28: Caring for Older People

Introduction

This unit looks at ageing and how we can promote and maintain both independence and well-being for older people.

As people live longer they are more likely to need health and social care services. The focus of care has moved towards health promotion and preventing people from becoming ill. It is more effective if services work with the older person to plan care that meets their needs, rather than requiring them to accept what is available.

In this unit, we move away from stereotypical views of older people to see ageing as a process beginning from birth. If you are 16 or 17 years old, you are already 'old' to a 5-year-old, and you probably think someone of 30 is quite old. Ageing is a process, not fixed; some people seem 'old' at 20 but there are also 90-year-olds who sky-dive.

We will look at what influences ageing and factors impacting on independence, health and well-being. We also examine the choices and quality people have at the end of life, using a holistic approach.

The unit brings together what you may have learned in Unit 4: Development Through the Life Stages, Unit 11: Safeguarding Adults and Promoting Independence, Unit 9: Values and Planning in Social Care and Unit 40: Dementia Care. It also links to psychological theories explained in Units 8 and 29.

Learning outcomes:

On completion of this unit, you should:

1 Understand the ageing process

2 Understand the role of health and care workers in supporting the well-being of older people.

1 Understand the ageing process

Definition of older age

The definition of older age depends on who is defining it and from what viewpoint. Governments responsible for paying pensions may define it one way. Researchers may define it another way. On a personal level, as you age, your own definition of older age may change.

Everyone gets old. An eight-year-old may feel that the school holidays last for ever. At ten, they cannot wait to be a teenager. By the end of their teenage years, they have made major decisions about their life, career, education and sometimes about relationships. Suddenly they are in their twenties and may have children of their own. In a few years, these children may regard their own parents as old-fashioned, thinking they do not understand what it is like to be young. Middle age comes as a shock to some people and they realise that old age is not far off. At this point, some people have a 'midlife crisis', trying to regain their lost youth and make up for what they feel they have missed. This view sees ageing as a series of different stages.

Have another look at Erikson's life stage theory in Units 8 and 29. Erikson believed that we pass through eight stages. Ideally we should achieve a balance between the opposing forces of each stage. If we do not, we may behave differently. For example, someone who does not find the right partner in life may either have a series of unsuccessful relationships, becoming intimate with many different people, or may become socially isolated, with no close friends or life partner.

At Stage 7, the individual may achieve a work–life balance that enables them to be creative (generative) and also relaxed. If they do not achieve this balance, they may become either an extremely creative workaholic, or a 'couch potato', doing nothing with their life.

At Stage 8, the individual may feel emotionally quite balanced, but if they have not negotiated this stage successfully they may look back in despair and spend their time wondering 'what if?' When people dwell on the past and have regrets about what might have been they do not live in the present and can become bitter and disillusioned.

Take another look at the ages in Table 28.1. Do you think they are the right ages for each stage? A criticism of stage theories is that, as individuals living in a changing world, we do not fit into neat categories. For example some women have children quite late, in their late forties or even fifties, following a career. Some people do not feel or look their age but the body ages, people live longer, and the stage of frail older age becomes inevitable. Erikson's theory seems to imply that people of 50 plus are similar, but there is a

Table 28.1 Erikson's stage theory

Erikson's stage theory	Age range
1 Trust v mistrust	Birth to 1 year
2 Autonomy v shame and doubt	2–3 years
3 Initiative v guilt	4–5 years
4 Industry v inferiority	6 years–puberty
5 Identity v role confusion	Adolescence
6 Intimacy v isolation	Young adulthood
7 Generativity v stagnation	Adulthood
8 Integrity v despair	Older age

big difference, physically and mentally, between a centenarian and a 50-year-old.

Did you know...

There are now more people over the age of 65 than there are people under 16 in this country.

Statisticians regard frail old age as those aged 85 years and older. This is the fastest growing group in the population. As health care improves, people live longer. According to the Office for National Statistics:

> 'those aged 85 years and older now represent just over 2 per cent of the population, compared to just over 1 per cent in 1982. In 2007, continued increase in the population over state pension age meant for the first time this sub-group of the population exceeded the number aged under 16.'
>
> Source: Population Trends 134, Winter 2008, Office for National Statistics on www.statistics.gov.uk/articles/population_trends/DunnellMortalityAndAgeingPT134.pdf

Researchers use a different measure of frail old age. A study funded by the Economic and Social Research Council looked at the quality of life of frail older people after going into residential care; 52 residents ranging from 65 to 99 years were interviewed. They included people below the age of 85 based on the quality of life and ability of the individuals.

The end of life is not a fixed stage either. Some people die quickly, for example, from a sudden heart attack; others may live several years with a disorder that slowly takes away their independence. People of any age can be at the end of their life if they have a terminal illness. The end stage of life may be days, weeks or even months.

Individual perspectives and attitudes

An individual's perspective on life can affect whether they consider themselves as old, affecting their attitude and behaviour. For example, Madonna is over 50 and Harrison Ford is almost 70, but they certainly have active lives. These may be extreme examples but many older people are living full and active lives.

Ageism is discrimination based on a person's age. In certain circumstances, it is illegal to discriminate on the grounds of age. The Employment Equality (Age) Regulations 2006 provide protection against age discrimination in employment, training and adult education, for people of all ages, not just for older people. Goods and services, facilities, and public functions are not currently covered but by 2012, under the Equality Act 2010 they will be (www.equalities.gov.uk/equality_bill.aspx).

The government perspective

People are living longer, spending more years in retirement so the cost to the government of paying state pensions is rising. Many people live for 20 or 30 years after retirement and their National Insurance contributions may not cover their full pension. Equality legislation means that it is illegal to discriminate against a person on the grounds of gender, and to have different retirement ages for men and women. The government response is to increase the age at which women can claim their state pension to equalise the situation. Currently, the retirement age is 65 for men but by 2020, it will be 65 for both, although some political parties think it should be moved towards 70.

Delivery of free services (dental, prescriptions, eye tests)

Once a person reaches 60 years, they are entitled to free NHS prescriptions and sight tests. Those receiving pension credits are also entitled to free NHS dental checks and treatment, a voucher towards the cost of glasses or contact lenses and travel costs for NHS treatment. To qualify, a person must be on a low income and have limited savings. The annual flu jab is free for those aged 65 and over. These free entitlements may change with government policy.

A good way to find out the latest information is to check the Age UK website: www.ageuk.org.uk.

Theories of ageing

Theories of ageing fall into two types – the social and psychological aspects of ageing and the biological aspects of ageing.

Sociological/psychological theories look at how a person engages with society around them.

Disengagement theory

In 1961, Cumming and Henry devised this theory to explain how, as people age, they discontinue social activities and they withdraw from social interaction with others. On retirement, they lose the social interaction of work colleagues and may no longer be able to afford to go out to meet friends, so they withdraw from that network, gradually disengaging from society.

Activity theory

This states that the more a person is involved in society, the better their satisfaction with life. (Knapp (1977). This has implications when planning services for older people; e.g. it might be better to fund an activity centre than extra hospital beds.

Social creation of dependency

This says that the way our society is structured makes people dependent. Described by Townsend (1981), he suggests this happens when:

- people are forced into earlier retirement
- low income for older people is accepted as the norm
- rights and choices in institutions such as hospitals or retirement homes are withheld
- community services assume that older people are passive, accepting and grateful for whatever they are given.

We have looked at three social/psychological theories of ageing. Now we look at three biological theories that focus on changes to the body as it ages. Biological theories do not consider any social or psychological factors.

Did you know...

Soma refers to the body as distinct from the 'psyche' or mind.

Disposable soma theory

Developed by Kirkwood (1977), this theory suggests that we age because the body does not invest enough resources into repairing cell damage. Evolution selects organisms that do not invest energy into cell repair if they live in risky environments. For example, a mouse may be caught by cats or owls. It lives a short life even if it does not get caught. For organisms living in less risky environments, such as the Galapagos tortoise that can live for 150 years, it is worth investing in cell repair.

Table 28.2 Sociological/psychology and biological theories of ageing

Sociological/psychological	Biological
Disengagement theory	Disposable soma theory
Activity theory	Genetically programmed theory
Social creation of dependency	Gender differences

Genetically programmed theory

This theory says that we are programmed to wear out at a certain time. Humans can live up to about 100 years. Some live to over 100, but no one has yet lived up to 130 years. The genetically programmed theory suggests our genes determine our life span. It is built into our DNA. Different species have different lifespans depending on their genes.

First World War veteran Harry Patch died in 2009, aged 111

Gender differences

This theory states that differences in ageing are due to gender, citing statistical evidence in support of this. Men die earlier than women just because they are biologically men. Statistics on life expectancy would seem to support this; according to the Office for National Statistics, life expectancy at birth is higher for females than for males. In 2006, for females it was 81.5 years and for males it was 77.2 years (www.statistics.gov.uk).

Key term

Life expectancy – the number of years a person might be expected to live.

Recent work by Brent *et al.* (2006) has challenged this idea, arguing that men lead riskier lives, which is why they die earlier. They argue that women *age* earlier than men, becoming infertile much sooner than men. On average, men die earlier because they may be driven by testosterone to be competitive.

Activity 1 P1 M1

Prepare a short presentation explaining the theories of ageing to an audience of older people. Choose two theories and compare them in detail. This works best if they are from different perspectives – for example one from the social/psychological and one from the biological perspective.

Changes in demography

Key term

Demography – the study of populations.

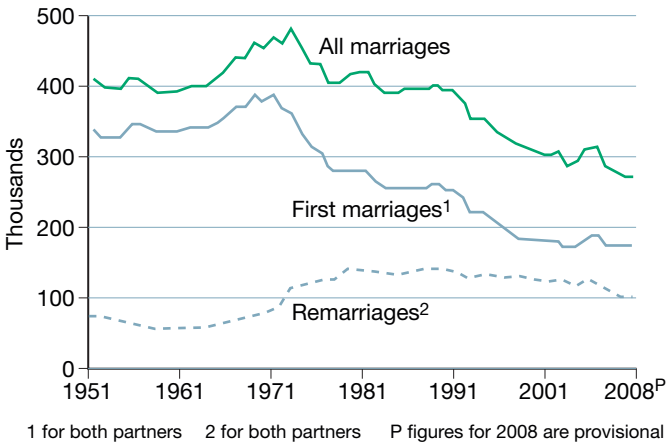
Demography examines population patterns and trends, which currently show an increase in average life expectancy. This means that people are living longer. Can you think of any reasons why this might be?

Did you know...

In 1901, baby boys were expected to live for 45 years and girls 49 years (www.parliament.uk).

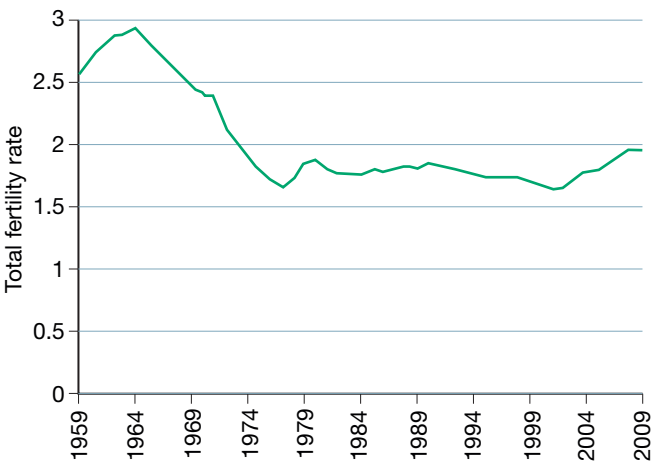
In 2006–2008, life expectancy for males was 77 years and for females it was 81 years (www.statistics.gov.uk).

Changing family patterns mean that families are smaller. Couples may live together without marrying and do not always stay together for life. People re-marry. The number of marriages is at its lowest since 1895. The graph on page 6 shows an overall declining trend from 1951 to 2008, although it has stabilised at a low level.



Marriage registrations in England and Wales
Source: www.statistics.gov.uk/cci/nugget.asp?id=322

Fewer babies are being born. The graph of live births below shows a declining trend.



Live births
Source: www.statistics.gov.uk/cci/nugget.asp?id=369

Case Study

Mrs M is 65 and a widow with two grown-up children. Her husband died a few years ago of lung cancer. Tom, her eldest son, is divorced. She rarely sees him because he works in London. She never sees his ex-wife or her two grandchildren. Her daughter, Sara, has a partner but they do not intend to have children as Sara does not want to give up her career. Occasionally, she pops back to see her mum on a quick visit.

So what does that mean in real terms for older people?

The real impact of falling marriage rates and falling fertility rates is that there are smaller family networks for older people. Traditionally, a lot of care was provided by adult daughters or grandchildren. When people divorce, grandparents may lose contact with their grandchildren. Many people have to move because of their careers and so cannot provide that day-to-day informal care that keeps older people involved in family life.

Retirement was a time when older people could relax and enjoy spending time with their family and grandchildren. The working age population is defined as 16–64 for men and 16–59 for women, so men over 65 and women over 60 might be expected to retire. However, data shows that more people are continuing to work, perhaps because they need the income or the company; or maybe they have no close family to spend time with.

In the labour market graph below, information on the left shows the percentage of women aged 50–59. The employed group is increasing but the number looking after family has decreased. The number in retirement in this age group remains around the same.

Information on the right of the graph gives information about men aged 50–64. Which group is increasing? Which groups have decreased?

Did you see that the percentage of unemployed men has fallen, as has the percentage of sick and disabled? The percentage retired in this age group stayed around the same.

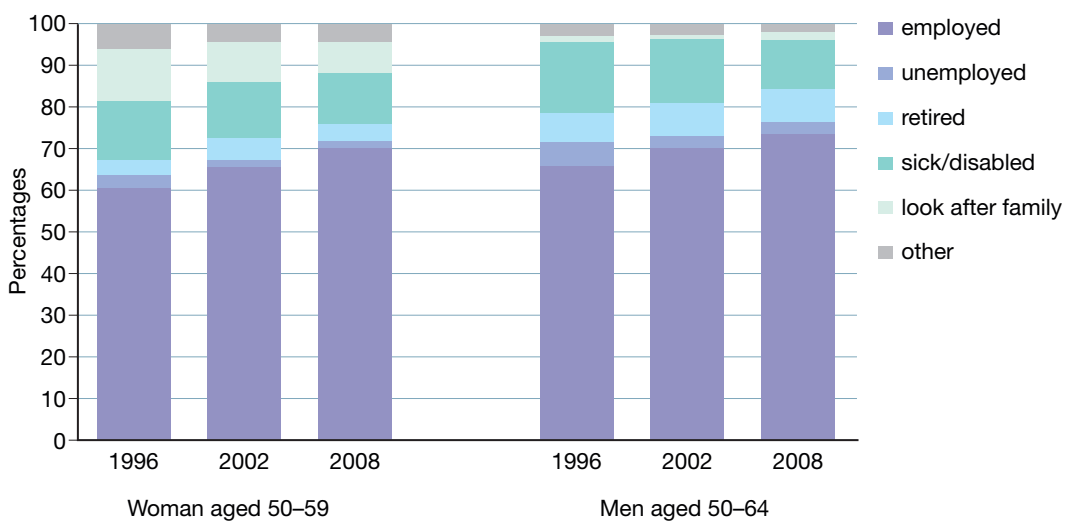
Other data shows that, of women aged 59–69, about a third of those without a partner worked. In the same age group, for women with a partner, less than a quarter worked. This may be because they have a low income and need to work or they like the social aspect of working.

Factors influencing health and well-being

As we saw earlier, in the eighth stage of life according to Erikson, people may feel integrity or despair. Despair is a negative emotion. Integrity, a feeling of wholeness and satisfaction with life, is a positive emotion. Activity theory says that the more a person is involved in society, the better their satisfaction with life.

Some factors might at first appear positive. For example, improvements in health care may be thought of as mostly positive. For most, they are positive factors but for someone who has their life prolonged against their wishes, even this might be negative.

The section in the box on page 8 is adapted from the government website for statistics.

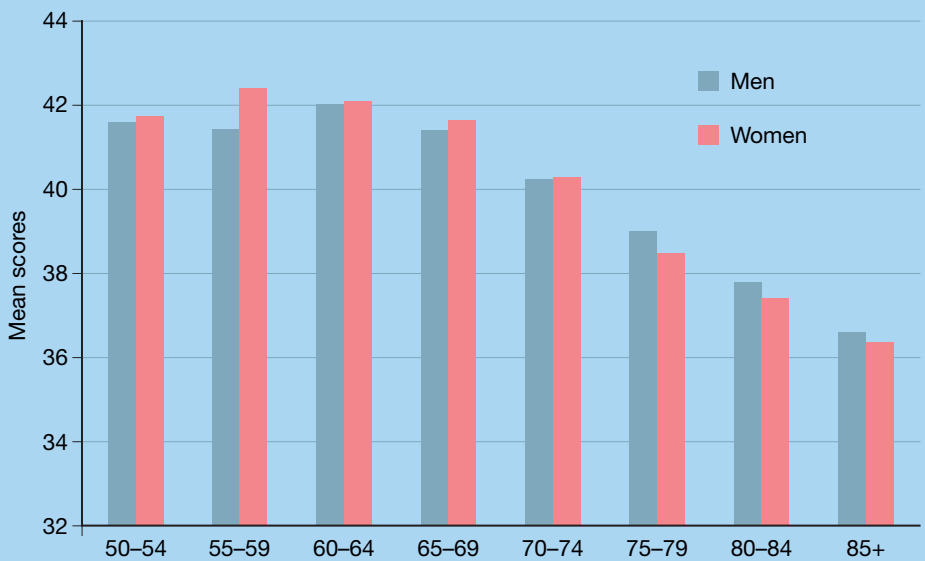


Labour market, 1996–2008
Source: www.statistics.gov.uk/cci/nugget.asp?id=1266

The English Longitudinal Study of Ageing (ELSA) measures the quality of life of older adults using the CASP-19 measures in four areas:

- C – Control: the ability to intervene actively in one's own environment.
- A – Autonomy: the right of an individual to be free from unwanted interference by others.
- S – Self-realisation: the active processes of human fulfilment.
- P – Pleasure: the sense of fun derived from the more active (doing) aspects of life.

The scale ranges from 0 (no quality of life) to 57 (total satisfaction with life). The overall quality of life increases between the age groups of 55–59 and 60–64 but then decreases from state pension age onwards, with the fastest decline occurring after the age of 70.



Quality of life of people aged 50 and over measured by CASP-19 scores, England, 2006

Social detachment is measured in ELSA using: societal involvement, participation in social or recreational activities, frequent contact with others, social support, participation in cultural activities and leisure. Participation in social or recreational activities fell with age, and women were more affected than men.

Older people need personal contact with somebody on a daily basis. In 2006, about 15 per cent of people aged 50 and over in England lived alone and met up with their children, family or friends less than three times a week. Frequent contact with people declined with age. About one in ten people aged 50 and over in England in 2006 had no-one strongly supporting them when in need.

Source: English Longitudinal Study of Ageing, Wave 3, 2005/06, on www.statistics.gov.uk/cci/nugget.asp?id=2174

This study shows the effect of disengagement theory, especially after the age of 70 for both men and women, but after 75 it is particularly marked for women.

Key term

Socio-economic – social and economic. Social is to do with society and other people; economic is about money.

Socio-economic factors. Social and financial factors determine whether people can afford to take an active part in society. Age UK advise older people about making the most of life. They suggest getting out and meeting people; a positive activity that all older people should do. However, taking part in sports and activities usually involves spending money, which is difficult for those on low incomes.

Living conditions vary for older people. According to the Office of National Statistics, most older people own their home but this means expensive maintenance bills. With increasing age comes the need for adaptations to enable them to continue living at home. Handrails, bathroom modifications and button alarms are the most frequently fitted aids.

Lifestyle depends partly on income. Those with enough money can afford holidays and activities, such as eating out, going to the cinema and the theatre, but not every old person can afford this. Over 95 per cent of those aged 80 and over had not participated in leisure activities at least once a year, perhaps because they could not afford it or because they had no one to go with, or a combination of both reasons.

Social isolation, bereavement and contact with family and friends influence health and well-being, according to the English Longitudinal Study of Ageing (ELSA), and *financial issues* determine whether an older person participates in social activities. Average income figures disguise the huge gap between rich and poor older people in Britain. The top fifth of pensioner couples has an income 3.8 times greater than the lowest fifth.

Improvements in health care have contributed partially to health and well-being. People are living longer, which is positive, but spend more years in poor health, which is negative. In 2006, males at birth can expect to spend 14.6 years of their life with a limiting chronic illness, and females can expect 17.7 years of life with a chronic limiting illness (www.statistics.gov.uk/focuson/olderpeople).

Reduction in harmful working practices has had a positive influence on health and well-being. Industrial injuries have reduced as heavy manufacturing has declined. A negative aspect however is that, as industries closed, people were made redundant and forced into early retirement, disengaging from society.

Changes in later life

The biological theories of ageing attempt to explain changes that occur as the body ages.

Physical changes

Changes in mobility may limit the quality of life.

Case Study

Mrs M has a painful arthritic hip and problems with balance, so she does not feel confident going out to the cinema or for a meal with friends. Her vision is also impaired by a cataract and her hearing is less acute, so she is afraid she will not hear or see the traffic. As she has reduced her social activity, her metabolism has slowed down. She is now less active, and so has lost muscle tone and put on weight.

Did you know...

Metabolism is the rate at which food is converted into energy in the body. Muscle needs more energy than fat. People with more muscle have a higher metabolic rate.

Cognitive changes

Cognitive changes are changes in thinking. These include the ability to:

- focus and maintain attention
- learn and remember information
- plan, carry out and monitor one's own activities
- think, reason and solve problems
- understand and use language
- recognise objects, judge distances and assemble things.

Of course, anyone who is tired or stressed at any age may have temporary cognitive changes, but sometimes the ageing process involves physical changes in the brain that result in such cognitive difficulties.

Diseases

Some diseases are age-related. This means that they are not usually present in younger people.

Alzheimer's disease

This is the most common cause of dementia, physically changing the brain, causing plaques and tangles and eventually death of the brain cells. Those with Alzheimer's may lack certain chemicals that help the nerves send messages in the brain. As the disease develops, symptoms become more severe.

Early symptoms may include memory loss, or not being able to find the right words. People with Alzheimer's may forget the names of things, people, and appointments. This can happen to anyone, but it is the persistence of these symptoms that is important. As the person starts to forget familiar names of people or places, they may become frightened and experience mood swings, gradually becoming more withdrawn. Eventually, they may need help with the basic activities of daily life, such as washing and dressing.

Terry Pratchett, author of the Discworld books, has recently been diagnosed with early onset Alzheimer's disease (www.alzheimers.org.uk/headroom).

According to the Alzheimer's Society:

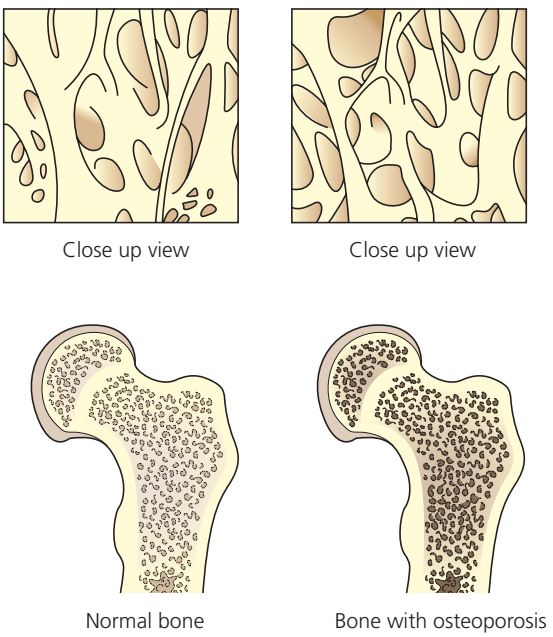
> 'Age is the greatest risk factor for dementia. Dementia affects one in 14 people over the age of 65 and one in six over the age of 80. However, Alzheimer's is not restricted to elderly people: in the UK, there are over 16,000 people under the age of 65 with dementia, although this figure is likely to be an underestimate.'
>
> Source: http://alzheimers.org.uk

Did you know...

'Osteo' refers to bones, so osteoporosis means 'porous bones'.

Osteoporosis

Normal bones are dense, with small spaces between bone cells and a hard outer shell. Inside is a mesh of collagen, calcium, blood vessels and bone marrow. Osteoporosis is age related loss of bone density resulting in a person getting fractures, most commonly in the spine, wrist and hips because the spaces between bone calls are larger, bones are weaker and more likely to fracture. It mostly affects post-menopausal women, although men too can be affected.



A normal bone and a bone with osteoporosis

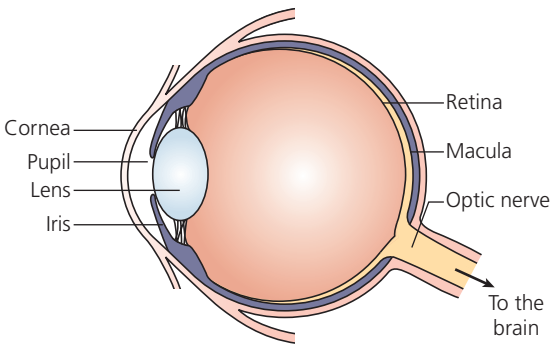
The National Osteoporosis Society is dedicated to improving the diagnosis, prevention and treatment of osteoporosis (www.nos.org.uk).

Macular degeneration

The macular is the back part of the inner eye; macular degeneration is a breakdown of the back part of the eye, affecting sight. This is what a person with macular degeneration (breakdown) sees.

There are two types of age-related macular degeneration (AMD). *Dry* AMD develops slowly and affects central vision; it is currently untreatable. *Wet* AMD can develop quickly as a result of new blood vessels growing. If detected early, it sometimes can be treated. AMD is the most common cause of poor sight in those over 60 but it rarely leads to total blindness.

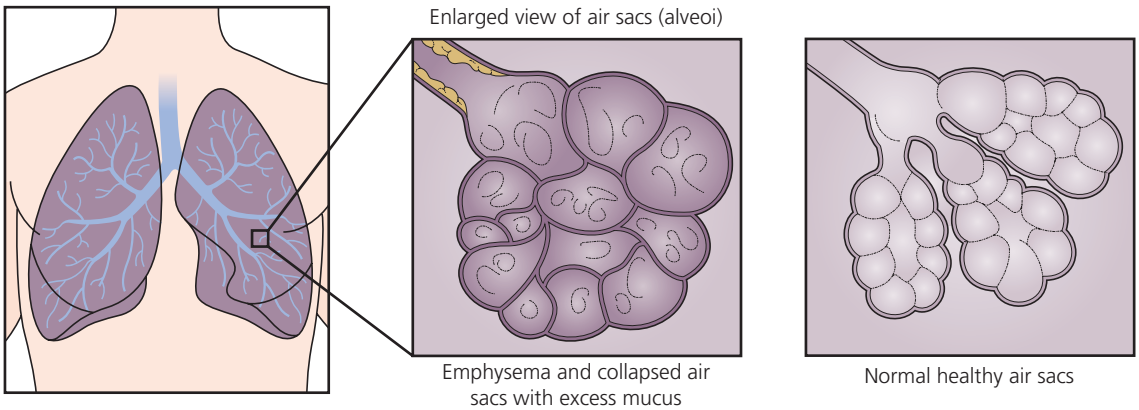
Vision with macular degeneration



Cross-section of the eye

Emphysema

Emphysema is a chronic disorder caused by smoking. It is called chronic obstructive pulmonary disease (COPD), because the tiny alveoli, or air sacs, of the lungs are damaged, causing breathlessness and eventually failure of the respiratory system. It is incurable.



Emphysema

Activity 2 P2

Prepare a report explaining to a new care worker the factors influencing ageing and the particular needs of older people. Include physical, emotional, social and intellectual well-being. Use case studies and examples in your report.

2 Understand the role of health and care workers in supporting the well-being of older people

Health and care workers are important in supporting the well-being of older people; they have a duty of care because they are in a powerful position. By abusing their power, they make life miserable for the older person.

Take the case of Mrs M, who is a widow and does not see her grown-up children very often. She is 65 and may remain healthy and active for some time. But in ten years' time some of the physical effects of ageing may be taking their toll. She might not hear very well and find it difficult to hear the phone ring. She might have just enough money for essential bills, but none for a holiday. She may have lost touch with friends because she cannot afford to socialise. She may have a carer to help with personal care but this may be her only contact with another person. Imagine how vulnerable she feels. Many older people are in these situations. To improve the quality of care the government devised guidance – frameworks for practice.

The main frameworks for practice are:

- National Service Framework for Older People
- Dignity in Care Initiative
- Mental Health Services for Older People
- Our health, our care, our say
- Codes of conduct
- Organisational policy and procedures.

National Service Framework for Older People

This was set up in 2001 to examine the problems faced by older people when receiving care

and to improve the services offered. These are national standards to be delivered locally in every community. The key standards are as follows.

Standard 1: Rooting out age discrimination

To ensure that older people are not discriminated against as a result of their age when accessing NHS or social care services. NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies.

Standard 2: Person-centred care

To ensure that older people are treated as individuals, receiving appropriate and timely packages of care which meet their needs, regardless of health and social services boundaries. This is achieved through the single assessment process, integrated commissioning arrangements and provision of services.

Standard 3: Intermediate care

To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. A new range of intermediate care services will promote independence by providing enhanced services from the NHS and councils at home or in designated care settings. There will be effective rehabilitation services enabling early discharge from hospital and preventing premature or unnecessary admission to residential care.

Standard 4: General hospital care

To ensure that older people receive the specialist help they need in hospital and receive the maximum benefit from having been in hospital. Older people will have specialist care by hospital staff who have the appropriate skills to meet their needs.

Standard 5: Stroke

To reduce the incidence of stroke and ensure that those who have had stroke have prompt access to integrated stroke care services. The NHS will act to prevent strokes, working in partnership with other agencies so that people thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service and participate in a multi-disciplinary programme of secondary prevention and rehabilitation with their carers.

Standard 6: Falls

To reduce the number of falls resulting in serious injury, ensuring effective treatment and rehabilitation following a fall. The NHS, working in partnership with councils, acts to prevent falls and reduce fractures or other injuries in older people locally. Older people who have fallen receive effective treatment and, with their carers, receive advice on prevention through a specialised falls service

Standard 7: Mental health in older people

To promote good mental health in older people, treating and supporting older people with dementia and depression. Older people with mental health problems have access to integrated mental health services, provided by the NHS and councils, ensuring effective diagnosis, treatment and support, for them and their carers.

Standard 8: The promotion of health and active life in older age

To extend the healthy life expectancy of older people, the health and well-being of older people is promoted through a coordinated programme of action led by the NHS with support from councils.

This information has been adapted from the National Service Framework for Older People on www.dh.gov.uk/en.

Did you know...

Some government publications are long and complex documents. Look out for the executive summary – it is a short, easy-to-read version.

Mrs M, at 75, may need an assessment of her needs. According to Standard 2 of the framework, it must be person-centred, and take into account her health and care needs. Standard 3 says that care should focus on maintaining independent

living, so no one can force Mrs M into a care home. Under Standard 6, the falls prevention service should help Mrs M to avoid falls. Perhaps her home needs adaptation to reduce the risk of a fall. Standard 8 says that the NHS should work with local councils to promote an active life in older age. Some local councils provide free travel to enable older people to get out. Some provide free swimming sessions.

Dignity in Care Initiative

This Department of Health (DH) campaign fits into the wider agenda of improving care. Poor management, staff shortages and a lack of training are highlighted as some of the reasons why there is a lack of dignity in care.

The DH's response was a green paper, 'Independence, well-being and choice' (2005), and then a white paper, 'Our health, our care, our say' (2006). Seven key outcomes were identified – one of these was personal dignity and respect. The Commission for Social Care Inspection (CSCI) included these in the new assessment framework, 'A new outcomes framework for performance assessment of adult social care' (2006). The Department of Health's National Service Framework (NSF) for Older People (2001) preceded these and started a 'culture change so that all older people and their carers are always treated with respect, dignity and fairness'.

The Dignity in Care campaign aims to put dignity and respect at the heart of care services. It started in 2006 and aims to change the way we think of care services, improving the quality of care services in hospitals, community services, care homes or support services. It includes action to:

- raise awareness of dignity in care
- inspire local people to take action
- share good practice and give impetus to positive innovation
- transform services by supporting people and organisations in providing dignified services
- reward and recognise those people who make a difference and go that extra mile.

A guide on the Dignity in Care initiative can be found on the Social Care Institute for Excellence website: www.scie.org.uk/publications/guides/guide15/index.asp.

Did you know...

Anyone can become a Dignity Champion – sign up and get involved on www.dhcarenetworks.org.uk/dignityincare/BecomingADignityChampion.

There is more about Dignity in Care in Unit 11: Safeguarding Adults and Promoting Independence.

Mental Health Services for Older People

This has already been mentioned as Standard 7 of the NSF for Older People. At a local level, primary care trusts and local councils are involved.

Case Study

Birmingham and Solihull Mental Health Services for Older People provides treatment and care to people over 65 experiencing mental health problems. These include conditions such as depression, anxiety, dementia and Alzheimer's disease. Support is provided in the community through outpatient facilities, day hospitals, community teams and inpatient units. There are three types of inpatient units within Mental Health Services for Older People – assessment units, continuing care units and a respite service. Most are purpose-built units based within the local community.

For more information see: www.bsmhft.nhs.uk/our-services/mhsop.

If Mrs M's GP referred her to this service for depression, she would receive a home visit from specialist staff and then may be referred for support to the community team. Integrated care is evident; occupational and physical therapy staff work as part of the mental health team. Investigate what is happening in your local area for mental health services for older people.

Our health, our care, our say

This is the 2006 white paper setting out changes in health and social care to personalise care so that it fits in with people's lives. The four key aims were:

1 Better prevention services with earlier intervention.
2 More choice and a louder voice for patients.
3 Tackling inequalities and improving access to community services.
4 More support for people with long-term needs.

Source: www.dh.gov.uk

Changes in funding will achieve this. Practice-based commissioning will give GPs responsibility for local health budgets. In social care, direct payments will allow people to employ the carers they wish, when they wish. There will be a shift towards more care in community hospitals and medical centres for services such as dermatology, ear, nose and throat medicine, general surgery, orthopaedics, urology and gynaecology.

As Mrs M's care needs increase, she may be entitled to direct payments to employ her own personal assistant. She will become an employer, needing to learn how to interview staff and choose who assists her with personal care.

Did you know...

Organisations such as Penderels Trust assist individuals who receive direct payments by helping them advertise for and recruit personal assistants (www.penderelstrust.org.uk).

Codes of conduct

The code of conduct for nurses and midwives states that the people must be able to trust them with their health and well-being. Nurses and midwives must:

- 'make the care of people your first concern, treating them as individuals and respecting their dignity
- work with others to protect and promote the health and well-being of those in your care, their families and carers, and the wider community
- provide a high standard of practice and care at all times
- be open and honest, act with integrity and uphold the reputation of your profession.'

Source: www.nmc-uk.org

Social care employers and social care workers must follow the General Social Care Council's codes of conduct. Employers are responsible for 'managing and supervising staff to promote effective practice and good conduct and support staff to address deficiencies in their performance' (Section 2.2 of code of practice for social care employers).

Social care workers must:

- 'protect the rights and promote the interests of service users and carers
- strive to establish and maintain the trust and confidence of service users and carers
- promote the independence of service users while protecting them as far as possible from danger or harm
- respect the rights of service users whilst seeking to ensure that their behaviour does not harm themselves or other people.'

Source: www.gscc.org.uk

Both codes explain the role of care workers in supporting the well-being of older people.

Organisational policy and procedures

These follow national guidelines, explaining how to put national strategies into practice. Local NHS and social service departments may have a falls prevention policy for older people. The box on page 16 shows an example of a procedure derived from the National Service Framework for Older People. The beginning of the policy is shown. Can you find one for your local area?

North Dorset Primary Care Trust
South West Dorset Primary Care Trust
West Dorset General Hospitals Trust
Dorset County Council Social Care and Health
Protocol for the Care and Management of Older People with Mental Health Needs

The NSF for Older People encouraged health and social care systems to agree protocols for the care and management of older people with mental health problems, setting out national priorities and targets.

The protocol was intended for use in primary care, the general hospital trust, care homes and social care, aiming to improve the experience of the user and carer by making the patient pathway between services as seamless as possible, and for the main principle to be the interests of the user and carer rather than the service.

Source: www.dorset-pct.nhs.uk

Legislation and regulations

Several laws and regulations apply to the role of health and care workers in supporting the well-being of older people.

The Human Rights Act describes people's legal rights, including the right to life, freedom from torture and degrading treatment, the right to respect for private and family life, freedom of thought, conscience and religion, and freedom to express your beliefs.

The Data Protection Act gives protection for personal data. (see Unit 2: Equality, Diversity and Rights for details).

Here is an excerpt from the Care Homes Regulations 2001:

> '12.(1) The registered person shall ensure that the care home is conducted so as –
> (a) to promote and make proper provision for the health and welfare of service users;
> (b) to make proper provision for the care and, where appropriate, treatment, education and supervision of service users.
> (2) The registered person shall so far as practicable enable service users to make decisions with respect to the care they are to receive and their health and welfare.
> (3) The registered person shall, for the purpose of providing care to service users, and making proper provision for their health and welfare, so far as practicable ascertain and take into account their wishes and feelings.'

This shows that the Care Homes Regulations promote the well-being of older people.

The Employment Equality (Age) Regulations 2006 protect against age discrimination in employment, training and adult education, for everyone, not just for older people. This ensures that all older people are treated equally in these areas. Legislation is somewhat slower in promoting well-being for the older person.

The Safeguarding Vulnerable Groups Act 2006 was passed following the Bichard enquiry into the Soham murders of 2002, when Ian Huntley, a school caretaker, murdered two girls at the school where he worked. This act created the Independent Safeguarding Authority, which vets all individuals who want to work or volunteer with children or vulnerable adults, preventing unsuitable people from working in England, Wales and Northern Ireland.

Services to support needs

Services to support the needs of older people may or may not be freely available in your area. Below are some examples. To find out more about these, see www.nhscareers.nhs.uk.

- Podiatry can help people with diabetes who may have poor circulation to the feet.
- Speech therapy and physiotherapy services help people after a stroke.
- Personal care and dietary advice may be used to support people in their own homes to enable them to live an independent life.
- Services such as creative and therapeutic activity, exercise and social activities may help those with mental health issues.
- Counselling may help people with depression, people with terminal disorders or their carers.
- The occupational health service helps people stay independent by providing equipment and resources to aid self-care.
- The palliative care service ensures those with an incurable disorder have the best quality of life.

If Mrs M became depressed and her GP referred her to the mental health service for older people, support from the community team may include counselling or planned activities at a day centre to take part in creative and therapeutic activities and social activities. She may be prescribed exercise on prescription. Check if your local primary care trust offers this where you live.

Promoting choice and independence

The aim of the National Service Framework for Older People and the Dignity Initiative is *empowerment*. Older people are no longer seen as passive recipients of care. They are encouraged to be actively involved in maintaining their own health, with the support of services. Older people have different needs – physical, intellectual, emotional, social and financial needs, which care planning must take into consideration. It is neither good practice, nor acceptable to look at just one set of needs. It is also an expensive way of meeting needs.

A holistic approach allows for individual involvement in care planning. Mrs M may be depressed and offered counselling. She may find this beneficial but may not want the exercise on prescription because she would rather join a gardening club with a friend she met at the day centre. She may not want the antidepressant tablets her GP has offered her. Health promotion is the aim of both her GP and herself but she has a choice in how she achieves that aim.

Of course, not every older person is able to make active choices about their care.

Case Study

Mr X has later-stage dementia. He cannot make choices for himself but an advocate represents his views and speaks up on his behalf. This advocate is an independent person with no conflict of interest; Mr X's wife finds it difficult to separate out her own personal issues from her husband's needs. Mr X has communication difficulties because of his dementia. He asks the same question several times, forgetting that it has been answered. His advocate, who has training in dementia care, has the patience to unravel what he wants to know and uses different ways of communicating to ensure his wishes are represented in care planning.

Safeguarding guidelines (see Unit 11) require that the person needing care should be treated equally, with dignity and respect, and where possible be enabled to maintain independent living. Rights and freedoms must be balanced with safeguarding by assessing and reducing risk, Mr X is entitled to care that supports his safe, independent living but Mrs X may be tired and stressed. Her needs as the main carer must be recognised under the Carers Recognition and Services Act 1995. The resulting care plan may require a carer to come in twice a day to help Mr X get up or go to bed or he may be able to visit a day centre for an afternoon a week to give Mrs X a break and to enable him to join in therapeutic activities.

Principles of care

Principles of care include meeting the requirements for diversity, respect, dignity, confidentiality and anti-discriminatory practice.

Case Study

Mr Z is 90 years old and lives alone. He has inoperable prostate cancer. He was very independent until he had a stroke last year. Now he needs a carer in the morning to help him with personal hygiene and getting up, and another in the evening to help him into bed. He potters around the garden in the day and likes a cigarette and a glass of whisky in the evening. He has strongly resisted the idea of a care home and says he wants to die in his own bed.

Good quality care is holistic and assesses all aspects of the individual's needs. Physically, Mr Z may receive more care in a residential home, but emotionally his wishes would have been ignored. Smoking is bad for health, but he argues that, at 90, he is not going to live much longer, so it does not really matter if he gets lung cancer. On the other hand, his carers should not be subjected to smoke in the working environment.

In this case, the principles of care relating to diversity must consider him as an individual. He does have a point in saying that, at 90, he does not think lung cancer is a worry. Respecting his wishes poses a problem, because carers have the right not to work in a smoky environment. A compromise is reached: Mr Z's neighbour pops round in the evening and they have a cigarette together before the carers arrive to help Mr Z to bed. His medication allows him an occasional drink so he has a glass of whisky with his neighbour every Sunday evening.

Mr Z is respected as an individual. His wants and needs are managed in a way that maintains his dignity and does not discriminate against him because of his age. His confidentiality is maintained – he does not want anyone to know about his cancer, because he does not want them feeling sorry for him. The carers maintain confidentiality and do not discuss his case with the neighbour.

In this case study, you can see the principles in action. Sometimes caring for older people results in an improvement or maintenance of well-being; sometimes it does not. In the next section, we look at both these outcomes.

Possible outcomes

In an ideal situation, care will improve or maintain well-being – for example, physical skills, mobility, balance, communication, social interaction, emotional stability and independent living.

Case Study

Mrs M was offered a variety of care for depression. She refused the tablets, but welcomed counselling sessions and increased her social and physical activity. She joined a gardening club, maintained her mobility by walking to the meetings, improved her social interaction and found her depression lifted. She gained emotional stability enabling her to continue living independently. Her mobility and balance improved as she became more physically active. Her communication skills improved as she began to talk with friends at the club, helping out at charity gardening events. She decided to take up the offer of a hearing aid and wished she had used one sooner.

Quality and choice at the end of life

Sometimes conditions do not respond to treatment and the end of life approaches. It is important to remember that this is not related to age. Young and old people both die from cancer. In this section, we look at quality and choice at the end of life for older people, but these issues are equally important at any age.

Quality is about the standard of something whether it is poor or good. *Choice* is about the power to choose.

Did you know...

'Around half a million people die in England each year, of whom almost two thirds are over 75. The majority of deaths at the start of the 21st century are caused by chronic illness such as heart disease, cancer, stroke, respiratory disease, neurological disease or dementia. Most deaths (58%) occur in NHS hospitals, with around 18% occurring at home, 17% in care homes, 4% in hospices and 3% elsewhere.'

Source: End of Life Care Strategy – 'Promoting high quality care for all adults at the end of life', Department of Health, 2008 (www.endoflifecareforadults.nhs.uk)

Factors that affect quality and choice at the end of life include:

- medicalisation of death
- informed choice
- emotional support
- living wills
- legality and ethics of assisted suicide and euthanasia.

Medicalisation of death

In the past, most people died of infections at home after a short illness. Death was part of family life. Most people had lost a close relative, often a baby brother or sister or a parent so were more aware of death than they are today. In 2008, only 18 per cent of people died at home, even though most people would prefer it. More than half of deaths occur in hospital, which reflects the medicalisation of death. It may also reflect Western society's expectations of being able to cure all disease.

According to Richard Smith, the editor of the *British Medical Journal*, 'medicalisation is the process of defining an increasing number of life's problems as medical problems' (from 'Where are the limits of medicine: are we turning the whole world into patients?', www.bmj.com/talks). He argues that death should be accepted as a normal part of life rather than trying see it as a disease to be cured. We should not rush people to intensive care or try to resuscitate them if they are at the end of life

The End of Life Care Strategy suggests that a 'good death' involves:

- being treated as an individual, with dignity and respect
- being without pain and other symptoms
- being in familiar surroundings
- being in the company of close family and/or friends.

It also says that most of the time this does not happen. The End of Life Care Strategy aims to change this. It builds on evidence from voluntary hospices, from the NHS End of Life Care Programme (2004–2007) including the Gold Standards Framework (GSF), Liverpool Care Pathway for the Dying Patient (LCP) and the Preferred Priorities for Care (PPC) and from the Delivering Choice Programme run by Marie Curie Cancer Care.

Informed choice

This is a choice made when all options have been fully examined. The individual decides, knowing all the facts. One aspect of choice is where to die. Most people want to die at home. The Marie Curie Cancer care charity provides free care in the community to enable those who are dying to die at home while being cared for by specialist nurses. They also provide hospices where people can be cared for with their relatives around them.

Previously, care for those at the end of life was uncoordinated. The community nurse might arrive to give an injection for pain relief or do a dressing just when the carer had got the person into the bath. The social worker might call just when the person was having a nap. This is what we mean by un-coordinated care. The Marie Curie Delivering Choice Programme changes this and coordinates care using a holistic approach. It helps care providers offer a joined-up approach and hence a better quality of life in the end stage of life (www.mariecurie.org.uk/forhealthcareprofessionals/deliveringchoiceprogramme).

Did you know...

Palliative care is care that reduces the effect of symptoms when there is no cure. It aims to reduce suffering and improve the quality of life for people with an incurable disorder.

Emotional support

Emotional support is provided by the hospice movement for the person at the end of life and their family. The aim is to enable people to live as actively as possible, providing emotional, spiritual and social support for the individual and for their families during the illness and through the bereavement. Respect and choice are key values in the hospice movement. Find your nearest hospice and see what they offer. Perhaps you might fundraise for them. Most hospices rely on charitable donations – the NHS fund only about a third of their work.

Living wills

This is a statement of wishes, or refusals of treatment, written in advance of an event. A living will gives a person some choice about what happens to them when they cannot make their wishes known.

> 'Every adult with mental capacity has the right to agree to or refuse medical treatment. To make your advance wishes clear you can use a living will. These can include general statements about your wishes, which aren't legally binding, and specific refusals of treatment called "advanced decisions" or "advance directives".'
>
> Source: www.direct.gov.uk

A statement might include treatment a person is happy to have or treatment they definitely wouldn't want. It can also include treatment preferences and name someone the person would like consulted about treatment decisions. To make a living will, the person has to be able to understand the decisions they are making.

Sometimes people in the early stages of dementia prefer to draw up a living will while they able to make choices. The Alzheimer's Society provides a fact sheet for those wishing to draw up a living will, clearly explaining that a living will cannot be used to refuse basic care or to ask for anything illegal, such as euthanasia or assisted suicide. See www.alzheimers.org.uk/factsheet/463.

Activity 3 P3 M2 D1

Draw on your placement experience, your general knowledge of older people, perhaps as friends or relatives, and information gained from carers. Make notes and then write an essay to explain and assess ways in which health and social care workers can support the independence and well-being of older people.

Using research from relevant websites in addition to you own knowledge, evaluate the ways in which sectors work together to do this. Give examples to support your evaluation.

Legality and ethics of assisted suicide and euthanasia

Did you know...

Suicide means to deliberately kill oneself. Euthanasia is painless killing to relieve suffering, done by one person to another. Euthanasia is illegal in most countries.

There is a clinic in Switzerland set up by a lawyer under Swiss law for assisted suicide. People who wish to die can apply to go there and are examined by doctors to ensure they are of sound mind. They are provided with a lethal dose of medication, but must drink it themselves.

The Human Rights Act gives choice but the Suicide Act 1961 does not. If a person wishes to commit suicide, it is not illegal, but anyone who helps them may be liable for prosecution.

In 2009, Sir Edward and Lady Downes travelled to the clinic in Switzerland to end their lives. He was 85 and almost blind. She was 74. They had been married for 54 happy years and decided to end their lives together, with their son and daughter nearby. Their son, who had booked the room for them, was uncertain whether he would be prosecuted under the Suicide Act.

Debbie Purdy, who has progressive and incurable multiple sclerosis, challenged lawyers to clarify the situation. She said that the current situation breached her human rights because it was unclear whether her husband would be prosecuted if he accompanied her to the clinic where she wishes to die if her condition gets worse.

Debbie Purdy and her husband

A legal decision by the Law Lords was reached in 2010. According to the government website www.direct.gov.uk, Keir Starmer QC, Director of Public Prosecutions, clarified that in certain circumstances the person may not be charged – for example, if they are motivated wholly from compassion. This was seen as a victory for Debbie Purdy.

The argument for assisted suicide

Some people argue that suicide is a legal right under the Human Rights Act. Others believe they should have the right to decide when and how they die. This is the argument put forward by the Secretary General of the Swiss clinic:

> 'Article 8 of the Convention was interpreted by the European Court of Human Rights in its decision in the case of Dianne Pretty of April 29th 2002 as follows:
>
> "Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees."'
>
> Source: extract from 'The function of assisted suicide in the system of human rights' a lecture by Ludwig A. Minelli, Secretary General, Dignitas, Attorney-at-law, Forch-Zurich, Amsterdam, March 2008

An ethical view suggests that people have the moral right to decide when to end their lives if they are in incurable pain, arguing that people may try and fail to commit suicide leaving them damaged, in pain and helpless. A moral view is that they should be assisted if they have freely made the decision to die, and there have the mental capacity to know what they are doing.

The argument against assisted suicide

It is illegal under the Suicide Act 1961 to assist anyone to take their own life and it is punishable by up to 14 years in prison.

The ethical argument is that no one has the right to end their own life – God decides when we live and when we die. Some people feel that it is morally wrong to take one's own life, even if you are in pain and there is no hope of a cure. Debbie Purdy has a disorder that means she will gradually lose the ability to speak, to move and to breathe. People with such conditions might feel that their loved ones would be better without them. Those against assisted suicide say that by legalising it, vulnerable people would be pressured into ending their lives, perhaps by unscrupulous relatives keen to get their money.

What do you think? When looking at an issue, it is important to look at both sides of a debate. You can read more about this important debate on www.guardian.co.uk/society/assisted-suicide.

Summary

In this unit, we have examined the ageing process, definitions of older age and theories of ageing. We examined changes in demography and their impact on older people, at factors influencing health and well-being and changes in later life, including some diseases associated with ageing.

We examined the role of health and care workers in supporting the well-being of older people through frameworks for practice, legislation and regulations, and through integrated services to support needs. We examined the role of health and care workers in promoting choice and independence using the principles of care and looked at possible outcomes. Finally, we looked at the controversial issue of how far we can have quality and choice at the end of life.

Assessment and grading criteria

In order to pass this unit, the evidence that the learner presents for assessment needs to demonstrate that they can meet all the learning outcomes for the unit. The assessment criteria for a pass grade describe the level of achievement required to pass this unit.

To achieve a pass grade the evidence must show that the learner is able to:	To achieve a merit grade the evidence must show that, in addition to the pass criteria, the learner is able to:	To achieve a distinction grade the evidence must show that, in addition to the pass and merit criteria, the learner is able to:
P1 explain theories of ageing [IE3; SM3]	**M1** compare two theories of ageing	
P2 explain factors influencing ageing [IE3; IE4; CT1; SM3]		
P3 explain ways in which health and social care workers support the independence and well-being of older people. [IE6; SM3]	**M2** assess ways in which health and social care workers support the independence and well-being of older people.	**D1** evaluate ways in which the sectors work together to support the independence and well-being of older people.

Resources

Department of Health (2001) 'National Service Framework For Older People' (executive summary available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010161).

Graves, B.M., Strand, M. and Lindsay, A.R. (2006) 'A reassessment of sexual dimorphism in human senescence: theory, evidence, and causation', *American Journal of Human Biology*, 18(2): 161–168.

Hyde, M., Wiggins, R.D., Higgs, P. and Blane, D.B. (2003) 'A measure of the quality of life in early old age: the theory, development and properties of a needs satisfaction model (CASP-19)', *Aging and Mental Health*, 7: 186–194.

Kirkwood, T.B.L. (1977) 'Evolution of ageing', Nature, 270: 301–304.

Knapp, M. (1977) 'The activity theory of aging: an examination in the English context', *The Gerontologist*, 17(6): 553–559.

Townsend, P. (1981) 'The structured dependency of the elderly: a creation of social policy in the twentieth century', *Ageing and Society,* 1: 5–28.

Weblinks

www.esrcsocietytoday.ac.uk/ESRCInfoCentre/ Plain_EnglishSummaries/LLH/index149.aspx:
'Exploring perceptions of quality of life of frail older people during and after their transition to institutional care'

http://alzheimers.org.uk:
Alzheimer's Society

www.ageuk.org.uk/money-matters/pensions/state-pension:
Age UK

www.alzheimers.org.uk/factsheet/463:
Advance decision factsheet

www.bsmhft.nhs.uk/our-services/mhsop:
Birmingham and Solihull Mental Health Services for Older People

www.dh.gov.uk:
Department of Health

www.dignitas.ch/index.php?option=com_content&task=view&id=117&Itemid=166:
Dignitas

www.direct.gov.uk:
Directgov – public services in one place

www.direct.gov.uk/en/NI1/Newsroom/DG_185749:
Information on assisted suicide

www.endoflifecareforadults.nhs.uk:
National End of Life Care Programme

www.equalities.gov.uk/equality_bill.aspx:
Equality Act 2010

www.guardian.co.uk:
The Guardian newspaper online

www.guardian.co.uk/society/assisted-suicide:
Articles on assisted suicide

www.guardian.co.uk/society/older-people:
Articles on older people

www.mariecurie.org.uk/forhealthcareprofessionals/deliveringchoiceprogramme:
Delivering Choice Programme

www.nhscareers.nhs.uk/index.shtml:
NHS Careers

www.rnib.org.uk/eyehealth:
RNIB – eye health

www.scie.org.uk/publications/guides/guide15/index.asp:
Dignity in Care

www.statistics.gov.uk/articles/population_trends/DunnellMortalityAndAgeingPT134.pdf:
'Ageing and mortality in the UK'

www.statistics.gov.uk/cci/nugget.asp?id=1266:
'Labour market – more older people in employment between 1996 and 2008'

www.statistics.gov.uk/cci/nugget.asp?id=322:
'Marriages – registrations in England and Wales remain stable'

www.statistics.gov.uk/cci/nugget.asp?id=369:
'Live births – fertility rates fall'

www.statistics.gov.uk/cci/nugget.asp?id=934:
'Health expectancy – living longer, more years in poor health'

www.statistics.gov.uk/focuson/olderpeople:
Focus on older people