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Care of Elderly Population

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ABSTRACT

Enabling the Nurses to analyze the difference in care of older adult by using the specific assessment method to provide holistic Nursing care with concern. As medical facilities have enhanced, the life expectancy has also increased in both developing of developed countries. This had led to an increase in old age population and eventually old age health problems requiring more attention and specialized care. With the increasing population of elderly in India, it is high time we start up with standard Nursing methods in care of geriatrics, which is a challenge to all of us. Nursing process for older adult Assessment: Normal ageing brings about in necessary and inevitable changes. These normal ageing changes are partially responsible for the increased risk of developing health related problems with the elderly population. Thus, we need to have an assessment which Fulmer has developed the assessment total with SPICES an acronym for the common syndrome of the elderly requiring nursing intervention (S, Sleep disorders; P, Problem with eating and breathing; I, Incontinence; C, Confusion and cognitive impairment; E, Evidence of fall and functional decline; S, Skin impairment). Based on the above the nurse assessment for geriatrics is designed specially to enable the Nurses in providing care with physical, mental, Social concern. The interventions are also based upon the assessment tool with SPICES. Conclusion: Accordingly, with advancing age more coordinated and active intervention are required to maintain the equilibrium of the aged and to maintain quality of life.

Keywords: aging, care of elderly, old adult

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INTRODUCTION

"Aging is not lost youth but a new stage of opportunity and Strength".

Betty Frieden

As medical facilities have improved the life expectancy has also increased in both developing of developed countries [1]. This had led to an increase in old age population and eventually old age health problems requiring more attention and specialized care [2]. Nursing care has to be focused towards geriatric nursing with specific assessment skills and implementation of care especially in developing countries because the 21st century will witness a gradual transition to an ageing population where countries like China and India will be the forefront [3].

Elderly Population in India

- 2001 – 71 million
- 2016 – 114 million
- 2025 – 168 million
- 2050 – 326 million

With the increasing population of elderly in India it is high time we start up with standard Nursing methods in care of geriatrics which is a challenge to all of us.

Six Senses Nurses Should Promote in Their Older Adults

- A sense of security
- A sense of significance
- A sense of belonging
- A sense of purpose
- A sense of continuity
- A sense of achievement

Nursing Process for Older Adult
Assessment

Normal ageing brings about in inevitable and irreversible changes. These normal ageing changes are partially responsible for the increased risk of developing health related problems with the elderly population. Therefore, we need to have an assessment which concentrates on the common problem of elderly rather than a general physical assessment. Fulmer has developed the assessment total with SPICES an acronym for the common syndrome of the elderly requiring nursing intervention.

S Sleep disorders
P Problem with eating and breathing
I Incontinence
C Confusion and cognitive impairment
E Evidence of fall and functional decline
S Skin impairment

Based on the above the Nurse assessment for Geriatrics is designed with the following parameters.

INITIAL NURSES ASSESSMENT FOR OLDER ADULT

Patient name	**Age & sex**
Arrival/entry data	
Arrival Date: _____Time:_____ □ Wheelchair; □ Stretcher. History informant: □ Patient; □ Other: Whom: _____; Relationship: _____ Contact in case of emergency. Whom:_____; Relationship:_____;	
Vital Signs	
Temperature:_____ □ Oral; □ Rectal ; □ Axillary ; Pulse:_____; Respirations: _____ Blood Pressure: _____; SpO_2: _____ ; Weight: _____□ Height: _____	
Previous Hospitalizations/Surgeries □ None	
Date (s)	Diagnosis/Type

Home medications □ None ; □ List unavailable physician contacted.					
Medication	Dose	Route	Frequency	Last dose taken	Comments
Prescription					
Herbals/vitamins/supplements					

Score result:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 and up	Very sleepy and should seek medical advice

History	Physical assessment	diagnosis
S – Sleep Duration of sleep Disturbed sleep Undisturbed sleep Nightmares No sleep	The Epworth sleepiness scale	Insomnia related to ageing process

Situation	Chance of dozing
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater, temple, prayer, public functions)	
As a passenger in car or bus for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and taking to someone	
Sitting quietly after a lunch	
In a car or bus while stopped for a few minutes in the traffic	
Total score	

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High change of dozing

P – Problems of breathing, eating		
Respiratory □ Cough □ Asthma □ TB □ COPD □ Pneumonia □ Cancer Smoker □ Cigarettes per day □ Tobacco chewing □	Breathing – irregular Shallow – use of an accessory muscles Cough: productive dry Secretion: thin – clear Frothy – thick – white Yellow – tanned – green Lungs on auscultation r-l Clear crackles rhonchi Wheezes.	Activity intolerance Fatigue Impaired gas exchange Impaired physical mobility Ineffective airway clearance Ineffective breathing pattern
	Normal parameter Bilaterally, respirations even, regular nonlabored. No productive cough, prolonged fever, or night sweats.	
Cardiovascular	Heart rate –	Ineffective tissue

□ No relevant history □ Angina □ MI, – HT – CABG Palpitations – cardiac murmur	Pulses Radial – r l Pedal - - Rythmn □ irregular Skin □ cool □ cold □ pale □ cyanotic Capillary refill. - within 3 secs - > 3 secs Edema: location----------scale-------	perfusion Decreased cardiac output Fluid volume deficit Fluid volume excess
	Normal parameters: Rhythm regular, no edema Peripheral pulses 2+, palpable No calf tenderness	
Gastro intestinal of nutrition		
GI Ulcer, diarrhea constipation, hepatitis A, B, C, anemia liver diseases, cancer, hernia hemorrhoids use of laxative, unintentional weight loss, self-feeding – assistance, loss of appetite, – lack of interest in eating Diabetes mellitus: type---- insulin------ OHA----	Nausea Diarrhea. Tarrystools incontinence constipation Abdomen: hard tender distended Bowel sounds Hypoactive Nutrition: Regular intake skipping of feeds Normal parameters: No diet restriction, feeds self No difficulty in swallowing, Bowel sounds present, Bowel Movement usual	Imbalance nutrition less than body requirement Imbalance nutrition more than body requirement Fluid volume defecit Fluid volume excess Impaired skin integrity Impaired swallowing constipation Diarrhea.
I – Incontinence □ Genitourinary □ Kidney stones UTI, □ Renal Failure dialysis---------- Female □ Reproductive Problem □ Performs self-breast examination □ Last pap smear test Male □ Last prostate examination □ Testicular	□ Nocturia – □ Dysuria □ burning Frequency – urgency □ Incontinence □ Hematuria □ Dribling □ stress incontinence □ Urine color – Cloudy Concentrated, sediment Normal parameters urine clear or yellow amber. No/C/o. nocturia, Anuria, Frequency Urgency and incontinence Male: No burning discharge Female: No menstrual or menopausal problem No nipple discharge	Incontinence {stress incontinence) Urinary retention Ineffective Sexuality patterns

examination □ BPH, □ Enlarged prostate Reproductive problems		

C – Confusion and Cognitive Impairment

Neurological/Mental Health □ No Relevant History	Cognitive/Perceptual □ No Relevant History
□ Headache/Migraine; □ Syncope; □ Seizures; □ Epilepsy □ CVA; Cancer; Paralysis: □ R □L; □ Neuropathy; □ Other: _____ □ Delirium □ Anxiety ; □ Depression; □ Suicidal Attempt ; □ Overdose; □ Psychiatric Illness; Details: _____	Vision: □ Glaucoma; □ Blind; Cataracts: □ R □L: □ Visual Aids: □ With Patient □ Not with Patient Hearing: □ Deaf ; □ Hearing: □ R □ L Hearing Aids: □ Other:
Psychosocial □No Relevant History	
Do you use: □ Alone □ Friends □ Alcohol: Type/Amount: _____ □ Recreational _____ □ Assistance required at home: Gambling □ Social Work Referral initiated: □ By Whom	

Neurological/Cognitive/Perceptual/Psychosocial □ WNL				
Awake, alert, and oriented to person, place, and time. Follows commands. Clear speech. Bilateral hand grasps equal. Maintains eye contact. Behavior is appropriate for age and	Disoriented No to: □ Person ; □ Place ; □ Time; □ Drowsy ; □ Lethargic; □ Forgetful; Speech: □ Slurred* Aphasic* LOC (Glasgow Coma Scale) – Circle below: Total:			□ High Risk For Injury □ Altered Level of Consciousness □ Altered thought Process □ Knowledge Deficit □ Memory Deficit □ Sensory Deficit □ Anxiety □ Body Image Disturbance
	Eye opening Response	Best Verbal Response	Best Motor Response	
	Spontaneous = 4	Oriented = 5	Obeys Commands = 6	
	To voice = 3	Confused = 4	localizes pain=5	
	To pain = 2	Inappropriate Words = 3	Withdraws to pain =4	

development. Communicates thought processes. No major worries and concerns.	None = 1	Incomprehensive Sounds = 2	Flexion to Pain = 2	□ Hopelessness □ Powerlessness □ Chronic low Self-Esteem □ Situational Low Self- Esteem
		None = 1	Extension to pain = 2	
			None = 1	

E – Evidence of fall & Function decline		
□ History of Joint Disease □ Arthritis – □ osteoporosis □ Chronic - Fractures □ Use of – walkers, - crutches Wheel chair – Cane	*Functional ability: GAIT – Staggering Normal* *ADL – self-assistance* *Falls –* *Decreased mobility* *Morse fall score*	Impaired – Physical mobility Risk for impaired Physical Mobility - Risk for falls related to age related changes
S – Skin Impairment		
History of skin Implants	*Color – Condition Turgor Temperature* Pale Rash Poor Mottled lesions Dry Cool Cyanotic Ecchymosis Cold	Impaired Skin integrity High risk for infection

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Nursing Management/Interventions

Sleeping Disorders

- Obtain baseline sleep information
- Reinforce sleep hygiene practice
- Avoid daytime naps
- Maintain a regular sleep schedule
- Treat reversible condition like iron or folate deficiency
- Environmental factors, hypothyroidism
- Avoid beverages
- Avoid bright light exposure [4]

Problems of Feeding and Breathing

- Verify condition of teeth and fit of dentures
- Allow adequate time for meals
- Feed slowly and frequent verbal cues to swallow
- Reduce distractions during meals
- Provide oral hygiene and determine individual food preference
- Serve meal in attractive manner [5]

Breathing

- Assess rate, rhythm and volume of peripheral pulses
- Assess presence of edema
- Avoid temperature extremes
- provide antiembolism garments
- Observe signs of cyanosis of Teach effective breathing and coughing exercise
- Maintain calm and restful environment
- Encourage use of spirometry as ordered
- Administer oxygen as per order [6]

Incontinence: Causes of Transient Incontinence

D – Delirium or confusional states
I – Infections (UTI)
A – Atrophy of urethra
P – Pharmaceutical product
P – Psychological disorders
E – Endocrine Disorder.
R – Restricted mobility
S – Stool infection [7]

Nursing Care

- Behavioral – increase ability to suppress urine, increase capacity, Kegel's exercise
- Develop a toileting schedule
- Modify clothing to facilitate toileting
- Pharmacological therapy which includes antispasmodics

C – Confusion and Cognitive Impairment

- Verbal communication should be purposeful and avoid baby talk.
- Nonverbal communication methods should be used.
- Give one idea at a time
- Always communicate positive statements
- Environmental modifications by placing calendars, clock of colorful pictures, articles with using bright lights
- Ensure safety by providing side rails, call bells
- Provide antislip mats
- Provide color coding to steps to identify space modification
- Keep medication in the locker
- Facilitate activities of daily liming

E – Evidence of Fall/Functional Decline

- Assess strength of joint mobility
- Teach maintenance of good body alignment.
- Provide good lighting of assistance device to assist balance
- provide assistive devices such as canes, walkers.
- Eliminate environmental hazards uneven walking surfaces
- Encourage moving slowing from lying to standing to orthostatic hypotension
- Encourage to do of daily lining
- Allow adequate time to perform activities of assist in ADL

S – Skin Impairment

- Perform daily skin inspection
- Use mild, nondetergent soaps of rinse thoroughly
- Turn of reposition frequently
- Reduce sources of pressure
- Provide adequate protein, vitamin, minerals of fluids
- Keep limes clean, dry of free four foreign objects [8]

CONCLUSION

Although older adults are experiencing age-related changes, the rate of response to

such changes are individual of require individualized and standardized care. Therefore, with advancing age more coordinated and active intervention are required to maintain the Equilibrium of the aged and to maintain quality of life. Thus, the above Information would enable the nurses to perform a skillful assessment and provide eminent Nursing care as nurses always make the difference.

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