SharedLivesPlus
THE UK NETWORK FOR SMALL COMMUNITY SERVICES

Working with older people

Health issues

Introduction

Working with and caring for older people, especially the oldest old, usually people over 85, brings great rewards but also a number of challenges, many of them health related. As life expectancy lengthens, many older people are generally well and able to care for themselves with just a little help. However the risk of living with one or more life limiting long-term conditions, such as dementia or arthritis, increases with age. For some people, the physical reserves which can help respond to shocks or crises are lower, meaning a relatively minor event can have a huge impact on health and wellbeing.

This factsheet is written for Shared Lives carers who may be working with older people for the first time. Although it concentrates on the health problems affecting older people, the goal of Shared Lives is always to live well and focus on the things we can do to improve peoples' lives. This factsheet looks at some of the most common health issues for older people, giving a brief overview of symptoms and risk factors and some of the simple things that can be done to mitigate the risks. The issues covered are:

- Falls and mobility
- Failing senses (sight/hearing loss)
- Arthritis and related conditions
- Memory loss
- Frailty
- Social isolation
- Delirium
- Continence
- Depression

Working and caring for people living with dementia is covered in more detail in other guides in this series, available on the Shared Lives Plus website at www.sharedlivesplus.org.uk .

Falls and Mobility

Falls and fractures in people aged 65 and over account for the use of over 4 million hospital bed days each year in England alone; this includes 70,000 hip fractures. Falls are the leading cause of accident-related mortality in older people. After a fall, an older person has a 50 per cent probability of having their mobility seriously impaired and a 10 per cent probability of dying within a year. Falls destroy

confidence, increase isolation and reduce independence, with around 1 in 10 older people who fall becoming afraid to leave their homes in case they fall again.

There are many different reasons why people fall in later life. It can happen as a result of dizziness caused by different medications or medical conditions, such as syncope (fainting) or Parkinson's disease. Falls can be caused by external factors such as poorly fitting footwear and uneven paving, or by the physiological conditions associated with ageing, such as natural deterioration in eyesight and muscle strength, which can make it difficult to balance, see and step over potential hazards. In many cases, it is not simply one, but a combination of these risk factors that lead to a fall.

Risk factors in falls include:

- Age – people over 80 are most at risk
- Low weight
- Low blood pressure
- Polypharmacy – taking multiple medications
- Alcohol abuse
- Diabetes
- Confusion and cognitive impairment
- Disturbed vision/disturbed balance or co-ordination
- Urinary incontinence
- Inappropriate footwear.
- Environmental factors including home hazards
- Muscle weakness
- Depression

How you can help
Although it is important that people at risk from falls are offered a range of interventions, including medication reviews and home safety or hazard assessments, research over the past twenty years has shown that therapeutic exercise is the most effective way of helping avoid falls altogether. Exercise classes are available at a wide range of community facilities and home based exercises are also available, although it is advisable to get some expert advice before embarking on these. Advice on where to access classes or get help is available from your local Age UK or Age Concern.

This information has been taken from a number of sources, predominantly NHS Choices at http://www.nhs.uk/conditions/falls/pages/prevention.aspx and Age UK at http://www.ageuk.org.uk/health-wellbeing/keeping-fit/falls-prevention/exercise-regularly/

Failing senses (eyesight/ hearing)

It is normal for our sight and hearing to change as a result of ageing. Normal changes to eyes include losing the ability to focus on things that are close-up (presbyopia), finding that it takes longer to adapt to changing lighting conditions and finding that we need more light to see things.

Age-related eye problems
There are several eye problems that are more common among people as they age, although they can affect anyone at any age. They include:

Difficulty reading or presbyopia
This is the loss of the ability to see close objects or small print clearly. It is a normal process that happens slowly over a lifetime, but any changes may not be noticed until after the age of 40. Presbyopia is often corrected with reading glasses.

Floaters
These are tiny spots or specks that float across the field of vision. Most people notice them in well-lit rooms or outdoors on a bright day. Floaters are often normal, but can sometimes indicate a more serious eye problem, such as retinal detachment, especially if they are accompanied by light flashes.

Cataracts
Cataracts are cloudy areas that cover part of or the entire lens. Since a healthy eye lens is clear like a camera lens, light has no problem passing through the lens to the back of the eye to the retina where images are processed. When a cataract is present, the light cannot get through the lens as easily and, as a result, vision can be impaired. Cataracts often form slowly, causing no pain, redness or tearing in the eye. Some stay small and do not alter eyesight. If they become large or thick, cataracts can usually be removed by surgery, typically using a laser.

Glaucoma
This condition develops when there is too much fluid pressure inside the eye. It occurs when the normal flow of the watery fluid between the cornea and the lens of the eye is blocked. If this isn't treated early, it can lead to permanent vision loss and blindness. Glaucoma is less commonly caused by other factors such as injury to the eye, severe eye infection, blockage of blood vessels and inflammatory disorders of the eye. Treatment may include prescription eye drops, oral medications or surgery.

Macular degeneration
Macular degeneration usually affects people aged over 50 and is known as age-related macular degeneration or AMD. This condition happens when ageing affects the retina at the back of the eye. This is the nerve tissue that sends signals about what you see to the brain. Dry macular degeneration is the most common type and becomes worse very slowly over time. Wet macular degeneration is more serious. It usually develops very quickly and needs urgent medical attention. AMD is more common in women than it is in men.

How you can help
Encourage everyone to have a regular eye test, once every two years is best for those without any significant problems but some people may be asked to have an annual test. There is very little that can be done to prevent deterioration as we age, but early detection and treatment can help.

This information has been taken from a number of sources, predominantly the RNIB at http://www.rnib.org.uk/

Age related hearing loss
There is no known single cause of age-related hearing loss. Most commonly, it is caused by changes in the inner ear that occur with ageing. A persons genes and loud noise (such as from rock concerts or music headphones) may play a large role. The following factors contribute to age-related hearing loss:

- Family history (age-related hearing loss tends to run in families)
- Repeated exposure to loud noises
- Smoking (smokers are more likely to have hearing loss than non-smokers)
- Certain medical conditions such as diabetes
- Certain medicines

While hearing loss is sometimes sudden, it is often gradual and may not be noticed at first. Being aware of the early signs can help identify the problem quickly**.** It's important to spot hearing loss as soon as possible because treatment is often more beneficial if started early.

Early signs of hearing loss can include:

- difficulty hearing other people clearly and misunderstanding what they say
- asking people to repeat themselves
- listening to music or watching television with the volume turned up high
- difficulty hearing the telephone or doorbell
- regularly feeling tired or stressed, due to having to concentrate closely while listening

Sometimes it is easier to recognise the signs of hearing loss in someone else before they notice it themselves.

How you can help
There is no cure for age-related hearing loss; it most often gets worse slowly. The hearing loss cannot be reversed and may lead to deafness. Treatment is focused on improving everyday functions. The following may be helpful:

- Hearing aids
- Telephone amplifiers and other assistive devices
- Sign language (for those with severe hearing loss)
- Speech reading (such as lip reading and using visual cues to aid communication)
- A cochlear implant may be recommended for persons with severe hearing loss. Surgery is done to place the implant. The implant allows the person to detect sounds again and with practice can allow the person to understand speech, but it does not restore normal hearing.

This information has been taken from a number of sources, predominantly NHS Choices at http://www.nhs.uk/Conditions/Hearing-impairment/Pages/Causes.aspx and Action on Hearing Loss at http://www.actiononhearingloss.org.uk/

Arthritis
In 2012 there were some 10 million people in the UK with arthritis. It is one of the leading causes of disability in the UK today and can cause stiffness and painful swelling in joints. Arthritis can affect people of all ages but is particularly associated with ageing. There are over 100 joint conditions which are covered by the term

arthritis, including some soft tissue diseases. Osteoarthritis is the most common type of arthritis, followed by rheumatoid arthritis and gout.

Osteoarthritis

Osteoarthritis is the most common type of arthritis in the UK, affecting around 8 million people. It often develops in people who are over 50 years of age although it can occur at any age as a result of an injury or another joint-related condition.

Osteoarthritis initially affects the smooth cartilage lining of the joint. This makes movement more difficult than usual, leading to pain and stiffness. The cartilage lining of the joint can then thin and tissues within the joint can become more active. This can lead to swelling between the bones, causing bone in the joints to rub together. The joints that are most commonly affected are those in the hands, spine, knees and hips.

Rheumatoid arthritis

This often starts when a person is between 40 and 50 years old. Women are three times more likely to be affected than men.

Rheumatoid osteoarthritis occurs when the body's immune system targets affected joints, which leads to pain and swelling. The outer covering (synovium) of the joint is the first place affected. This can then spread across the joint, leading to further swelling and a change in the joint's shape. This can cause the bone and cartilage to break down. People with rheumatoid arthritis can also develop problems with other tissues and organs in their body.

Gout

Gout is a metabolic disorder that causes acute, intermittent and painful attacks of arthritis in the joints of the foot, knee, ankle, hand and wrist – especially the big toe. If the underlying condition is left untreated, attacks become more frequent, more prolonged and more generalised. Gout occurs most frequently in men between the ages of 40 and 60, particularly in those who are overweight or genetically predisposed.

How you can help

There is some evidence that diet can help with managing arthritis, and being overweight can exacerbate the pain. Diets that avoid sugars and acids are generally best and people suffering from any of the forms of arthritis should be encouraged to consider their diets. Many people living with a form arthritis report that they experience pain for much or all of the time. Pain management may involve doing everyday tasks in ways that reduce the stress on damaged joints and finding exercise that protect and support the joints. There are a number of self-management programmes for people living with arthritis and of, course, the doctor will advise on pain relief medication.

This information has been taken from a number of sources, predominantly Arthritis Care at http://www.arthritiscare.org.uk and NHS Choices at http://www.nhs.uk/Conditions/Arthritis/Pages/Introduction.aspx

Memory problems

Memory loss is not an inevitable part of the ageing process and age-related memory changes are not the same thing as dementia. Forgetfulness can be a normal part of ageing. As people get older, changes occur in all parts of the body, including the brain. As a result, some people may notice that it takes longer to learn new things, they don't remember information as well as they did, or they lose things like their glasses. These usually are signs of mild forgetfulness, not serious memory problems.

Some older people also find that they don't do as well as younger people on complex memory or learning tests. Scientists have found that given enough time, healthy older people can do as well as younger people do on these tests. In fact, as they age, healthy adults usually improve in areas of mental ability such as vocabulary.

Some memory problems are related to health issues that may be treatable. These include:

- medication side effects
- vitamin B_{12} deficiency
- chronic alcoholism
- tumours or infections in the brain, or blood clots in the brain can cause memory loss
- Some thyroid, kidney, or liver disorders can lead to memory loss.
- Emotional problems, such as stress, anxiety, or depression, can make a person more forgetful and can be mistaken for dementia.

For some older people, memory problems are a sign of a serious problem, such as mild cognitive impairment or dementia. People who are worried about memory problems should see a doctor.

How you can help

If someone is worried about a memory problem, it's important to talk to a doctor. They may suggest a visit to the memory clinic or further tests to establish whether this a natural part of the ageing process or there is a more serious underlying problem.

This information has been taken from a number of sources, predominantly NHS Choices at http://www.nhs.uk/conditions/memory-loss/Pages/Introduction.aspx

Frailty

We often talk about frail older people, without fully understanding that frailty is a medical condition. It is defined by the British Geriatrics Society as a clinically recognised state of increased vulnerability (*Fit for Frailty, BGS 2014*). It results from ageing associated with a decline in the body's physical and psychological reserves.

Frailty varies in its severity and individuals should not be labelled as being frail or not frail but simply that they have frailty. The degree of frailty of an individual is not static; it naturally varies over time and can be made better and worse. Frailty is not an inevitable part of ageing; it is a long-term condition like diabetes or Alzheimer's disease.

Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health (e.g. infection, new medication, fall, constipation or urine retention). Many people with multiple long-term conditions will also have frailty which may be overlooked if the focus is on long term conditions. Other older people whose only long term condition is frailty may not be known to their doctors until another condition exacerbates the frailty.

Frailty symptoms
If someone suffers from one or more of the following, this could be an indication that person has frailty.

- Falls
- Sudden Immobility
- Delirium
- Incontinence
- Susceptibility to side effects of medication

The doctor will have some simple assessment tools to indicate whether there is frailty, there is no routine screening for the condition.

How you can help
The main method of managing frailty in older people is a process of care known as Comprehensive Geriatric Assessment (CGA). CGA involves a holistic, interdisciplinary assessment of an individual and has been demonstrated to improve outcomes. Ideally everyone with frailty should have a holistic medical review by their GP based on the principles of CGA. This should include a review of current symptoms and signs and consideration of underlying medical conditions. Some people may then need a referral to a geriatrician or old age psychiatrist for support with diagnosis, intervention or care planning, while others may be referred to other specialists in the community such as therapists, specialist nurses, dieticians and podiatrists.

The result of the CGA should be a personalised Care and Support Plan (CSP) focusing on the person's needs and goals.

This information has been taken from a number of sources, predominantly the British Geriatrics Society at http://www.bgs.org.uk/index.php/fit-for-frailty

Social isolation and loneliness

Living with frailty can be associated with loneliness, but it is in fact a much more persistent problem across older age and particularly in the oldest old. Although there isn't a completely objective definition of loneliness, it can usefully be seen as a subjective feeling of loss or lack of something needed by an individual. A recent

CentreForum report on loneliness defined it as a ‘feeling of not having the desired quantity and quality of relationships’ *(Ageing Alone, Kempton and Tomlin 2014*).

Importantly, loneliness is not the same as social isolation. Rates of loneliness can be high in communal settings such as care homes and can be low in some physically isolated rural areas. Research has revealed that some older people can feel lonely when surrounded by family or in social settings which lacks the peer friendships and support. Where this happens, loneliness itself is the problem as opposed to isolation or lack of social contact. This is an important distinction.

Apart from the often severe impact on general wellbeing, the prevalence and impact of loneliness is often underestimated, particularly in the oldest old which has been shown to be increasing. It is difficult to tell whether this increase is because rates of loneliness are actually growing, or because people are more willing to identify themselves as lonely.

The health impact of loneliness is becoming better understood. It is not only having a profound effect on the quality of life of many older people, it also has serious implications for their physical and mental health. Loneliness is not an inevitable part of ageing, although the range of risk factors is more prevalent. These include loss of spouses and loved ones; major life changes such as retirement; loss of mobility and increasingly poor health. It is the cumulative effect of such factors rather than being a consequence of getting older.

How you can help
There are a few things that can be done to help older people without intruding or interfering with the choices they have made about how they live out their later life. Encouraging an older person to keep in touch with family and friends can help. Learning new things at any age is a stimulus, and keeping active within the physical limitations that may be present will increase sociability. However as people become socially isolated they also lose confidence in their ability to do quite simple things, so it is important to go at an appropriate pace for that person.

This information has been taken from a number of sources, predominantly the Campaign to End Loneliness at http://www.campaigntoendloneliness.org/ and NHS Choices at http://www.nhs.uk/livewell/women60-plus/pages/loneliness-in-older-people.aspx

Delirium
Delirium is a state of acute mental confusion that can happen to anybody with health problems, but is particularly prevalent among older people and people with dementia. Someone who is delirious often experiences a world that makes no sense to us but is very real to them. Medical problems, surgery and medications, especially starting a new drug, can all cause delirium. It often starts suddenly and usually lifts when the condition causing it gets better. It can be frightening – not only for the person who is unwell, but also for those around him or her. Delirium is more common in people who:

- are older
- have memory problems
- have poor hearing or eyesight

- have recently had surgery
- have a terminal illness
- have an illness of the brain, such as an infection, a stroke or a head injury

People with delirium are generally:
- Less aware of what is going on around them
- Unsure about where they are or what they are doing there
- Unable to follow a conversation or to speak clearly
- Have vivid dreams, which are often frightening and may carry on when they wake up
- Hear noises or voices when there is nothing or no one to cause them
- See people or things which aren't there
- Worry that other people are trying to harm them
- Become very agitated or restless, unable to sit still and wandering about
- Can appear very slow or sleepy
- Sleep during the day, but wake up at night
- Have moods that change quickly. They can be frightened, anxious, depressed or irritable
- Be more confused at some times than at others – often in the evening or at night

How you can help
You can help someone with delirium feel calmer and more in control if you:
- Stay calm.
- Talk to them in short, simple sentences. Check that they have understood you. Repeat things if necessary.
- Remind them of what is happening and how they are doing.
- Remind them of the time and date. Make sure they can see a clock or a calendar.
- Listen to them and reassure them.
- Make sure they have their glasses and/or hearing aid.
- Help them to eat and drink.
- Try to make sure that someone they know well is with them. This is often most important during the evening, when confusion often gets worse.
- If they are in hospital, bring in some familiar objects from home.
- Have a light on at night so that they can see where they are if they wake up.

This information has been taken from a number of sources, predominantly the Royal College of Psychiatrists at *http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/delirium.aspx*

Continence
Urinary incontinence is the unintentional passing of urine. It is a very common problem and is thought to affect millions of people worldwide.

Around one in four people has experienced bowel or bladder weakness. It affects men and women, both young and old, although it becomes more common with older age. People develop strategies to cope with their continence problems, such as denying there is a problem, hiding it, or planning regular trips to the toilet. Coping strategies can be seen as positive when people make a conscious effort to control

and manage their situation, such as by choosing incontinence pads to suit them or controlling their fluid intake.

However, people can feel unable to express their choices and preferences when they are being cared for by others, and coping strategies become more like a passive acceptance of their situation, which affects their self-esteem. Being discreet when providing care or discussing incontinence can help to relieve some anxiety as people may not want others to know.

Incontinence is often seen as a woman's problem, but that's not the reality. Women are more likely than men to have bladder incontinence (32% of the female population experience it compared to 13% of the male population), but men are just as likely as women to develop a bowel control problem.

There are several types of urinary incontinence, but the most common are:

- stress incontinence – when the pelvic floor muscles are too weak to prevent urination, causing urine to leak when your bladder is under pressure, for example when you cough or laugh
- urge incontinence – when urine leaks as you feel an intense urge to pass urine, or soon afterwards

Bowel incontinence is an inability to control bowel movements, resulting in the involuntary passage of stools. It is also sometimes known as faecal incontinence. The experience of bowel incontinence can vary from person to person but the most common are:

- urge bowel incontinence, where the person feels a sudden, urgent need to go to the toilet, and incontinence occurs because they are unable to reach a toilet in time
- passive incontinence or passive soiling where the person may experience no sensation before passing a stool, or they may pass a small piece of stool while passing wind

Some people experience incontinence on a daily basis, whereas for others the problem only occurs from time to time. Bowel incontinence is not a normal part of ageing and will not go away if left untreated.

How you can help

Bowel incontinence needs medical help and anyone suffering from this should be encouraged to see their doctor. There are however some things a person can do to lessen bladder incontinence. These including weight management, reducing alcohol intake and taking daily exercise. Pelvic floor exercises are particularly helpful for women.

This information has been taken from a number of sources, predominantly the Continence Foundation at http://www.continence-foundation.org.uk/

Depression

Depression is not just feeling low. When people are depressed, the feelings of sadness and general lack of motivation that we all experience from time to time are more intense and can persists for weeks or months. These feelings can interfere

with every aspect of a person's life, leading to other health problems and social isolation.

Depression can just happen out of the blue, although in many cases it can be triggered by significant life events, especially events connected with loss. In these terms, loss isn't just the distress of bereavement but other types of loss which become more and more common as we grow older and may affect a person's self-esteem and how they see themselves. These different types of loss include:

Retirement
Many people look forward to retirement but when it comes, find it hard to adjust to the loss of a structure to the day, contact with colleagues and the purpose that working gives. For many people, their job defines their place in the world and gives status and without that, there can be a loss of identity.

Health
The loss of good health and the lessening ability to undertake activities is a significant factor for many older people. Difficulties with hearing and sight, as well as living with pain, are the most common factors affecting mental health in later life.

Independence
Needing to rely on other people for everyday tasks can lead to a significant sense of loss. Simply not being able to drive anymore can be a trigger for depression and having to leave your own home to live in a cared for environment is a major life event.

Social networks
Not being able to do the things you used to because of poor health or financial difficulties can be a major factor in developing depression.

Having depression in later life may make a person more prone to experiencing memory loss and have difficulty concentrating. It may also lead to difficulty coordinating several activities to achieve one aim, such as preparing a meal. Other common symptoms of depression in later life include:

- Feeling unhappy most of the time
- Low energy levels
- Difficulty remembering things
- Feeling that life is pointless
- Difficulty sleeping and waking early in the morning

How you can help
It can be difficult to tell the difference between sadness, a natural grieving that should be respected, and clinical depression that can be treated through medication, alternative therapies or talking therapies. However, practical things you can do include:

- be aware of signs of changes in moods and a general air of sadness, offer emotional and practical support
- look for signs that someone is neglecting themselves or perhaps drinking more alcohol than usual

- encourage them to make an appointment with their GP or another professional they feel comfortable with and offer to go with them

This information has been taken from a number of sources, predominantly Age UK at http://www.ageuk.org.uk/health-wellbeing/conditions-illnesses/depression/what-is-depression/ and the Mental Health Foundation at http://www.mentalhealth.org.uk/help-information/mental-health-a-z/o/older-people/

Disclaimer: This guide has been prepared by Shared Lives Plus and contains general advice only, which we hope will be of use to you. Nothing in this guide should be construed as the giving of specific advice and it should not be relied on as a basis for any decision or action.

Shared Lives Plus does not accept any liability arising from its use. We aim to ensure the information is as up to date and accurate as possible, but please be warned that certain areas are subject to change from time to time. It is always a good idea to seek expert advice on your personal situation. Please note that the inclusion of named agencies, websites, companies, products, services or publications in this guide does not constitute a recommendation or endorsement by Shared Lives Plus.