needs of the body.

The respiratory system

The lungs of older people may be less elastic. This can make breathing less efficient, thus reducing oxygen intake. Because the lungs are less efficient, the ribs and the diaphragm do not move as much. This can put older people at risk of chest infections. Other common respiratory problems include (Byrnes 2011: 76):

- Chronic obstructive pulmonary disease (COPD): Over 400,000 people in Ireland are estimated to have this disease
- Cough
- Dyspnoea (breathlessness)
- Influenza (flu): Vaccination is recommended for everyone over 65
- Asthma: Over 477,000 people in Ireland are estimated to have this condition
- Emphysema: Results from a combination of chronic bronchitis and old age
- Lung cancer: Ireland has over twice the EU average of this disease.

The digestive system

As we get older, taste buds and sense of smell become less acute. This may explain why older people have a smaller appetite. Gums recede as we get older, teeth may fall out and there may be less saliva produced in the mouth. A combination of these problems may make eating difficult. The muscles of the digestive system are less effective and food takes longer to pass through, often causing constipation. Nutrients are not absorbed effectively because blood flow is reduced and because some enzymes needed to break down and absorb the nutrients are not produced.

Common problems in the digestive system include:

- Bowel cancer
- Constipation
- Diarrhoea, causing loose stools and pain
- Diverticular disease: Small bubbles in the intestinal lining can pop through the muscular intestinal wall; these are called diverticula and can become inflamed when faecal matter collects in them
- Dysphagia: Difficulties with swallowing, often caused by stroke or neurological disorders
- Haemorrhoids
- Indigestion: This is caused by a range of problems that can occur anywhere along the digestive tract
- Inflammatory bowel disease.

Neurological disorders

Neurological disorders include:

- Dementia
- Motor neurone disease (also known as Lou Gehrig's disease)
- Multiple sclerosis (there are over 7,000 people in Ireland with this condition)
- Parkinson's disease.

Sensory difficulties

Ears

The ear is associated with balance, which may deteriorate due to age, leading to an increase in unsteadiness and falls. Deafness is a common change brought about by ageing. However, deafness can also occur due to disorders or illness. High-frequency tones are often the sounds that are missed by older people.

Conditions that affect the ears include:

- Otitis externa
- Otitis media (middle ear infection)
- Hearing loss.

Sight

Deterioration in eyesight is another common change. As we get older our eyes take longer to react to light and darkness and to change from looking at a distance to looking close up. Cataracts, which cover the lens, may develop, making vision more difficult. Older people find it harder to discriminate between colours, particularly between blue and green.

Conditions that affect the eyes include:

- Cataracts: These form on the lens, making it opaque and affecting vision.
- Glaucoma: This can cause a loss of peripheral vision. It is caused by pressure building up inside the eye.

The four most common health problems experienced by older people today are:

- Heart disease, such as heart attacks and strokes
- Cancer
- Arthritis and other bone diseases
- Brain disease leading to a loss of mental ability.

DEMENTIA

Dementia is a group of related symptoms associated with an ongoing decline of the brain and its ability to function. It affects people's thinking, language, memory, understanding and judgement. According to WHO, the number of people suffering from dementia will triple in the next 40 years, leading to catastrophic social and financial costs. Dementia is a brain illness that affects memory, behaviour and the ability to perform even common tasks, affecting mostly older people. Currently over 5 million people in the US are suffering from dementia (this correlates with vast numbers of people over the age of 80 living in the US). Medical intervention means we are living longer, and the risk of developing dementia increases by 25% after the age of 85 (Byrnes 2011: 47).

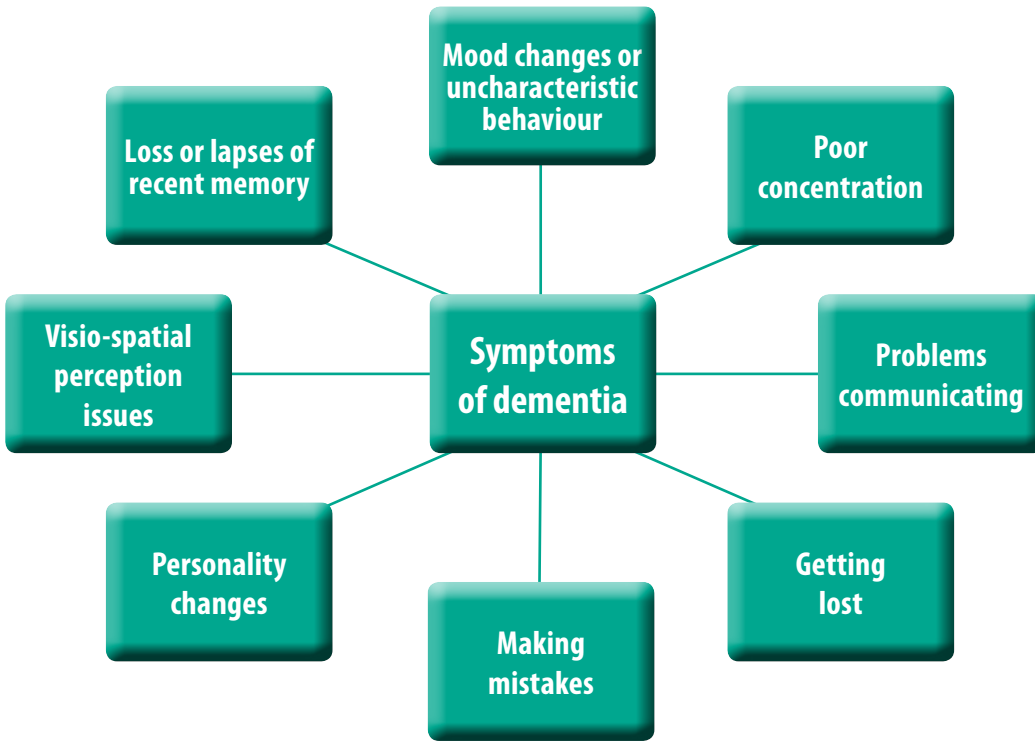
The Dementia Services Information and Development Centre states that in Ireland, it is estimated that some 38,000 people are likely to have dementia due to our ageing population. These figures are likely to reach between 80,000 and 100,000 over the next 30 years. Within the HIQA standards there are a set of sub-standards that are dementia specific and require that all services working with people who have a dementia diagnosis will have care plans in place that emphasise autonomy, independence and activity to promote quality of life and well-being.

Listed below are some of the different types of dementia.

- **Alzheimer's disease**, where small clumps of protein, known as plaques, begin to develop around brain cells. This disrupts the normal workings of the brain.
- **Vascular dementia**, where problems with blood circulation result in parts of the brain not receiving enough blood and oxygen.
- **Dementia with Lewy bodies**, where abnormal structures, known as Lewy bodies, develop inside the brain.

- **Fronto-temporal dementia**, where the frontal and temporal lobes (two parts of the brain) begin to shrink. Unlike other types of dementia, fronto-temporal dementia usually develops in people who are under 65. It is much rarer than other types of dementia.

Figure 2.2: Symptoms of dementia



Source: Skills for Care and Skills for Health (2011).

In later stages, these signs will be more pronounced and it can become more difficult for people to live well with dementia.

Common problems for people with dementia include:

- Not recognising foods
- Forgetting what food they like
- Refusing or spitting out food
- Resisting being fed
- Asking for strange food combinations.

As the number of people with dementia increases, it will be essential that society can enter their world. Person-centred planning is essential in working with people who have dementia. People with this disorder are best understood in the context of their own life history. 'As their dementia progresses, people may be less able to enter our world – we may need to enter theirs and enjoy it with them' (Barbara Pointon, CCA).

According to Gitlin and Corcoran (2005), key person-based contributors to behaviours in the rehabilitation context may include:

- Pain that the individual is unable to identify, understand or articulate as occurring
- Fatigue, poor sleeping patterns
- Fear, anxiety or a sense of a loss of control
- Misunderstandings of the therapeutic process and anxiety as to what is expected
- Underlying incipient medical conditions, such as an infection (e.g. urinary tract infection)
- Clinical depression or psychotic symptoms (hallucinations)
- Significant sensory changes (e.g. reduced visual efficiency, hearing loss)
- Constipation or dehydration.

Key environmental-based factors contributing to behaviours may include:

- A physical environment such as the home or clinic that is too cluttered, distracting and difficult to navigate
- A physical environment that is unfamiliar or too complex, such that the person has difficulty interpreting the meaning of environmental cues and thus responding appropriately
- Presence of others during therapeutic sessions, which may be distracting, confusing and a sensory overload
- Communication patterns that are too complex and confusing.

Dementia and people with a learning disability

Studies carried out by Cooper (1997), as cited in Kerr (2007: 28), show that there has not been much research into the prevalence and incidence of dementia amongst people who have a learning disability. Research that is available suggests

that for people with a learning disability with causes other than Down syndrome, there is a prevalence rate higher than would be found in the general population. Studies cited in Kerr (2007: 30) have shown that people with Down syndrome have a much higher rate of Alzheimer's-type dementia than the general population. However, not everyone with Down syndrome will develop the condition. From manifestation to end, this disease could last between eight and 15 years.

As disability services increasingly care for an older population of people due to medical advances, it will be essential that levels of monitoring are higher in these groups.

According to the Alzheimer's Society (2000), as cited by Mathieson (2004), dementia tends to present in people with a learning disability in a similar way to the general population, but early signs are more likely to be missed. Research has also shown that plaques found in brain tissue in certain kinds of dementia contain an amaloid protein that is linked to a gene on chromosome 21, which is significant in the cause of Down syndrome. They state that the incidence is higher in people with a learning disability and suggest that 13% of people aged 50 and over and 22% aged 65 and over are affected – this is around four times the general incidence.

A report, *Home for Good* by Wilkinson et al (2004), paints a bleak picture. Key findings suggest that:

- A lack of planning leads to unsatisfactory ad hoc arrangements for people with dementia
- People with dementia had been inappropriately moved to nursing homes due to the lack of coherent strategies to care for them
- A lack of consistent practice in diagnosis and assessment was evident
- Good training is crucial and training opportunities varied markedly
- Staff in all settings struggled with pain management and helping people with dementia to eat.

Communicating with a person with dementia

According to Gitlin et al (2003), the following strategies are recommended:

- Move and speak slowly and calmly
- Provide simple one- or two-step verbal instructions at a time
- Do not rush
- Allow the patient sufficient time to respond to a command

- Reassure the person that they are doing a good job
- Avoid using negative words and negative approaches (don't scold or argue)
- Eliminate noise and distraction while communicating
- Be aware of facial expressions; make eye contact but do not stare
- Express affection – smile, hold hands, give a hug.

IMPACT OF PHYSICAL CHANGES ON EMOTIONAL DEVELOPMENT

As has been previously suggested, sometimes the emotional development of older people is affected by the physical changes that accompany the ageing process. According to Ewles and Simnett, as cited in Schriven and Ewles (2010: 7), there are six dimensions of health: physical, mental, emotional, social, spiritual and societal. This is known as the holistic view of health. Seedhouse (2001), as cited in Schriven and Ewles (2010: 8), proposes an idea of health as the foundation for achieving a person's realistic potential, enabling people to fulfil their own potential. These views demonstrate clearly that health is about empowering individuals to claim responsibility for their own health. We know that this will vary considerably in society. We also know that where individuals are active and responsible agents for their own health, longevity and quality of life are substantially better.

IMPACT OF ILLNESS ON EMOTIONAL DEVELOPMENT

Sometimes the emotional development of older people is affected by illness, either physical or mental. It is sometimes the case that older people feel socially disempowered. The disempowerment of older people can occur by exchange; CCAs may inadvertently enable disempowerment and disablement. It is important when working with the older person to think about what they *can* do. It is important to enable the person to contribute in every possible way, allowing the person to live each day with maximum participation.

It is hard to feel happy and fulfilled when struggling with less mobility, failing eyesight or loss of appetite. Changes in sleep patterns can quickly affect the emotional development of older people and short-term memory loss can be very frustrating. This stage of life may lead to loss of status, a perceived reduced role in life and less contact with friends and colleagues from work.

Other factors that may impact on the mental health of this age group include a gradual deterioration in health and physical capability, loss of financial stability, changing environments (moving home) and a loss of the sense of 'belonging' and other social and psychological factors.

It is not all negative, however. For some, advancing years can mean a time of freedom from the grind of employment, the child-rearing years and other responsibilities. It can offer an opportunity to do the things they hadn't had time to do before and a chance to develop new social contacts. In some cultures, reaching old age might mean increased social status.

Task

Imagine for a moment that you had to leave your own home and go into a nursing home. How would you feel? What would you bring with you?

CCAs AND OLDER PEOPLE

The qualities of a CCA will include:

- Being a good listener
- Being able to put yourself in someone else's shoes (empathy)
- Knowing how to treat people as individuals
- Keeping a confidence (if appropriate) and being aware of the feelings of others.

Good CCAs can observe the needs of their client and show patience, allowing the individual time and assisting the person to maintain independence, and will be capable of treating people with respect.

There are a number of important interpersonal skills that will help the CCA understand and support the needs of the older person. Interpersonal skills are behaviours that help and encourage people to communicate, to understand, to be understood and to express their needs, thoughts and feelings. As we get older we tend to become more dependent on other people, so it is therefore very important that CCAs do all they can to ensure the needs of the older person are met. This book places a great emphasis on therapeutic communication. It is the cornerstone of good care.

Confidentiality

It is essential for the older person to trust people, especially their CCA. It is therefore very important that confidentiality is maintained. Everyone has the right to privacy. Information given to you should only be passed on if the individual gives you permission to do so. If the confidence involves something legal or may cause harm to someone, the information may need to be shared – always take advice from a supervisor or senior member of staff. Refer to Chapter 6 for further information.

Task

Have you ever told a friend something in confidence, only to find out later that they told someone else? How did you feel? Would you confide in them again?

Communicating with older people

It is important that our personal communication styles and behaviour are incorporated into our self-reflection in order to enhance our overall clinical performance. According to Berglund and Saltman (2002), we all need to recognise our own preferred way of communicating in order to determine our own strengths and weaknesses. We need to look at ourselves first before we can become effective communicators with others. You will need to note that your communication style will differ according to the audience (for example, family interactions will differ from interactions at work).

Always ensure that you compliment and acknowledge the person. It is imperative that you develop a relationship that provides comfort, is honest and conveys a positive attitude. It is essential to explain, providing a clear rationale for every procedure, ensuring at all times that privacy, confidentiality and feelings of independence are respected. For more detailed understanding of the importance of communicating appropriately with an older person, refer to Chapter 6.

SAFEGUARDING OLDER PEOPLE

According to the HSE (2002), elder abuse is defined as 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights'.

A study carried out by Naughton et al (2012) over a 12-month period examined the prevalence of elder abuse and neglect in community-dwelling older people in Ireland and examined the risk profile of people who experienced mistreatment and that of the perpetrators. This study showed that the prevalence of elder abuse and neglect was 2.2%. The types of mistreatment were financial (1.3%), psychological (1.2%), physical abuse (0.5%), neglect (0.3%) and sexual abuse (0.05%). It is worth noting that neglect is often unrecognised and sexual abuse is not reported.

Older people are more vulnerable and consequently are susceptible to abuse. It is important that CCAs can identify signs, risk factors and possible causes of abuse. There are four types of abuse: physical, psychological/emotional, sexual and financial. Abuse can occur in the person's own home or in an institutional setting, such as a residential home, day service or hospital. Perpetrators can be a partner, relative, friend, CCA or volunteer.

Physical abuse

Physical abuse is physical force or violence that results in bodily injury, pain or impairment. It includes assault, battery and inappropriate restraint. Physical abuse includes:

- Grabbing, shaking, pushing, pinching, hair pulling, hitting, etc.
- Withholding food or drink
- Inappropriate supervision
- Restraining inappropriately
- Failure to provide aids, glasses, dentures and frames.

Signs of physical abuse: Bruises, burns, lacerations, hypothermia, dehydration, malnutrition, poor hygiene, weight loss, inexplicable falls, old wounds.

Psychological/emotional abuse

Psychological/emotional abuse is like brainwashing in that it systematically wears away at the victim's self-confidence, sense of self-worth, trust in their own perceptions and self-concept. Whether it is done by constant berating and belittling, by intimidation or under the guise of 'guidance', 'teaching' or 'advice', the results are similar. Psychological/emotional abuse includes:

- Verbal abuse, shouting, teasing, swearing, name calling
- Ignoring the person
- Causing the person to feel ashamed (especially commenting on bowel movements or incontinence).

Signs of psychological/emotional abuse: Insomnia, loss of appetite, weight loss, loss of self-esteem, confusion.

Sexual abuse

Sexual abuse is any misuse of a child or adult for sexual pleasure or gratification. Sexual abuse includes:

- Teasing
- Touching
- Kissing
- Caressing
- Molesting
- Rape.

Signs of sexual abuse: Bruising, pain, anal or vaginal bleeding, difficulty walking or sitting, overt sexuality, especially in confused people, sexually transmitted diseases.

Task

Read the HSE document *Open Your Eyes*. Think about what is expected of you if you witness abuse.

Financial abuse

Financial abuse is the improper taking or misuse of the money or property of a vulnerable adult for the benefit of someone other than the vulnerable adult. The term 'financial abuse' describes the situation where an abuser:

- Is borrowing money from a vulnerable adult
- Is refusing to give a vulnerable adult access to his/her money.

Signs of financial abuse: Personal belongings go missing, disparity between income and living conditions.

Neglect

The HSE defines neglect as a 'type of maltreatment that refers to the failure to provide needed age-appropriate care', such as shelter, food, clothing, education, supervision, medical care and other basic necessities needed for the development of physical, intellectual and emotional capacities. Signs of neglect include:

- Malnutrition due to insufficient monitoring of nutritional needs
- Physical harm in the form of cuts, bruises and burns due to lack of supervision
- Passive restraint, bed bound, chair bound or left alone for long periods of time.

Medical neglect is the failure to provide appropriate health care for a person when financially able to do so. Medical neglect can result in poor overall health and compounded medical problems.

Living with neglect can significantly increase the person's chances of becoming ill or dying early. The stress of living with abuse or neglect may also make other health problems worse.

Many vulnerable adults who experience neglect also face emotional and/or financial abuse. This can lead to ongoing distress in the person's life. If the abuser controls the vulnerable person's money, they may have fewer resources to take care of their own health, secure and maintain proper housing or obtain good nutrition and participate in healthy activities.

Task

Consider your own thoughts and feelings about abuse of older adults.

How do we prevent abuse?

The most successful way of preventing abuse in older people is to make them aware of what constitutes abuse. Very often the perpetrators of abuse are family and it is difficult for the victim to actually accept that the person will behave in this way.

- Take all reports of abuse seriously.
- Treat all those involved with respect.
- Respect confidentiality.
- Always seek consent before taking any action.
- Remember, the victim is an adult and is free to decide. People may choose to continue in a situation that is abusive.

The appropriate action to take is to contact the GP, public health nurse or senior case worker or phone the HSE information line on 1850 241 850.

DEATH AND DYING

In the 21st century, dying is a changing experience. Degenerative long-term diseases now mean that we need to change our approach and think about the experience of dying. Diagnosis of diseases that lead to cognitive impairment means we need to allow people to think about this process much earlier.

According to *DML Services for Older People*:

> *Chronic diseases and terminal diseases are the common reason for adopting a palliative care approach. People with life-limiting, non-malignant diseases can experience a range of physical and psychological symptoms throughout the course of their disease. Their symptom burden has been shown to be equal to that of people dying with cancer. In addition, their disease process can be more complex and often of a much longer duration. These aspects of*

non-malignant disease demonstrate the need for a palliative care approach to be incorporated as part of their routine care.

Some life-limiting diseases that require particular consideration for palliative care include:

- Dementia
- Heart failure
- Advanced respiratory disease, such as COPD
- Chronic kidney disease
- Motor neurone disease
- Cardiovascular accident
- Multiple sclerosis.

It will be important to assess symptoms. Areas of concern will include:

- Pain management
- Communication
- Equipment
- Wishes
- Dignity, respect and privacy
- Decision-making ability, for example, around resuscitation
- Information
- Support services that may be required by family
- Conflict management of current or potential issues
- Cultural beliefs and practices
- Legal implications of life being withheld or withdrawn
- Spiritual beliefs and wishes.

BEREAVEMENT

It is essential when working with older people that we can guard against depression, so we need to observe and support individuals who experience the loss of a significant other. It can be the case that following the loss of a significant other after a chronic and protracted illness, the spouse may have been so immersed and absorbed by the needs of the other person that they

have entirely neglected their own needs. It is important to support people and direct people towards support groups and bereavement counselling as necessary.

Another consideration for older people is the level of bereavement faced by many older people. They may lose family or friends and this is sometimes sudden, such as an accident or heart attack, or after a long illness such as cancer. Grieving is a difficult process and older people need help and understanding in dealing with their emotions.

DEPRESSION

Ageing brings with it enormous developmental challenges. The loss of significant others, loss of function and reduction in independence can all lead to depression. It is essential that the mental health of older people is promoted through activation programmes that will enhance and support their social and emotional health. Older people have traditionally gained support through spiritual groups, which enhance social contact for people generally. Increasingly in Irish society, attachment to spiritual groups may be in decline, and this support network, which has played a significant role in the socialisation of older people, needs consideration. Depression and its signs and symptoms will be dealt with in greater detail in Chapter 5.

When we are communicating with older people who are grieving, it is important to employ an empathetic approach to get a sense of their feelings and emotions. We must listen and allow the person to speak, but also allow the person to be silent.

SUMMARY

This chapter illustrates how important our perceptions of ageing are when working with older people. Examination of the ageing process helps us to understand the dimensions of health and their interactions in the maintenance or deterioration of health. It is essential that all those working with older people understand diseases such as dementia and can recognise problems that arise in the safeguarding of older adults. This chapter concludes with an identification of some of the issues faced by older adults at the end of life.

REFERENCES

Berglund, C.A. and Saltman, D. (eds) (2002) *Communication for Health Care*, Melbourne: Oxford University Press.

Byrnes, N. (2011) *Your Health Matters*, Dublin: Blackwater Press.

Department of Health and Children (2009) Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009, Dublin: Stationery Office.

Department of Health and Children (2010) Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010, Dublin: Stationery Office.

Gitlin, L. and Corcoran, M. (2005) *Occupational Therapy and Dementia Care: The Home Environmental Skill-building Program for Individuals and Families*, Bethesda, MD: American Occupational Therapy Association.

Gitlin, L., Liebman, J. and Winter, L. (2003) 'Are environmental interventions effective in the management of Alzheimer's disease and related disorders? A synthesis of the evidence', *Alzheimer's Care Quarterly*, 4(2), pp. 85–107.

HIQA (2009) *National Quality Standards for Residential Care Settings for Older People in Ireland*, HIQA.

HSE (2002) *Protecting Our Future: Report of the Working Group on Elder Abuse*, Dublin: Stationery Office.

HSE (2011) 'What is elder abuse?', available online at www.hse.ie (accessed 8 November 2012).

Kerr, D. (2007) *Understanding Learning Disability and Dementia*, London: Athenaeum Press, pp. 14–21.

Mathieson, A. (2004) 'Learning disability and dementia', *Learning Disability Practice*, 7(7), pp. 12–13.

National Council for Ageing and Older People (NCAOP) (2004) *Population in Ireland: Projections 2002–2021*. Dublin: NCAOP.

Naughton, C. et al (2012) 'Elder abuse and neglect in Ireland: Results from a national prevalence survey', *Age and Ageing*, 41(1), pp. 98–103.

NHS (2009) *Common Core Principles to Support Self Care: A Guide to Support Implementation*, Leeds: Skills for Care. www.skillsforcare.org.uk

Schriven, A. (2010) *Promoting Health: A Practical Guide*, 6th edition, Oxford: Bailliere Tindall/Elsevier, pp. 6–8.

Schriven, A. and Ewles, L. (2010) *Promoting Health: A Practical Guide*, 6th edition, Edinburgh: Bailliere Tindall/Elsevier.

Skills for Care and Skills for Health (2011) *Common Core Principles for Supporting People with Dementia*, Leeds (www.skillsforcare.org.uk, www.skillsforhealth.org.uk).

Strydom, A., Hassiotis, A., King, M. and Livingston, G. (2009) 'The relationship of dementia prevalence in older adults with intellectual disability (ID) to age and severity of ID', *Psychological Medicine*, 39, pp. 13–21.

Tyas, S.L., Snowdon, D.A., Desrosiers, M.F., Riley, K.P. and Markesbery, W.R. (2007) 'Healthy ageing in the nun study: Definition and neuropathologic correlates', *Age and Ageing*, 36(6), pp. 650–5.

Wilkinson, H., Kerr, D., Cunningham, C. and Rae, C. (2004) *Home for Good? Models of Good Practice for Supporting People with a Learning Disability and Dementia*, Brighton: Pavilion Press.

Zaretsky, H., Richter, E. and Eisenberg, M. (2005) *Medical Aspects of Disability: A Handbook for the Rehabilitation Profession,* 3rd edition, New York: Springer Publishing, pp. 292–3.