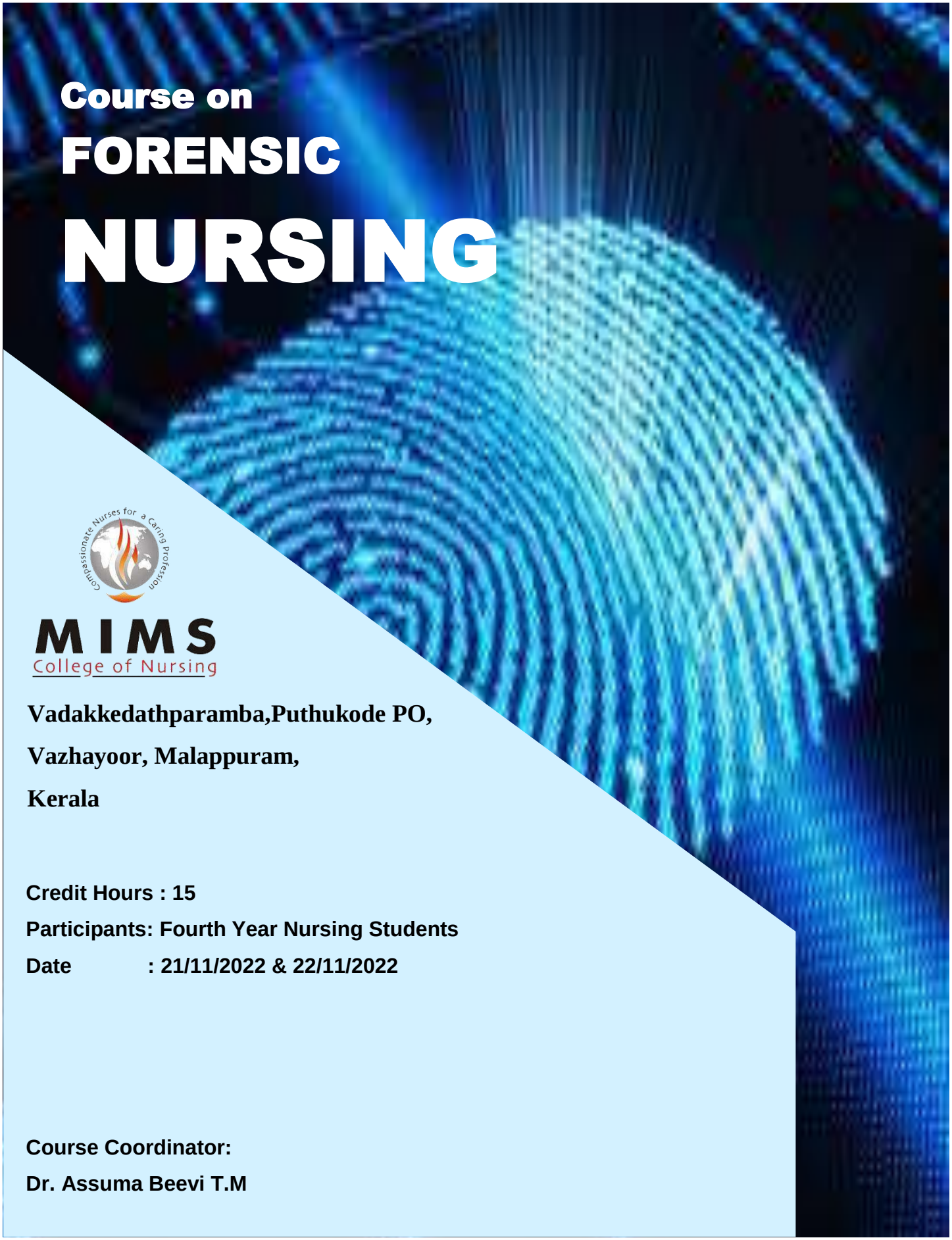

Course on
FORENSIC
NURSING

MIMS
College of Nursing

Vadakkedathparamba,Puthukode PO,
Vazhayoor, Malappuram,
Kerala

Credit Hours : 15
Participants: Fourth Year Nursing Students
Date : 21/11/2022 & 22/11/2022

Course Coordinator:
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Module 1

Forensic nursing

Introduction to Forensic Nursing

Forensic nursing practice is one of the fastest growing nursing specialties of the 21st century[1]. From 1980s nursing literature started discussing the need for specialization for nurses in forensic nursing. According to American Nurses Association, Forensic nurses provide a vital link in the multidisciplinary treatment of victims, perpetrators, survivors, or individuals falsely accused of abuse and violence. Indian Nursing Council also had started Forensic Nursing as a specialty for undergraduate nurses in India from 2000 onwards. This course is imparted by various universities in the country. But it has not reached as it should be due to the lack of initiation form government machinery that has not created adequate opportunities for forensic nurses.

Aim

The aim of this course is to acquaint the undergraduate nursing students with forensic evidence collection by the nurses and give them a working knowledge of the steps involved to preserve the chain of custody and safeguard the validity and admissibility of evidence for legal purposes in any hospital settings with special emphasis on emergency department. The information contained within this module is not meant to serve as a comprehensive resource on evidence collection.

Specific Objectives

By the end of this educational encounter, the nurse will be able to:

1. Brief the history and scope of forensic nursing
2. Name the important terminologies of forensic nursing in practice
3. Define Forensic science, forensic medicine and nursing
4. List the unique characteristics of forensic nursing
5. List the importance of forensic nursing

1. History of Forensic Nursing Practice

The emergence of modern forensic nursing began in USA with the establishment of the sexual assault nurse examiner (SANE) programs in the mid-1970s in Minnesota, Tennessee, and Texas. SANEs are trained to collect forensic evidence from sexual assault survivors. The formal recognition of forensic nursing was accomplished in USA at the Annual Meeting of the American Academy of Forensic Sciences in Anaheim, California, in February 1991. In that same year, the ANA published a position statement on violence as a nursing practice issue.

- Before the recognition of forensic nursing as a specialty by the American Nurses Association (ANA) in 1995, forensic nursing was a respected practice in the scientific investigation of death. It has been a significant resource in the field of forensic psychiatry as nurses worked with victims of violence and perpetrators in primary care, in the emergency room, and in psychiatric and correctional institutional settings. Clinical Forensic medicine was existing in nursing curriculum in its rudimentary form

2. Scope of Forensic Nursing Practice

Forensic nursing practice is a unique practice of the expansive role of registered nurses and is independent and collaborative in nature. It has been recognized as a significant resource in forensic psychiatric practice and in the treatment of incarcerated clients. The victim can be the client, the family, the significant other, the alleged perpetrator, or the public in general.

According to ANA, the scope of forensic nursing practice encompasses three areas (ANA & IAFN, 1999; IAFN, 2005d):

- Application of the nursing-related sciences, including biopsychosocial education, to public or legal proceedings
- Application of the forensic aspects of health care in scientific investigation
- Treatment of trauma or death victims and perpetrators (or alleged perpetrators) of abuse, violence, criminal activity, and traumatic accidents

The forensic nurse provides direct services to nursing, medical, and/or law-related agencies, as well as consultation and expert testimony in areas related to questioned investigative processes, adequacy of services delivered, and specialized diagnoses of specific conditions as related to forensic nursing and/or pathology (ANA & IAFN, 1999; IAFN, 2005d). Sharing responsibility with the legal system to augment resources available to victims and perpetrators of trauma or violence represents a holistic approach to legal issues for clients in clinical and community-based facilities (Muscari, 2004).

3. Unique Characteristics of Forensic Nursing

The scope of forensic nursing is considered to be multidimensional and possesses unique characteristics because it is compelled to provide direction to health care providers, educators, attorneys, researchers, and administrators, as well as other health professionals, legislators, and the public in general.

- Identifying injuries and deaths with forensic implications
- Collecting evidential material required by law enforcement or medical examiners
- The scientific investigation of death

- Provisions of care in uncontrolled or unpredictable environments and providing continuity of care from the emergency department to the court of law
- Providing expert witness testimony
- Interacting with grieving families
- Thoroughly reviewing and analyzing medical records

4. Terminologies related to forensic nursing

Forensic Science: Forensic science is not just one discipline, but is composed of scientific knowledge from a wide variety of scientific areas. The knowledge from these many fields of science come together with the disciplines of law and justice to create forensics. Forensics deals with the recognition, identification, and evaluation of evidence collected in criminal investigations.

Forensic Nursing: Forensic nursing is defined as the application of the nursing process to public or legal proceedings, and the application of forensic health care in the scientific investigation of trauma and/or death related to abuse, violence, criminal activity, liability, and accidents.

A forensic nurse is a Registered or Advanced Practice Nurse who has received specific education and training. Forensic nurses provide specialized care for patients who are experiencing acute and long-term health consequences associated with victimization or violence, and/or have unmet evidentiary needs relative to having been victimized or accused of victimization.(IFAN)

Forensic Nursing:

- Application of forensic health care in the scientific investigation of trauma and/or death related to abuse, violence, criminal activity, liability, and accidents.
- Application of forensic aspects of health care combined with bio-psychosocial education of the registered nurse in the scientific investigation and treatment of trauma, death, violence or criminal activity, and traumatic accidents within the clinical or community institution (Lynch, 1991).

Forensics: Pertaining to the Law

Forensic Nursing: Application of Nursing to the Law

Forensic is not about dead people but about law or Jurisprudence

Living victims deserve forensic expert than a dead person

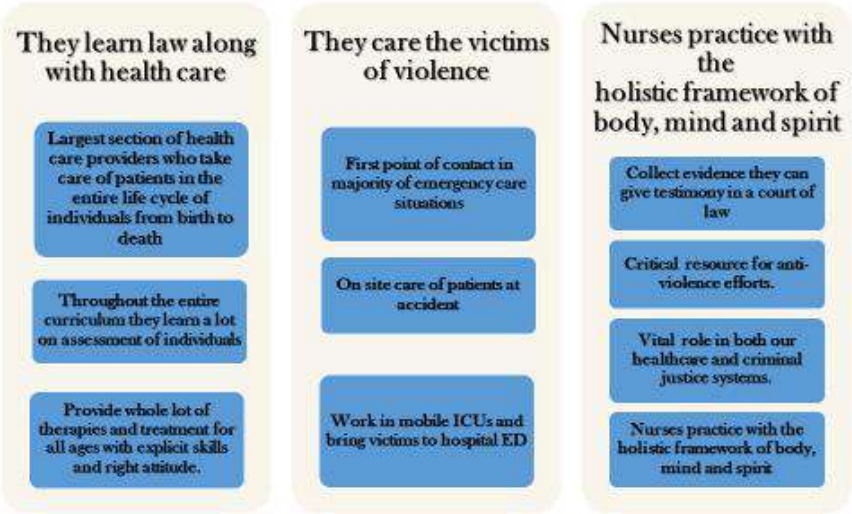
There are three main areas of forensics:

Biology: the investigation of crimes against people. Involves the collection of
body fluids, hairs, and fibers among other types of evidence from living sources.

Drugs and Toxicology: involves criminal and non-criminal deaths as well as crimes associated with the use of drugs such as drunken driving, overdose, or crimes committed while intoxicated.

Chemistry: involves the identification and analysis of paint chips, drugs, glass, or other chemical compounds to determine their composition and origin.

Why Forensic nursing important



5. Nurses via media for health disparity???

a. Provide compassionate care to victims of violent crime, abuse, or neglect while gathering evidence to support law enforcement
b. Rural areas lack the provision of a forensic surgeon
c. Rural community also require the services of forensic experts
d. Prepared professional who can help the rural community in their pursuit of justice
e. Can provide services from these professionals on issues related to social justice and justice inequality
f. Guide social mobility of resources
g. Nurses make a commitment, by means of affirmation, to observe an ethical code
h. Regardless of age, gender, race, ethnicity, economics, or social status is a person who is always an end and never a means to accomplish some objective

6. Forensic Nurses works in:

a. Trauma Care Units/ER
b. Sexual Assault Response team
c. Nurse Coroners/Forensic Nurse Death Investigators
d. Nurse Attorneys/Legal Nurse consultants

e. Psychiatric & Mental Health
f. Correctional Health
g. Domestic Violence
h. Human right protection institutions

- **Tenets of social justice**
  - Vulnerable people be protected from harm
  - Treat them to achieve their full status in society
- **Health inequities**
  - Unequal distribution of resources, inadequate care, racism, or other harmful social structures that result in social injustice
  - Nurses care patients of all ages, from different social strata ,
  - different ethnic and vulnerable groups

Study questions

1. Define Forensic nursing
2. Who is the founder of forensic nursing
3. Why is it important for nurses to learn forensic nursing?
4. What are scope of forensic nursing?
5. How forensic nurses can help socially deprived people?

Module 2

Forensic Nurses skills required

Introduction:

Forensic nursing is now regarded as a nursing specialty. Nurses trained in forensic sciences are now a part of emergency medical team. They work in various hospital settings where care related to legal issues arise.

Specific objectives

Identify the different roles of a forensic nurse
Discuss the educational requirements for a forensic nurse

SKILLS AND SPECIALIZATIONS REQUIRED

Forensic nursing is not limited to the domains of law and medicine.
Some common forensic nursing specializations include sexual assault, medical-legal consulting, death investigation, and forensic psychiatric nursing, domestic violence investigator etc.

Forensic nurse roles

- Sexual Assault examiner
- Death investigator
- Medico legal consultant
- Forensic psychiatric nurse
- Paediatric / child abuse investigator
- Domestic violence investigator

Work settings Include:

- General hospitals/ ERs
- Psychiatric hospitals
- Medical examiner and coroner offices
- Community anti-violence organizations
- Correctional institutions, and community crisis centers

THE EXPERTISE OF FORENSIC NURSES MAY BE REQUIRED IN THE FOLLOWING SITUATIONS:

- Arson
- Suicide & Homicide
- Drug and Alcohol abuse
- Bioterrorism
- Medical error
- Tissue and organ transplant
- Sexual/ physical abuse

Other Required Domains are:

- Risk management
- Employment litigation
- Human Rights abuse

Required skills

- Identifying, evaluating, trauma and documenting injury/ trauma
- Specialized knowledge of legal system
- Dealing with death and dying on a daily basis
- Providing patients with crisis intervention
- Contributing to investigation by examining potential suspects
- Serving all victims to help with crime related injuries

Responsibilities

- Forensic nurses have a variety of responsibilities such as:
    - treating and educating patients,
    - examining prospective suspects as part of an investigation,
    - providing crisis intervention to patients,
    - using forensic photography to recover evidence, and referring patients to ongoing programs.
    - responsible for serving victims to assist with crime-related injuries and testifying in court as a fact witness or as an expert.

- providing testimonies in court as expert witness

Forensic nurses in Emergency department

- Identification
- Care for the Survivor
- Care for the Perpetrator
- Identification & Collection of evidence
- Clothes
- Injury and patterns of injury
- Documentation
- Injury- Measurements in centimeters, Location, Description & Photography Sexual assault nurse Expert (SANE)

➢ **SANEs are responsible for collecting evidence accurately, treating and evaluating minor injuries, and taking preventative measures, such as preventing pregnancy and sexually transmitted diseases.**

Required skills for SANE are:

➢ Compassion, sensitivity and prompt attention to victims needs

➢ Knowledge of victimization

➢ Counseling and investigative skills

➢ Every 45 seconds a women is Sexual Assaulted. (1:5 Women1:10-20Men)

➢ Sexual assault nurse is part of sexual assault response team

Forensic psychiatric nurses responsibilities

They are expected to have communication skills to treat patients who have experienced physical or emotional trauma.

They are also responsible for providing child patients with advice on how to find an outlet for safety as a way to deal with trauma.

- Develop Strategies for promotion of mental health and prevention of psychiatric disorders.

- The provision of appropriate care within the criminal justice system.
- The equitable provision of care for children and adolescents

The responsibilities of the nurse death investigator(NDI)

- Documenting findings to assist the medical examiner or forensic surgeon
- Photographing the crime scene
- Conducting examinations of the body
- Conducting examinations of the body and identifying the diseased

Correctional nurse specialist

- Providing medication
- Physical exams
- Health care to detainees and inmates
- Medical knowledge

Legal nurse consultant:

- Research and analytical skills
- Educating attorneys with medical facts related to a case
- Specialization in fields such as personal injury, medical malpractice, probate and worker's compensation
- Knowledge of the legal system and medical field
- A legal nurse consultant must liaise between physicians and clients and attorneys while educating attorneys on case-related medical facts.

Forensic nurse educator:

- Teaching classes across multiple specializations
    - Child maintenance or abuse
    - Elder abuse
    - Domestic violence
    - Adult and pediatric SANE
    - Evidence collection and management

Nurse Attorneys/Legal Nurse Consultants Goals

- To establish a leadership role in health care policy making.
- To influence health care social policy, health care legislation and nursing practice acts.
- To educate the public about health law issues.
- To educate the public about nurse attorneys.
- To educate nurses about the legal system.
- To represent the public; client advocate.

What they do?

Identification and reporting along with health care

Identification is necessary in

(1) Living persons.
(2) Recently dead persons.
(3) Decomposed bodies.
(4) Mutilated and burnt bodies.
(5) Skeleton.

Who can become a forensic nurse?

- Indian Nursing Council prescribed a detailed curriculum for forensic nurse practitioner
- The basic qualification is a BSN with RN RM registration of any state of India and having minimum one year experience after under graduation
- According to INC, they can play an important role in bridging the gap between the law and medicine.

Nurses trained in this field can document injuries, collect biological fluids, and preserve clothing with evidence of assault, counsel victim, provide compassionate care to victims and family

What INC says----??

- Forensic nursing combines nursing practice and forensics in the scientific investigation of death and injury resulting from criminal activity and accidents.
- In addition to providing care, forensic nurses act as multidisciplinary team members with and consultants to other nursing and medical professionals and law enforcement.
- They receive advanced training in collecting and preserving evidence, treatment protocols, and legal proceedings and testimony.
- The specialized training that forensic nurses receive related to both the medical and legal needs of these patients drives demand for the specialty.

- Crime victims face a higher risk of Post- traumatic stress disorder, depression, suicide, and medical complications than other patients; forensic nurses improve both legal outcomes and quality of life for these patients relative to standard emergency care in ED
- Forensic nurses also assist in providing professional insight to potential causes of patient injuries in situations in which witnesses are unavailable.
- In addition to documenting obvious injuries, forensic nurses specialize in looking for subtle signs of assault, such as petechiae, voice changes, and loss of bowel or bladder function
- Forensic nurses document patient injuries through tools including cameras, measuring tapes, fluid swabs, rape kits and a high-powered light that can reveal hard-to-see bruises and fluids like semen, urine, or saliva.
- They can document every injury for potential use as evidence in a later court case, where they may be called as an expert witness to testify to the injuries.

Course of study

Subject	Subject Theory	Practical
Paper I - Forensic Nursing – I Including i. Fundamentals of Forensic Nursing ii. Medico – legal Investigative Aspects of Nursing	210 Hours	
Paper II - Forensic Nursing-II Including i. Clinical and Forensic Psychology ii. Forensic Psychiatry	200 hours	
Paper III - Supervision and Management, (Clinical teaching) and (Elementary Research and Statistics)	90 Hours (30+30+30)	
IV. Internship		160 Hours
TOTAL	**500 Hours**	**1440 Hours**

Clinical experience

Sl. No	Area of posting	Duration
1	Counselling Centres	4 weeks
2	Casualty, Emergency and Trauma Centre	4 weeks
3	Forensic department (Autopsy dept., Pathology dept etc.)	8 weeks
4	Forensic Lab	8 weeks
5	Police Administration	4 weeks
6	Witnessing different court proceedings	4 weeks
7	Organ Transplant centres	2 weeks
8	Fertility centres	1 week
9	Toxicology unit	1 week
10	Correctional facilities	2 weeks
	Total	38 weeks

Certification

- Forensic Nurse/ Forensic Nurse practitioner course of approved university that is recognized by Indian Nursing Council
- POST GRADUATE DIPLOMA IN FORENSIC NURSING

Module 3

Forensic Nursing in emergency department

Introduction

Forensic nursing skills are needed by nurses in every healthcare setting as it the
is not limited to just nurses who choose to specialize in this field of medicine. In the ER, you may encounter rape victims, child abuse and elder abuse as well as domestic violence cases. There may be hit and run accidents or gunshot wounds. Victims of hit and run accidents and gunshot wounds are likely to make it into an OR where you might be working, or sent home with complex dressings that you will need to teach and monitor as a home health nurse. In all these scenarios, the evidence collection can make or break a case for a patient who has been the victim of a crime; or worse yet committed the crime.

- The ED is the portal that funnels victims and perpetrators of violent crimes into the healthcare system
- Emergency department (ED) nurses care for victims of trauma almost daily.
- ED is chaotic when a trauma patient arrives and staff members must do everything possible to save the patient's life
- Preservation of evidence is also crucial when it is a forensic patient
- An integral responsibility of the staff nurse is collection and preservation of forensic evidence
- Emergency nurses must be trained for evidence recognition, handling of clothing, gross/trace evidence, documentation, packaging of evidence, and use of the “chain-of-evidence” form.

Objectives

- List the types of forensic patients attending ED
- List the types of evidences in ED
- List the collection techniques of evidences
- Explain the handling and preserving evidences
    - Packing of evidences
    - Registration of evidences
    - Use of chain of evidences
    - Verify the integrity of chain custody
    - Report development and report writing
    - Counseling victims and relatives
    - Maintain documents
    - Expert Testimony

Forensic Patients in the Emergency Department

Who is a forensic patient?

- A forensic patient is any client or that person's significant others whose nursing problems bring him or her into actual or potential interaction with the legal system. patients.Hoyt (1999)
- A large number of emergency department patients require collection and preservation of evidence (Pasqualone, 1998).
- Pasqualone identified 24 types of forensic patients attending a general hospital
- They are:
- 1. Occupational injuries. 2. Transportation injuries. 3. Substance abuse. 4. Personal injury. 5. Child abuse and neglect 6. Forensic psychiatric admission 7. Environmental hazards 8. Assault and battery 9. Abuse of the disabled 10. Human and animal bites 11. Questioned death cases. 12. Elder abuse and neglect 13. Domestic violence. 14. Clients in police custody 15. Sexual assault. 16. Sharp force injuries. 17. Product liability. 18. Transcultural medical practices 19. Organ and tissue donation. 20. Burns over 5% body surface area 15. Sexual assault 16. Sharp force injuries 17. Product liability 18. Transcultural medical practices 19. Organ and tissue donation. 21. Firearm injuries. 22. Food and drug tampering. 23. Gang violence. 24. Malpractice or negligence.

Types of forensic cases in India

- All cases of injuries and burns
- All vehicular, factory or other unnatural accident cases specially when there is a likelihood of patient's death or grievous hurt.
- Cases of suspected or evident sexual assault.
- Cases of suspected or evident criminal abortion.
- Cases of unconsciousness where its cause is not natural or not clear.
- All cases of suspected or evident poisoning or intoxication.
- Cases referred from a court or otherwise for age estimation.
- Cases brought dead with improper history creating suspicion of an offense.
- Cases of suspected self-infliction of injuries or attempted suicide.
- Any other case not falling under the above categories but has legal implications.

Role of forensic nurse in Emergency department

1. PROCEDURE FOR REGISTERING A MEDICO LEGAL CASE

- TREATMENT (All legal formalities to be suspended till the patient is resuscitated)
- IDENTIFICATION (Whether the said case falls under Medico Legal Case or not)
- INTIMATION TO POLICE (if it does fall in this category, then he must register the case as an MLC and/ or intimate the same to the nearest police station, either by telephone or in writing.)
- ACKNOWLEDGEMENT RECEIPT (From the police should be received for future reference.)

2. REPORTING OF MEDICO LEGAL CASE

- Reports must be prepared in duplicate on proper pro-forma giving all necessary details
- Avoid abbreviations, over writings. Correction if any, should be initiated with date and time.
- Reports must be submitted to the authorities promptly.
- Medico-legal documents should be stored under safe custody for 10 years
- Age, sex, father's name, complete address, date and time of reporting, time of incident, brought by whom.
- Identification marks and finger impressions
- All MLC to be informed to the police for taking legal evidence
- If the patient is dying, inform the magistrate to record 'dying declaration'.

3. Evidence Collection

- History Collection: The evidence collection process begins with taking a thorough history
- The medical record is a tool that may result in the conviction of an assailant if the case ever goes to court.
- Clearly document all findings, interventions, and actions in a legible manner
- Record what the patient says verbatim enclosing in quotation marks as needed.
- Record a description of the incident as the patient relates it, and history or incidents of prior abuse if applicable.

1. History Collection:

- The nurse should document statements exactly as they are made without bias, alteration, or interpretation.

Use open-ended questions to obtain the most information

- If the patient is reluctant to speak frankly or it seems they are not telling all the truth
- Document the patient behavior using objective language.
- Include other areas of physical or mental concern that may relate to the abuse.
- Include the name and as much demographic information as possible about the abuser and their relationship to the victim
- The nurse should document statements exactly as they are made without bias, alteration, or interpretation.
- Use open-ended questions to obtain the most information
- Document the patient behavior using objective language.
- Include other areas of physical or mental concern that may relate to the abuse.
- Include the name and as much demographic information as possible about the abuser and their relationship to the victim
- Document injuries as completely and thoroughly as possible noting location, size, shape, color, and apparent age.
- Also, include anatomical charts and color photographs of the injuries before treatment

2. Photography

- If photographs are taken, attach a consent form to the chart and use a Polaroid or digital camera to take the images.
- One photograph should be a full body shot that includes the victim's face.
- Include a torso image and close-ups of all bruises and wounds.
- Include two shots of each injury taken from two different angles with a reference device such as a ruler in the picture to indicate size of the wounds.
- On the back of the photograph write the patient name, medical record number, date and time of the photograph, name of the photographer, location, and names and titles of witnesses.
- The photographer should sign the photograph.
- One the back of the photograph indicate the location of the injury and the subjects stated cause of injury.
- Torn and damaged clothing also may be photographed.

- Document injuries not clearly indicated by photographs on a body chart.
- Preserve any damaged clothing, jewelry, or weapons using the chain of evidence protocol.
- If the patient has been sexually assaulted, and has wounds to the genital area, careful draping of the patient and close up photography of the injuries can preserve patient dignity.
- Be certain to document the patient's name and the exact location of the injury on the photograph

3. Describing and Diagramming

- A written description of assessment findings including details about the patient injuries must be made according to an institutional policy.
- Precision is important - wounds should be measured in centimeters and described according to size, shape, appearance, and location using a readily recognized landmarks.
- Signs of abuse or neglect can be subtle and may not be immediately recognized.
- For elderly patients, fractures, abrasions, decubitus ulcers, or dehydration should be documented because these can be signs of abuse or neglect.
- The descriptions of wounds should be made using medical terminology and should be specific and accurate.
- A laceration is a tear of the skin or tissue that occurs when external blunt force is applied.
- A laceration has marginal abrasion and the tissue bridging, where as a cut severs the tissues cleanly and there is no bridging.
- A body charts should be used to describe the exact location of a person's injuries.
- Diagrams are visual supplements to written assessment findings.
- Drawings are also important to show the relationship of injuries one to another and provide a pattern of wounds present.
- Objective and detailed information

Body charts and identification data that can be used for describing and diagramming

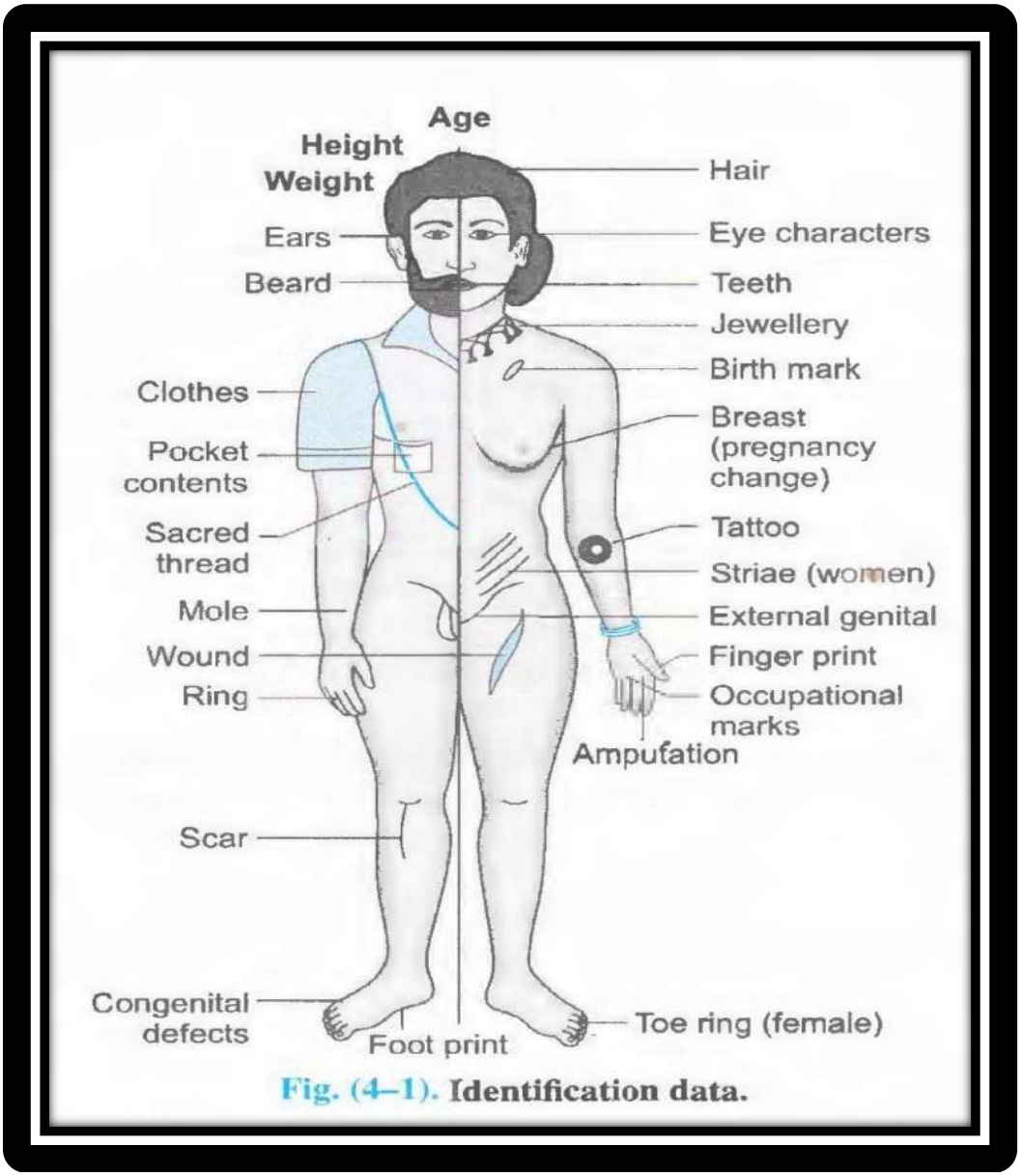


Fig. (4–1). Identification data.

	Trait	Male	Female
(1)	Gonads:	A functioning testis. The penis, prostate, etc., are only appendages.	A functioning ovary. The uterus, vagina, etc., are only appendages.
(2)	Build:	Larger with greater muscular development.	Smaller with less muscular development.
(3)	Shoulders:	Broader than hips.	Narrower than hips.
(4)	Waist:	Ill- defined.	Well defined.
(5)	Trunk:	Abdominal segment smaller.	Abdominal segment longer.
(6)	Thorax:	Dimensions more.	Shorter and rounded.
(7)	Limbs:	Longer.	Shorter.
(8)	Arms:	Flat on section.	Cylindrical on section.
(9)	Thighs:	Cylindrical.	Conical due to shorter femur and greater deposition of fat.
(10)	Gluteal region:	Flatter.	Full and rounded.
(11)	Wrists & ankles	Not delicate.	Delicate.
(12)	Breasts:	Not developed.	Developed.
(13)	Public hair:	Thick and extends upward to the umbilicus(rhomboidal).	Thin, horizontal and covers mons veneris only (triangular).

(14)	Body hair:	Present on face and chest.	Absent on face and chest.
(15)	Head hair:	Shorter, thicker and coarser.	Longer, thinner and finer.
(16)	Larynx:	Prominent. Length 4.8 cm.	Not Prominent. Length 3.8 cm.

Useful data for describing in reports

4. Documentation & Chain of evidence

- Remember that documentation is an important part of the chain of evidence and should include:
- Site and time of assault.
- Nature of physical contacts.
- Race and number of assailants.
- Relationship to assailant(s).
- Weapons and restraints used.
- Actual and attempted penetration of which orifice by penis, objects or fingers.
- Ejaculation, if known, and where.
- Use of condom.
- Activities of the victim that may have destroyed evidence, such as bathing, douching, bowel movement.
- Consenting sex within the last 72 hours and with whom.
- Use of tampon.
- Change of clothes.
- Contraceptive use.
- Current pregnancy.
- Allergies.
- Victim’s general appearance and response during exam.
- Physical injuries.

1. Collecting Physical Evidence

- Dr. Edmond Locard developed a theory of evidence called Locard’s principle of exchange.
- It is universally followed.

- This theory states that criminals leave marks of their passage while on the other hand at the same time by inverse action take with them on their body or clothing evidence of his deed.
- Whenever there is contact between two objects mutual exchange of material occurs
- Physical evidence is defined as any object or part of an object showing that a crime has occurred or establishing a relationship between a victim and a perpetrator.
- Physical evidence can be tangible or transient such as redness or trace body fluids.
- Clothing, footwear, hairs, fibers, stains, bullets, sharp objects, physical injuries, and laboratory specimens are all classified as physical evidence.
- Gloves are always worn during the handling of all physical evidence.
- Gloves should be changed often during evidence collection.
- Label all packages used to collect evidence with the date, time, patient's name, description, and source of the material including the body location.
- Also, include the name of the healthcare provider, and names with initials of everyone who handled the material.

2. Collecting Forensic Evidence from Clothing

- The clothing must be removed carefully because it can contain hair, fibers, or other trace evidence.
- If the patient is ambulatory, they should remove one item of clothing at a time while standing over a clean sheet or piece of paper placed on the floor.
- This sheet should be covered with a second clean sheet or piece of paper to capture evidence that may fall from the clothing of the person.
- This top sheet is folded and packaged separately.
- If clothing must be cut off, out cutting through any tears, holes, or defects in the fabric.
- Avoiding excessive, shaking, or handling, place each item in a bag as it is removed and seal the bag.
- Each item must be placed in a separate paper bag to prevent cross-contamination.
- Plastic bags are not used because moisture can form within the bag and degrade the evidence.
- If any hair, fibers, or debris clings to the clothing, do not remove it,
- Air-dry any wet clothing before it is packaged.
- Place protective paper between stains to prevent them from touching.
- Shoes are also included in the collection of clothing.

3. Collection of Body Evidence

- Forceps with plastic coated tips are used to carefully remove hair, fibers, or other debris from the body.
- Each item is placed in a separate paper envelope.
- Dry surface debris is gently scraped onto a glass slide.
- Any sharp objects that are retrieved such as glass, needles, or knives are placed in a double peel pouch.

- A double peel pouch is a heavy polyethylene pouch with a tamper evident seal.
- Plastic, cardboard, or glass containers may also be used for the collection of sharp objects.
- Evidence that is on the hands can be preserved until processing by securing paper bags over the hands.
- Evidence beneath the fingernails may be collected by swabbing, scrapping, or clipping the fingernails.
- The evidence is placed into paper envelopes, if paper envelopes are not available, then the fingernails or scrapings along with the swab or orange stick used to collect them are placed in the center of a clean piece of paper, which is folded and sealed.
- Comb the hair carefully to remove evidence that cannot be visibly seen.

4. Bullets

- Bullets should be wrapped in gauzed to preserve the evidence and then placed inside another container such as a cup, envelope, or bag.
- Do not use metal instruments to touch bullets.
- If gunpowder residue is present, use a piece of tape to collect the residue and then apply it to a glass slide.
- remove bullets or fragments with plastic-shielded forceps and handle as little as possible

5. Body Fluids

- Use a high intensity lamp to visualize stains on the skin or the presence of saliva, semen, urine, or blood.
- Dry secretions are collected by moistening a swab and rubbing over the stains.
- The swab is air dried before packaging.
- Bite marks are first photographed and then swabbed.
- If the victim has been sexually assaulted, swab body orifices for evidence, collecting as much secretion as possible.
- The samples should be taken before drinking, smoking, eating, or voiding to prevent contamination and loss of evidence.

Toxicology screening

- Laboratory specimens for toxicology screens and DNA reference samples should be collected from the victim.
- In many cases after a rape or molestation, seminal fluid may not be present.
- This may be due to a variety of factors.
- Rapists or molesters may use foreign objects or fingers to commit the rape or molestation.
- Blood, saliva and semen are usually used for DNA testing

- As many as 40% of rapists are thought to use condoms during the commission of their crime.
- Another 34% are thought to be sexually dysfunctional.
- Seminal fluid is usually examined for the presence of sperm, but sperm will not be present if the perpetrator has had a vasectomy.
- The presence of seminal fluid can still be verified by measuring the amount of acid phosphatase present.
- Acid phosphatase is usually found in high levels in seminal fluid but in low levels in vaginal secretions.

Preservation of Evidence

- The following steps will be taken to preserve evidence:
    - do not move anything unless absolutely necessary
    - to the extent possible, avoid contaminating evidence
    - photograph or video record the scene as well as individual objects before moving anything
    - protect forensic evidence from the elements
    - record and identify any evidence found or moved (i.e. what, where, by whom and when)
    - maintain evidence in possession of the person who seized it until it can be handed over to police or properly stored using the Contraband/Unauthorized Item Seizure Tag
    - keep each piece of evidence separate from other pieces of evidence in order to prevent cross-contamination
    - use a paper bag for blood-stained items
- Isolate witnesses from each other and from other persons, and record their statements on the Statement/Observation Report in the prescribed format
- Do not disturb a computer when it is part of an incident scene, and immediately notify both the Chief, IT Client Services, and the Manager, Information Technology Security
- When a computer is part of an incident scene and there is an apparent attempt to alter computer evidence (such as a rapidly blinking hard drive access light), turn the computer off as quickly as possible and protect it from contamination

- When a cell phone or other mobile device(s) is part of an incident scene, take precautions to safeguard the information on the device by turning off the device as quickly as possible, removing the SIM card (if applicable) and contacting the Institutional Operations
- Secure range tapes and Main Communication Control Post recordings following a suicide or any other incident that is likely to result in a national investigation.

Chain of Custody-forensic nurse's role

- *Chain of custody* refers to the paper trail that ensures the integrity of evidence, by documenting who has handled the evidence in every step of collection and processing.
- The chain of custody will be closely scrutinized in court, and if it is broken or compromised, may be subject to challenge and allegations of tampering or mishandling.
- The chain of custody begins as soon as the nurse locates and collects evidence.
- Regardless of whether the nurse has proper training in forensics, the nurse must initiate and maintain the chain of custody for this evidence.
- The chain of custody is initiated by labeling each item of sealed evidence with the patient's name, the item description, the source of the material including the anatomic location, the name of the person sealing the evidence along with the date and time, the names of the persons releasing and receiving the evidence and the time that the transfer took place.

Appearing In Court-Expert witness

- The nurse who applies forensic principles by recognizing and preserving evidence must also be able to be present when the evidence goes to trial.
- The patient who has been the victim of a criminal act has the right to expect that their health care providers are prepared and capable witnesses.
- One of their purposes for appearing in court is to verify the chain of custody of the evidence, and to authenticate the process of evidence collection.

Role in Crisis Intervention

- Other major areas of consideration include crisis intervention, mental health assessment, and follow up counseling.
- Community resources that can provide on going assistance to the victim should be provided whenever possible.
- Assess the victim's safety for returning home.
- Follow you state's mandated reporting guidelines.

- Victims of assault often experience ongoing fears and anxieties that may severely affect their overall functioning on a daily basis as well as their personal and social relationships.
- Victims are prone to develop long term physical and mental health issues including depression and PTSDs
- The victim should be strongly encouraged to receive counseling.

Forensic nurses in ER- in nutshell

- Identification
- Care for the Survivor
- Care for the Perpetrator
- Identification & Collection of evidence
- Clothes
- Injury and patterns of injury
- Documentation
- Injury- Measurements in centimeters, Location, Description & Photography

Responsibilities

- Forensic nurses have a variety of responsibilities such as:
    - treating and educating patients,
    - examining prospective suspects as part of an investigation,
    - providing crisis intervention to patients,
    - using forensic photography to recover evidence, and referring patients to ongoing programs.
    - responsible for serving victims to assist with crime-related injuries and testifying in court as a fact witness or as an expert.
    - providing testimonies in court as expert witness

Conclusion

- Nursing professionals, who are on the front line in the care of patients in emergency services, in addition to having specific attributions to preserve life and reduce sequelae, must collaborate with the preservation of the traces present in the victim, in the possible aggressor, in the objects and at the crime scene.

- Such traces, of high presence in Nursing care in emergency services, are essential elements for the success of the criminal investigation and for integrity of the chain of custody, as such chain consists of maintenance and documentation of traces, from their identification, collection, possession and handling until their disposal

Study questions

1. **Which of the following examples is NOT a good example of the nurse's collection and preservation of evidence?**

a. Measuring the wound in centimeters
b. Using photographs instead of written documentation
c. Documenting statements exactly as the victim stated them
d. Marking a wound on a body diagram

2. **Which statement by the victim should be documented that might compromise the evidence to be collected?**

a. I took a shower immediately after the men raped me.
b. I tried fighting them off as best I could.
c. I came to the emergency room as fast as I could.
d. I grabbed a wad of hair from one of the men.

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Identifiy basic steps in evidence collection.

2. Recognize the importance of chain of custody.
3. Recognize the need for all nurses to be familiar with evidence collection.

Introduction

- Importance of power dynamics
    - The deep root cause of injustice is very well understood by nursing professionals.
    - The very nature of the work of forensic nurses is grounded in social justice.

MIMS COLLEGE OF NURSING

Vadakkedathparamba, Puthukode PO, Vazhayoor,

Malappuram, Kerala,

NURSING DOCUMENTATION

CREDIT HOURS : 15

Date: 12/12/2022 & 13/12/2022

Participants : **Fourth Year Nursing Students**

Course Coordinator:

Dr. Assuma Beevi T.M

Nursing Documentation

Introduction

Quality documentation and reporting are necessary to enhance efficient, individualized client care (Potter, Perry, Ross-Kerr, & Wood, 2006). Documentation is not separate from care and it is not optional. It is an integral part of registered nurse practice, and an important tool that RNs use to ensure high-quality client care. Documentation is an evidence that shows the care given. If the given care is not documented then there is no evidence to prove that care is given.

What is a Nursing Document?

- Any written or electronically generated information about a client that describes client status or the care or services provided to that client.
- "Care not documented is care not done."

Why nursing documentation?

- Nursing Documentation is that part of the clinical record written by nurses and is the total written information concerning patient's health status, nursing needs, nursing care, and response to nursing care.
- Key components are:
    - assessments, nursing diagnoses, planned care, nursing interventions, patient teaching, patient out come, and interdisciplinary communication

Purposes of documentation

- Communicating and Providing Continuity of Care
- Accountability/ professional responsibility
- Legal Document
- Financial billing/ reimbursement
- Education
- Research

- Risk Management/ audit /monitoring/ quality assurance
- Facilitating Evidence-Based Practice

GUIDELINES FOR DOCUMENTATION

- Objective/Factual Documentation
- Timeliness
- Use of Space
- Use of Abbreviations
- Follow-up
- Correcting Errors
- Recording Medication Administration
- Recording Assistance with Care
- Designated Recorder in Emergency Situations
- Clarification of Orders
- Recording a Telephone orders
- Interactions with other Health-care Professionals
- Client Education
- Documenting an Incident in the Health-care Record

Objective/Factual Documentation

- Documentation should be relevant related to client care, not opinions or assumptions.
- Objective documentation is the result of direct observation and measurement.
- For example, if a client was suctioned, the documentation would include why the client needed suctioning, what the outcome was, and the client's response to suctioning.
- Recording should be : CC FLAT
- Concise, complete, factual, legible, accurate and timely.
- Use only appropriate terminology.
- Use a consistent format for documentation

- Take credit for care given and sign completely using first initial, full legal surname and designation

Timeliness

- **Documentation of an intervention should never be completed before it takes place.**
- Documentation in chronological succession reveals change pattern in a client's health status
- The frequency and amount of detail documented are dictated by:
- facility/agency policies and procedures
- the complexity of the health problems
- the degree of client's health risk and risk of procedure/ care

For very ill and patients with unstable health care needs and unpredictable outcomes require more comprehensive, in depth and frequent documentation

	Low	Medium	High
Acuity			
Complexity			
Variability			
Frequency of documentation			

Use of Space

- Documentation must not have empty lines or spaces, and the time when assessments and interventions were completed must be noted.

Use of Abbreviations

- Nurses need to know what abbreviations are acceptable in their agency and use only accepted abbreviations

Follow-up

- Follow-up of assessments, observations or interventions must be recorded
- Failed attempts to reach a physician or other care provider, the follow-up action taken, and the client's response to interventions etc need to be documented

Correcting Errors

- To correct an error in a paper-based health-care records system use SLIDE Rule (cross through the word(s) with a single line, and insert your initials, along with the date and time) then enter the correct information/explanation**.**
- Some hospital uses other format like writing void/ error/ mistaken entry etc along with the initials of RN

Recording Medication Administration

- Document the administration of medications immediately after its administration.
- The person administering medicine only should document it.
- *No proxy documentation of medication is allowed.*
- RNs should only record medications they have administered themselves.
- Pertinent information to record :
- Related to the *process of administering* medications
- i.e., self administration, client questions, client refusal of medication.
- Related *interventions*-i.e., client education, communication with a prescriber.
- *Outcomes of care* -i.e., therapeutic drug response, side effects.

Recording Assistance with Care

- When a RN assists another RN in providing care (e.g., when assisting another RN to ambulate a patient or insert an IV), the RN providing care documents the actions and the client's responses and notes that another care provider assisted.
- Not required to name the person who assisted
- In critical incident such as a fall, record the name of the person assisted

Designated Recorder in Emergency Situations

- When acting as a designated recorder, the recorder identifies the persons involved and the care they provided

Clarification of Orders

- Never guess or rely on group consensus to interpret an order.

Recording telephone orders-

- Nurses should clearly record the medicines by clarifying even the spelling with dose and route with time and date.
- Put the signature of the RN with RN number and write telephonic order/ prescription.
- It must be get countersigned by the physician at the earliest on arrival to the unit
- Write down the time and date on the physician's order sheet.
- Write down the order given by the physician.

- Read the order back to the physician to ensure it is accurately recorded.
- Record the physician's name on the physician's order sheet, state "telephone order,"
- Print your name, sign the entry and identify your status (e.g., RN).

Interactions with other Health-care Professionals

- **Record the outcomes or agreed upon plans of action and the names of the people involved**
- When it is needed?
- developing care plans,
- documenting on flow sheets,
- completing narrative or computerized documentation, or participating in team or family conferences

Client Education documentation

- Document all client education with the extent of the client's understanding
- Written education entries should include:
- A brief description of the material taught
- The method(s) used for teaching (e.g., written, visual, verbal, auditory, and Instructional aides used)
- The involvement of and the interaction between client and family in the Teaching/learning process, and evaluation of the teaching objectives with validation of client comprehension and learning
- Signed the entry with date and time.

Example- Client education

Date/time	topics	remarks
13/03/2014 10.a.m	Orientation to the unit	Explained – physical set of the ward, location of nurses station, office, billing section, pharmacy, toilets, routine meal times, calling systems Checked the understanding of the client and relatives. expressed their understanding by answering questions

1.00 p.m	Diabetic diet	Discussion with charts on foods that can be taken Made calculation of calories of food items Patient and relative expressed their understanding and asked clarification of calorie calculation

Documenting an Incident in the Health-care Record

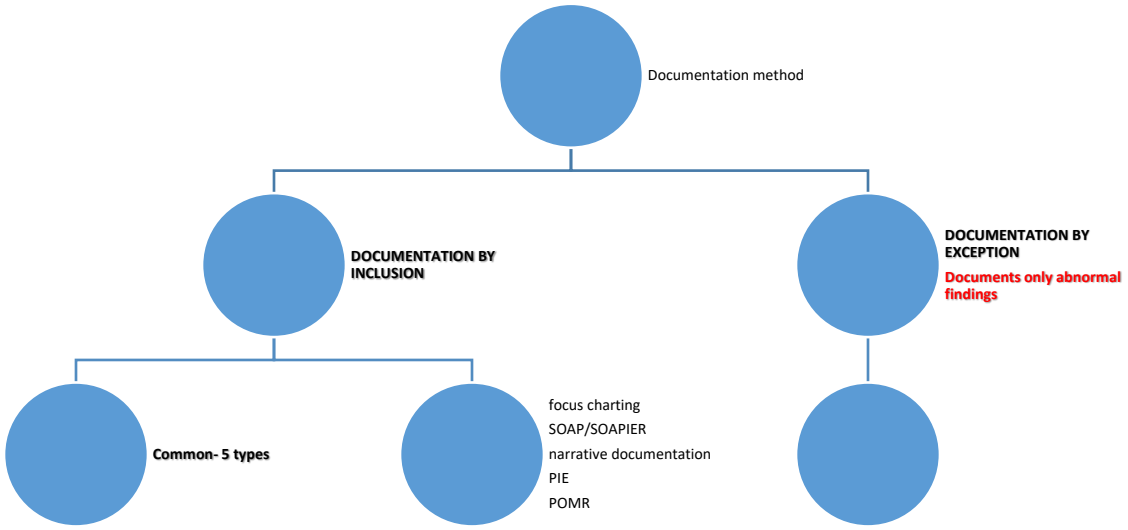
- Pertinent data should be documented on the health-care records of the client(s) involved in the incident
- Be concise, accurate and objective.
- Record what was seen, and describe the care provided, who else was involved and the client's (person's) condition.
- Do not try to guess or explain what happened (e.g., the RN should record that side rails were not in place, but should not write that this was the reason the client fell out of bed).
- Record the actions taken by other health-care providers at the time.
- Do not blame individuals in the documentation.
- Always record the full facts.

Example- incident report

Date / time	Incident	Remarks
13/03/2014 11.a.m	Fall in the bath room	Mrs.A had a fall in the bath room. She was assisted to get up from bed and accompanied to bath room. After making her to seat on the toilet as she insisted to leave alone. After repeated warning , too she insisted the nurse to be out. After toileting while she was getting up from the seating she had fallen down. The door was not locked and I called for help and entered to the toilet and helped her to get up. Mrs. R, SN helped me to bring her back to the bed. Her vitals were

		checked and assessed for injury. No injury was found and the patient was stable. Still informed the doctor and had a physician check up. Ms. L/ SN. 9607

DOCUMENTATION METHODS



F O C U S C H A R T I N G

- Here, the nurse identifies a "focus" based on client concerns or behaviors. (client centered)
- Work best on acute care setting
- Determined during the assessment. For example, a focus could reflect:
- A current client concern or behavior, such as decreased urinary output.
- A change in a client's condition or behavior, such as disorientation to time, place and person.

- A significant event in the client's treatment, such as return from surgery.
- Typically writes each focus as:
- A nursing diagnosis (ie. Risk for infection)
- A sign or symptoms (ie. Chest pain)
- A patient behavior (ie. Unable to ambulate)
- A acute change in the clients condition (loss of consciousness)
- Or A significant event (surgery)

F O C U S C H A R T I N G- Progress notes-

- The assessment of client status, the interventions carried out and the impact of the interventions on client outcomes (progress notes) are classified under 3 headings: (DAR)
- **D**ata (D)
- **A**ction(A)
- **R**esponse(R)
- **Data**: Subjective and/or objective information that supports the stated focus or describes the client status at the time of a significant event or intervention.
- **Action:** Completed or planned nursing interventions based on the nurse's assessment of the client's status.
- **Response**: Description of the impact of the interventions on client outcomes.
- Continue to record routine nursing tasks on flow sheets and check lists
- Flow sheets and checklists are frequently used as an adjunct
- to document routine and ongoing assessments and Observations such as personal care, vital signs, intake and output, etc.
- Information recorded on flow sheets or checklists does not need to be repeated in the progress notes.

Pros of focused charting

- Flexible enough to adapt to any clinical setting
- Centers on nursing process
- Information on a specific problem is easy to find
- Encourages regular documentation of Pt responses
- Helps to organize the thoughts and document succinctly and precisely

Cons of focused charting

- Staff may need in depth training if they are used to charting with another system
- Need to use many flow sheets and check lists which can lead to inconsistent documentation
- If forgotten to include the patient's response to interventions, focus charting resembles long narrative charting

Sample- focused charting

Date	Time	Focus	Progress notes
13/03/2014	8.30 a.m	Knowledge deficit	D- Pt states that she does not know what her diagnosis means A- Illness explained to Pt according to her level of understanding. Pt taught symptoms she may expect and why she is having current symptoms. Treatment and procedures explained R- Pt verbalized better understanding of her illness
13/03/2014	10.a.m	Anxiety	D- Pt states I am afraid of all this blood A- Emotional support provided. Encouraged verbalizations. Explanation given regarding treatment and procedure Family into provide support R- Pt observed talking and laughing with family. States she feels less anxious

S O A P / S O A P I E (R) C H A R T I N G

- It is a problem-oriented approach to documentation
- The nurse identifies and lists client problems;
- Documentation then follows according to the identified problems.
- S = subjective data (e.g., how does the client feel?)
- O = objective data (e.g., results of the physical exam, relevant vital signs)
- A = assessment (e.g., what is the client's status?)
- P = plan (e.g., does the plan stay the same? is a change needed?)
- I = intervention (e.g., what occurred? what did the nurse do?)
- E = evaluation (e.g., what is the client outcome following the intervention?)
- R = revision (e.g., what changes are needed to the care plan?)
- Similar to focus charting, flow sheets and checklists are frequently used as an adjunct to document routine and ongoing assessments and observations.

N A R R A T I V E C H A R T I N G

- Narrative charting is a method in which nursing interventions and the impact of these interventions on client outcomes are recorded in chronological order covering a specific time frame.
- Data is recorded in the progress notes, often without an organizing framework.
- Narrative charting may stand alone or it may be complemented by other tools, such as flow sheets and checklists.
- ***Use narrative when something goes wrong, during a code, trauma's in the ER. etc***

Pros of narrative charting

- Most flexible charting system
- Suitable in any clinical setting
- Strongly conveys the nursing intervention and client responses

- Combines well with other documents
- **Cons**
- Reading entire repots time consuming
- Difficult to track problems
- No specific guide for writing
- May contain vague or inaccurate language

Example

- **Ms. G. H. is a 74-year-old female** who was admitted to an acute-care facility from a long-term care facility. Her history includes a cerebrovascular accident 2 years ago, resulting in weakness of the left leg. She was admitted to the acute care facility 2 days ago with a diagnosis of left lower lobe pneumonia.

Date	Time	Notes
13/03/2014	8.30 am	Pt 4 hours post op: awakes easily, oriented X3 but groggy. Incision site in LLQ, 5cms, without dressing, no bleeding, sutures intact. Pt denied vomiting but stated she nauseated. Vomited 100 ml of clear fluid. Pt attempted to get OOB to ambulate to the bathroom with assistance, but felt dizzy upon standing. Assisted to lie down on bed. Voided 200ml clear, yellow urine in bed pan. Asha.S. RN.RM
13/3/2014	10 am	Pt continues to feel nauseated. Phenergan 5 mg IM in R. ventrogluteal Asha.S. RN. RM
13/3/2014	12 noon	Pt states that she is no longer nauseated, remains pain free. No further vomiting Asha.S RN.RM

Use of Technology

- Technology may be used to support client documentation in a number of ways.
- If technology is used, the principles underlying documentation, access, storage, retrieval and transmittal of information remain the same as for a traditional, paper-based system

E L E C T R O N I C D O C U M E N T A T I O N

- As with traditional or paper-based systems, documentation in electronic health records must be comprehensive, accurate, timely, and clearly identify who provided what care ,with all details .
- Reduces time spent on documentation and increases accuracy
- Helps to identify client education needs
- Supplies data for nursing research and education
- Each person would have their computer ID
- These codes helps to maintain client privacy

Pros and cons

- Pros
- Storing and retrieval of information is fast and easy
- Can constantly update information
- Uses standard terminology which improves communication among HCP
- Always legible
- Can send request slips and client info from one terminal to another very fast
- If security measures are neglected, can threaten client confidentiality
- Standard phrases and limited vocabulary can make info inaccurate or incomplete
- Some people have trouble adjusting to computers
- Charting can take extra time if too many nurses try to chart on too few terminals
- Expensive to initially establish the system

Electronic documentation policies

- Should explain how:
- Correcting documentation errors or making “late entries”;
- Preventing the deletion of information;
- Identifying changes and updates to the record;
- Protecting the confidentiality of client information;

- Maintaining the security of the system (passwords, virus protection, encryption, firewalls);
- Tracking unauthorized access to client information;
- Processes for documenting in agencies using a mix of electronic and paper methods;
- Backing-up client information; and means of documentation in the event of a system failure.

Forms of documents that nurses handle

- Nursing assessment sheet
- Nursing care plan
- Nurses progress notes
- Vital signs
- Fluid balance chart
- Medicine/ Drug chart
- Procedure note
- Informed Consent
- Incident/accident Form
- Discharge plan

Hospital/ Ward: Date:

Hospital Number:

Surname:

Forenames:

Date of Birth:

Sex:

Fluid intake					Fluid output				
Time(hrs)	Oral	IV	Other (specify route)		Urine	Vomit	Other (specify)		
01.00									
02.00									
03.00									
04.00									
05.00									
06.00									
07.00									
08.00									
09.00									
10.00									
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19.00									

20.00									
21.00									
22.00									
23.00									
24.00									
TOTAL									

PRINCIPLES OF DOCUMENTATION

DOCUMENTATION MUST BE CONSISTENT WITH PROFESSIONAL AND AGENCY STANDERDS, COMPLETE, ACCURATE , CONCISE, FACUAL, ORGANIZED AND TIMELY, LENGTHY, PRUDENT AND CONFIDENTIAL.

Directives for Documentation

What is a directive?

- Directive is a legal guideline/ Standard as per protocol or regulations.
- Different types of directives for documentation , sharing, retention and disposal of documents exists
- Drawn from several sources.
- **1.Statutory regulations**
- **2. Standards of Practice**
- **3. Hospital policies**
- **4. Legal principles**

S T A T U T O R Y R E G U L A T I O N S

- There are no specific laws in India stating specifically how and what nurses must document.
- Hospitals /Agencies generally develop documentation policies which reflect government statutes and/or other relevant documents

Statues are:

Nurse practice act

Hospital policy

Health acts

Medical practitioner's act

S T A N D A R D S O F P R A C T I C E

A standard is a desired and achievable level of performance against which actual performance can be compared

The standard of care is established by the law for the protection of consumers against unreasonable practices which create risk or harm.

Safe Nursing Practice includes an understanding of the legal boundaries in which nurses must function.

Nursing Practice act describe and define the legal boundaries of nursing practice within each state

Nurse practice acts- The responsibilities of the Indian Nursing Council, State Council and University to regulate the standard of the Nursing

- An understanding of the implication of the law supports critical thinking on the Nurses part.
- The role of the Nurses and the ethical dilemmas associated with client care have increased and often becomes legal issues.

Consumer protection Act, 1986- Challenge to nursing profession

- It protects the interests of the consumer.
- Consumer means any person who buys any goods against consideration
- In health care delivery, patient is a consumer.
- People who pay for services only come under the ambit of consumer
- Government institutions do not come under the purview of CPA

CPA- Provisions

- Right to considerate and respectful care.
- Right to information on diagnosis, treatment and medicines.
- Right to obtain all the relevant information about the professionals involved in the patient care.
- Right to expect that all the communications and records pertaining to his/her case be treated as confidential
- Right to every consideration of his/her privacy concerning his/her medical care programme.
- Right to expect prompt treatment in an emergency
- Right to refuse to participate in human experimentation, research, project affecting his/her care or treatment.
- Right to get copies of medical records
- Right to know what hospital rules and regulations apply to him/her as a patient and the facilities obtainable to the patient.
- Right to get details of the bill.
- Right to seek second opinion about his/her disease, treatment,etc.

Why nurses are sued?

- Professionals are people who are socially committed, undergone a course of study in the prescribed format, they earn their living by practicing their profession.
- They are liable to be legal and ethical
- Nurses are professionals bound to practice their profession
- Nursing is a calling
- Nursing is a profession
- Nurses care sick whichever may be the setting
- Nurses takes remuneration for the care
- People who takes remuneration are bound to duty
- if duty is not met standards, they get sued

Negligence

- Negligence is the conduct that falls below the standard of care.
- Professionals such as Nurses, doctors having special skills and knowledge will be sued if negligence occurs.

Common Sources of Negligence

1. **Medication errors** that result in injury to client.
2. **Intravenous therapy** errors resulting is infiltration or phlebitis.
3. Burn to clients caused by **equipment,** bathing, or spill of hot liquids and food.
4. Falls resulting in **injury** to client
5. Failure to use aseptic **technique** where required.
6. Errors in sponge, instruments, or needle count in **surgical cases**.
7. **Failure to** give a **report,** or giving an incomplete report, to an oncoming shift.
8. Failure to adequately **monitor a client's condition**.
9. Failure to **notify a physician** of a significant change in a client's status.

Present scenario

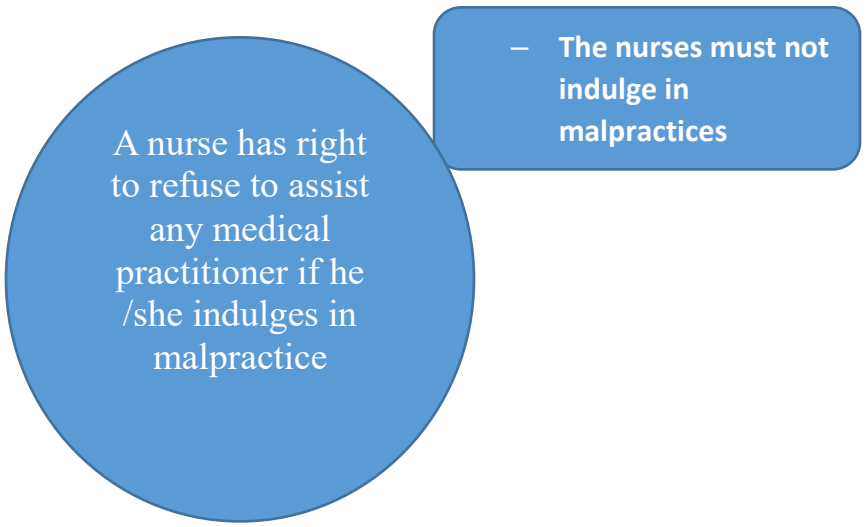
- In previous years, the consumers were hardly moving court cases against nurses, but now, due to commercialization of the nursing profession, there has been mushrooming of nursing schools / colleges.
- The product coming out is far below the standards.
- Graduates from these institutions are not up to the mark; nurses from these institutions have not developed the proper knowledge, right skills, attitude towards their profession.

What should nurses do?

Avoiud litigation- HOW?

- Abide by laws on
- informed consent
- Invasive procedure
- Correct identity of patients, medication

- Proper maintenance of medicolegal records
- Records of observation documentation should be accurate, complete,
- do not cross the line if some error has occurred
- care of valuables and money
- death and dying; birth & death certificate;
- resuscitation; organ donation;
- autopsy;
- Will - the nurse may be asked to witness a will and
- good Samaritan law assisting in a emergency and render reasonable care under such circumstances.



Prevention of Error

1. Reduced reliance on memory by using checklists protocols and computerized decision aids for recording/ documentation.

2. Improved information access with availability of computerized medical record at bedside.

3. Error proofing - use of forcing function in computer programmes so that a physician cannot enter an overdose or prescribe a medication to which the patient is allergic.

4. Standardisation of drug doses and time of administration, of information displays, equipment and supplies location in hospital.

5. Training of HCPs and other staff in safe practice.

Prudent strategies for nurses

1. Read prescription carefully. Physician's prescriptions are at times illegible and lead to litigation and medication errors.

MCI regulation says that physician should write their prescription in capital bold letters.

2. Medication errors occur due to mistakes (knowledge- based or rule-based) and slips of action and lapses of memory.

Focus on the task at hand. Knowledgeable and experienced nurses can easily identify the mistakes.

3. Be careful while administering drugs / doses. Doctor should avoid trailing zeros e.g. 10.0 mg which may be read 100 mg.

4**.** Beware of high-risk situations e.g. elderly patients on multiple drugs.

5. Review basic drug-related information from approved standard textbook.

6. Avoid use of a drug for unproved unlabelled indications especially where risk of drug use is higher than expected benefits.

7. Communicate effectively when patients, families, pharmacists question prescriptions**.**

How Nurses Meet the Professional Standards on documentation

Responsibility and Accountability

- Document all relevant data.
- Ensure that each entry clearly identifies the nurse.
- Be familiar with and use the documentation method used in the agency.
- Advocate for agency policies and procedures that are clear and consistent with documentation standards of the agency.

Code of Ethics: Adheres to the ethical standards of the nursing profession.

- Be familiar with agency policies related to confidential information.
- Safeguard the security of printed or electronically displayed or stored information.
- Dispose of confidential information in a manner that preserves confidentiality (e.g., shredding).
- Act as an advocate to protect and promote clients' rights to confidentiality and access to information
- Use documentation to share knowledge about clients with other nurses and health care professionals.
- Regularly update kardex information and ensure that relevant client care information is captured in the permanent health record.
- Keep the care plan clear, current and useful.
- Self-Regulation: Assumes primary responsibility for maintaining competence and fitness to practice
- Keep current with changes in the documentation method used

Remember to:

- Make sure each page has client ID
- Write legibly
- Use non erasable black ink
- Place date and time at beginning of entry
- Chart observations objectively & in an organized and sequential manner
- End the entry with your professional title
- record all facts
- chart only for yourself-never chart for someone else
- chart while the intervention is in progress or after it is completed-you would chart meds after they are given
- use correct spelling and grammar- VERY IMPORTANT
- use only approved abbreviations
- use correct method when error is made- mark through with 1 line and initial it

- use correct method for a late entry
- use correct method to end & start page
- **Avoid using:**
- Block charting
- Leaving blanks
- Trying to “erase”
- Illegal alterations of the record- you cannot make changes in the records (eg name or address changes).
- You cannot make changes in a record from yesterday, you have to make a late entry (& note that it is late).
- DO NOT change the spelling or make corrections on someone else’s notes.
- Making any judgments or giving an opinion
- Using general or non descriptive/vague terms such as normal, good, WNL, appears, etc- be very specific. Use adjectives
- Using the word PT or client- the chart is about a specific PT so there is no reason to use either of these words

ASTER MIMS HOSPITAL P O L I C I E S A N D P R O C E D U R E S

- Most health care agencies have documentation policies.
- These policies provide direction for nurses to document the nursing care provided and the process of clinical decision-making in an accurate and efficient manner

What a documentation policy should have?

- Description of the method of documentation;
- Expectations for the frequency of documentation;
- Processes for “late entry” recording;
- Listing of acceptable abbreviations or the name of a reference text in which acceptable abbreviations are found;
- Acceptance and recording of verbal and telephone orders; and
- Storage, transmittal and retention of client information.
- Agency policies guide nurses in managing each of these specific situations.

In situations where policy changes are necessary, nurses advocate for the appropriate changes

L E G A L P R I N C I P L E S

- Nurses' notes are recognized as documentary evidence.
- Prior to 1970, nurses' notes were not considered legal evidence admissible in court unless the nurse was called to testify to the truth of the contents.
- Nurses' notes must be made contemporaneously;
- Nurses' notes must be made by someone having personal knowledge of the matter then being recorded; and

Nurses' notes must be made by someone under a duty of care to make the entry or record

Who owns the health record?

- The agency in which the client's health record is compiled is the legal owner of the record as a piece of physical or electronic property.
- The information in the record, however, belongs to the client.
- Individuals have a right of access to personal information about themselves (including their health records) and a right to request correction of such information.
- Unauthorized collection, use or disclosure of personal information by a public body is violation.

Is the information in the client's health record confidential?

- Yes. Information in the health record is considered confidential.
- Client consent for disclosure of this information to agency staff for purposes related to care and treatment is implied upon admission, unless there is a specific exception established by law or agency policy.
- Nursing documentation must be produced according to agency policy when:
- Clients request access to their personal records to inspect or investigate records; (e.g., negligence suit); or a statutory mandate requires the release of the information (e.g., reporting communicable diseases or child abuse).

What happens to third party information when information in a health record is to be released?

- When a client's record has another person's name on it or contains information about another person – especially if the information was given in confidence - the record may need to be "severed" before it is released.
- For example, if the client's record included the name of a friend of the client or another client, the section of the record that includes this information would need to be removed before releasing the record to the client

How is client information contained in communication books and shift reports communicated?

- Communication books and shift reports are used to alert the health care team to critical information.
- These tools are used to direct others to the health record where the pertinent information is recorded in detail.

Should I document incidents where calls are made because of a concern about a specific client, but are not returned?

- It is important to document only facts on client health records.
- In cases where calls are made because of a concern about a specific client, a notation of these calls is made in the progress (nurses') notes.
- A notation is made after each call, regardless of whether the call was returned.
- If a call is returned, that is noted.

Under which circumstances are verbal orders appropriate?

- Telephone orders
- Orders accepted over the telephone are generally made without the physician's direct assessment of the client's condition.
- Decisions are based solely on the nurse's assessment of the client

Documenting Telephone Orders

- Write down the time and date on the physician's order sheet.
- Write down the order given by the physician.
- Read the order back to the physician to ensure it is accurately recorded.
- Record the physician's name on the physician's order sheet, state "telephone order,"

- Print your name, sign the entry and identify your status (e.g., RN).

On-site verbal orders

- On-site verbal orders also have the potential for error and are avoided unless in an emergency situation, such as a cardiac arrest.
- Nurses need to be aware of the agency's policy with regard to accepting and documenting on-site verbal orders.
- Of nursing staff, only registered nurses take verbal orders (and telephone orders) pertaining to medications.

How are "after the fact" notes developed by nurses for potential use in the future handled?

- There are occasions when nurses write notes "after the fact" (e.g., one day later, one week later), most often to provide clarification following an "incident" or an unexpected client outcome.
- Nurses usually write these notes while the event is current in the nurse's memory, in case of an investigation or lawsuit at a later date

How long do health records need to be kept?

- Current legislation needs to be considered in the development of these policies.
- Legislation differs, depending upon the setting.
- Primary documents (e.g., physicians' orders, nursing admission assessment, consultations, discharge summary, and notice of death) - 10 years
- Secondary documents (e.g., most diagnostic reports, medication records, flow sheets and nurses' notes) – six years
- Transitory documents (e.g., diet report, graphic chart) - one year
- Depending upon agency policy, records of minors may be required to be kept longer than the time periods listed above.

Nursing students and documentation

- They are not yet RNs.
- They must record separately and get it verified by RN
- Then enter it in documents and the sign by them counter sign by the concerned RN
- No teachers or clinical instructors should counter sign as the patient is not under their care.

- Lots of controversy present in this matter

In nut shell

- Nurses documents are legal documents
- All legal documents needs protection
- Nurses are professionals
- They are liable to be sued
- If nurses follow directives of documentation, future litigation can be reduced
- All litigation comes from dissatisfaction on care provided
- See that your patients are satisfied with your care.
- Florence Nightingale(1820-1910) pledge as the foundation for modern nursing ethics.- Lystra E. Gretter- Farrant Training School in 1893
- Four Promises related to various aspects of a nurse's life
- To live a pure life and Practice faithfully
- Not to administer any harmful drug
- Maintain and elevate the standard of the profession
- Devoted to the care of the patient

Conclusion

- Rules and regulations framed by statutory bodies must be strictly followed at all levels.
- Nursing students, during their training period, should be made aware of the Consumer Protection Act. Continuing nursing education programme through workshops, conferences and in-service education courses to refresh their knowledge and also to create awareness among nurses regarding new technologies in medical sciences, which will be beneficial for self-development, to patient and society at large.

Documentation in Quality Health Care

Introduction

- Effective patient care documentation is as important as the delivery of care itself.
- The process of health information management by healthcare professionals presents challenges and legal responsibilities.
- In all documentation, Health care professionals must abide by professional standards, ethical codes, accreditation standards, and legal requirements in creating a permanent record of patient/client data.
- Legally, the records created serve as the best evidence of patient information obtained and shared, the care rendered, the role of the healthcare provider, and whether the professional and legal standards of care were met or breached.
- For these reasons, health care professionals who document and collect patient health information (PHI) need to understand medical record/health information laws to ensure that they act responsibly and in compliance with applicable laws, and identify when expert legal advice is indicated.
- When we think about health care services, there are many types of settings and even in a hospital or clinic there are various areas were documentation is done.
- The inpatient setting in a hospital is broken into different hospital units based on certain criteria - the patient's diagnosis or procedure or even the acuity of care required.
- The outpatient setting is more diverse, including multiple care locations such as the emergency department (ED), different areas based on medical specialties, hospital observation care, physician clinics, home health services, and ambulatory or day care surgery/ Chemotherapy.
- The importance of high-quality clinical documentation across the continuum of healthcare can be compared to a sailing cruise.

Sometimes patients will be at one location for their care and the documentation is the anchor that provides the information needed for the healthcare teams to stay on course

Characteristics of good documentation

- Accuracy of the medical record. (Correctness of the data collected)
- Comprehensiveness of data.
- Consistency of information in the medical record.
- Timeliness of information.
- Relevancy of the medical records.
- Accessibility of the medical record.

The Six C's of charting.

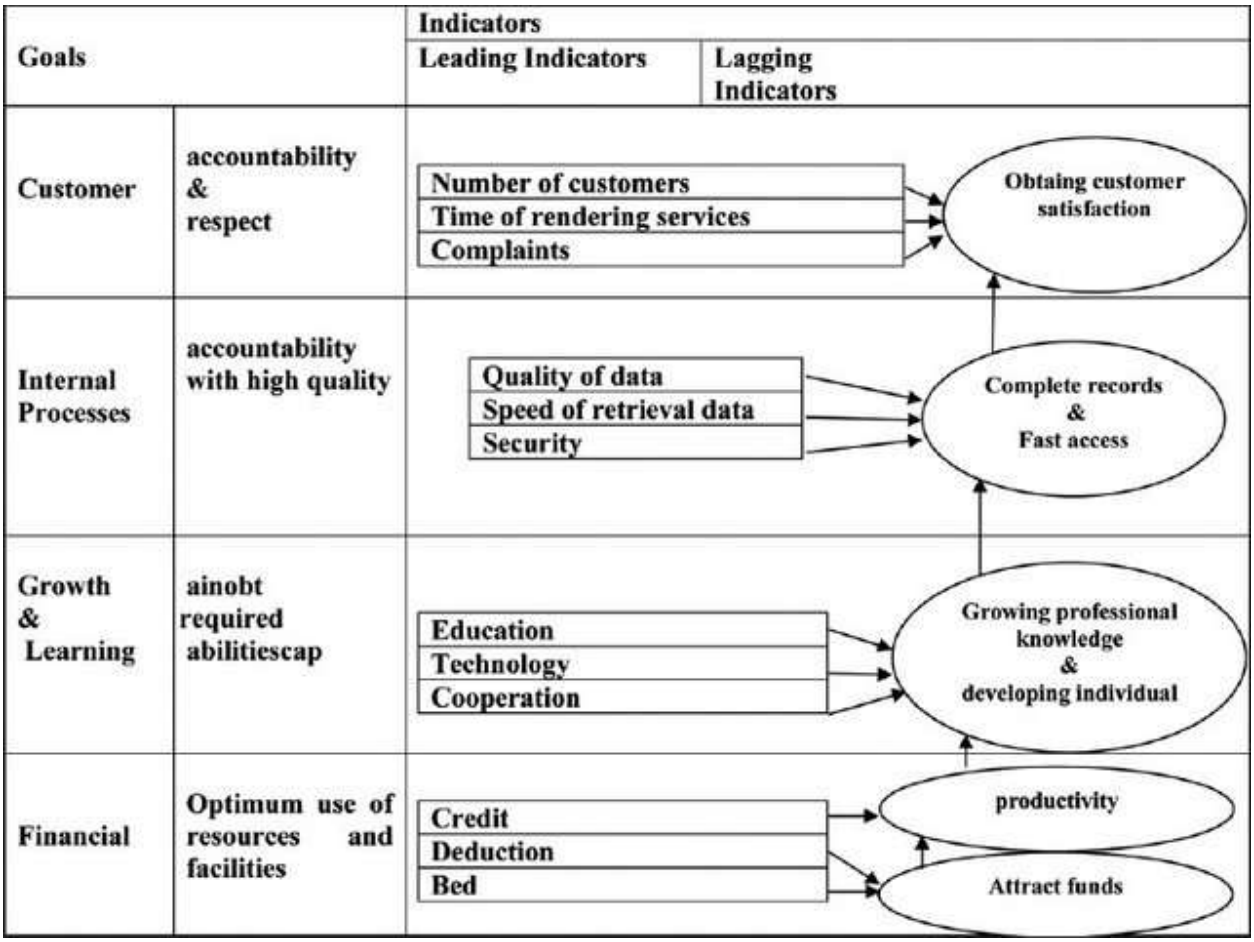
- Client. The pt's own words must be used.
- Clarity. Must be achieved when recording information using proper spelling & medical terminology & abbreviation.
- Completeness. Is essential for all information recorded in a medical chart.
- Chronological. Order of information.
- Confidentiality.

The Hospital Industry's 10 Most Critical Metrics

- Average Length of Stay. What is this metric? ...
- Time to service. What is this metric? ...

- Hospital Incidents. What is this metric? ...
- Patient Satisfaction. What is this metric? ...
- Physician performance. What is this metric? ...
- Patient readmission rate. ...
- Inpatient mortality rate. ...
- Operating Margin.
- Developed performance assessment indicators should possess characteristics of a SMART & D system (SMART & D: Specific, Measureable, Achievable, Realistic, Time Frame, and Database).

Cause and effect relationship between goals and indicators of the Medical Records Department according to the Balanced Scorecard in the Fatemeh Al-Zahra Hospital



Documentation Matters for quality

Patients clinical records and its importance

- It is the most important part of the records documented as far as patient is concerned
- It is knowledge of events in the patient illness, progress in his/her status/ recovery and the type of care given by the hospital personnel and the referrals made for that particular patient.

These are :

- Scientific and legal
- Evidence to the patient that his or her case is intelligently managed
- Avoids duplication of work
- Information for medical and legal nursing research
- Aids in the promotion of health and care
- Legal protection to the hospital/ doctor and the nurse

Quality of care:

- Provides evidence that care was necessary
- Describe responses to care
- Describes any changes made in plan of treatment and care

Coordination of care:

- Plan interventions
- Decision making about ongoing interventions
- Evaluation of patient's progress
- Used by all team members

- Other purposes
- Each Medical Record shall contain **sufficient, accurate information to:**
- **identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers**

Legal and ethical value

- Ethics and documentation
- Adequate medical documentation assures patient confidentiality and ensures that standards of care being met
- Doctors and other health professionals have an obligation to treat illness to the best of their ability in regard to information documented in a patient's medical record.
- What are the legal aspects of medical record?
- LEGAL ASPECTS: Police authorities and court can summon medical records under the due process of law. **Limitation period for filing a case paper is maximum up to 3 years under** limitation Act. According to the consumer protection act it is up to 2 years.

What are the 8 legal uses of health records?

- List eight legal uses for the health record according to your text.
- Establish the applicable standard of care.
- Evidence in civil actions.
- Evidence involving the credentialing process.
- Disciplinary proceedings of healthcare professionals.
- Establish the cause of death.
- Determine blood alcohol content.

They form the backbone of every professional liability action and are used to establish whether the standard of care was met. They are also used in civil actions, such as credentialing and

disciplinary proceedings. They may be used in criminal actions to establish the cause of the victim's death, an insanity defense, or a party's physical condition

HEALTH CARE OPERATIONS AND QUALITY CONCERNS

- The significance of documenting patient care accurately, comprehensively, concisely, objectively, contemporaneously or within reasonable time, and legibly cannot be overemphasized.
- Content substantiates billing for reimbursement and need for present and future therapy/medical services.
- The consequences of altered, incomplete, or nonexistent records can be legally and personally catastrophic.
- Practical application of risk management (prevention of any type of loss—financial or otherwise) and quality care includes proper documentation.
- The medical record frequently is the most important document available in defending against or preventing legal actions, including but not limited to personal injury suits, criminal cases, workers' compensation actions, disability determinations, and claims of negligent or improper healthcare (medical malpractice), and is generally admissible at a trial.
- It also serves to communicate with others as to the patient's status and progress in therapy.
- Patient medical records may be accessed for routine healthcare operation purposes, including, but not limited to:
- Peer Review Committee activities;
- Quality Management reviews including outcome and safety reviews;
- Documentation reviews; and
- Teaching

When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements

- Identify the new entry as a “late entry”
- 2. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed.
- 3. Identify or refer to the date and circumstance for which the late entry or addendum is written.

- 4. When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.
- An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.
- Document the date and time on which the addendum was made.
- Write “addendum” and state the reason for creating the addendum, referring back to the original entry.
- When writing an addendum, complete it as soon as possible after the original note.
- Errors in Scanning Documents
- If a document is scanned with wrong encounter date or to the wrong patient, the following must be done:
- Reprint the scanned document.
- 2. Rescan the document to the correct date or patient, and void the incorrectly scanned document in the permanent document repository
- Quality documentation and reporting are necessary to enhance efficient, individualized client care (Potter, Perry, Ross-Kerr, & Wood, 2006).
- Documentation is not separate from care and it is not optional.
- It is an integral part of Health care practice, and an important tool to ensure high-quality client care.

Study questions

- Are the entries made in the health record ordinarily subject to cross-examination? Why or why not?
- What questions are typically presented to the custodian of records in order to introduce a health record into evidence?
- List the three requirements that establish a foundation for the business record exception to the hearsay rule.
- Explain how a court order is different from a subpoena.
- What legal processes may be used to remove the health record from the health-care provider's safekeeping?

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MODULE ON CRITICAL THINKING

MIMS COLLEGE OF NURSING

CRITICAL THINKING

Introduction

Thinking critically as a student will confer benefits in many areas of life. Critical thinking skills are a vital part of academic life– when reading, writing and working with other students. We use critical thinking skills in domestic decision making or at work for example, when we are choosing our personal belongings like dress or assessing how to move forward in a project. A student needs to transfer these skills to academic life.

What is critical thinking?

Critical thinking is the skilled and active interpretation and evaluation of observations and communications, information and argumentation.

Fisher and Scriven

Critical thinking as a composite of attitudes, knowledge, and skills that include defining a problem, choosing information, finding solution, recognizing stated and unstated assumptions, formulating and selecting relevant and promising hypotheses, drawing conclusions, and judging the validity of the inferences.

Hickman

Critical thinking is the process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information”

Scriven and Paul

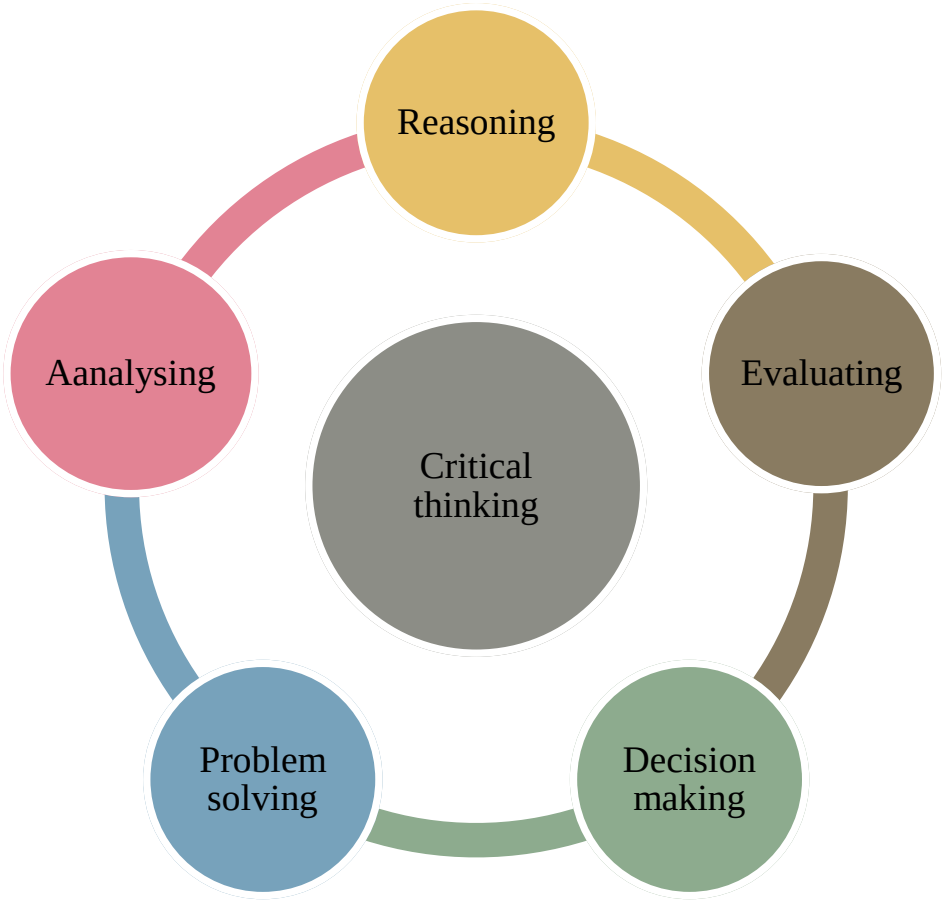
Importance of critical thinking in nursing

We believe that skilled nursing depends upon a well-reasoned philosophy of nursing rooted in a deep and rich conception of critical thinking Critical thinking is essential to skilled nursing and is therefore essential to nursing education.

Intuitive nursing practice when performed automatically, without care, vigilance, and routine critique, can result in many significant negative implications.

Critical thinking is crucial for clinical decision-making. Proficiency in critical thinking is integral to life-long learning and the capacity to deal effectively with a world of accelerating change.

Components of critical thinking



Analysis

Analysis means having the ability to take something apart and examine the essential or constituent parts, and the relationships between the parts. For example, when you take your car in for a service check, the mechanic systematically does an analysis to determine the problem that needs to be fixed. They are masters at taking things apart and putting them back together.

Evaluating

Evaluating is making an assessment or judgment based on criteria, a set of standards, data, or information. For example, when you go to the doctor, he or she completes a number of vital signs tests, looks at data and your records, and arrives at a judgment about the status of your health.

Reasoning

Reasoning is your ability to form a coherent and logical argument, and to be able to use reasons to justify your argument. It is the process of using your mind to consider something carefully and to be able to demonstrate that it is either true or false.

The main function of reasoning is to be able to devise and evaluate arguments intended to persuade others. For example, lawyers use reasoning in the courtroom to convince a jury that the defendant is either guilty or innocent.

Problem solving

Problem solving is the ability to understand the root causes of an issue or situation, consider alternative solutions, and arrive at a decision about which solution is best to address the problem. For example, a sales team is brought

together because sales have dropped 25% in the last quarter. They need to work through a systematic problem solving process in order to find a solution.

Decision making

Decision-making is the ability to identify and choose a course of action from alternatives, based on values and preferences. For example, when you buy a house, we usually start with determining the amount of money we have to spend. Then, we need to consider location, size, and amenities. Typically, we end up having to decide between House A and House B.

Skills for critical thinking

Critical thinking is the ability to think clearly and rationally. A person who is a good critical thinker can:

- evaluate information in a systematic way
- understand the logical connections between ideas
- identify inconsistencies in others' thinking
- effectively solve problems and make informed decisions
- separate what is important and what is irrelevant information
- construct strong evidence-based arguments
- view situations from different perspectives
- ask hard questions to challenge observations and assumptions

Critical thinkers typically engage in self-reflection and independent thinking. They think about their thinking, and they are often able to think "outside the box." Critical thinkers closely examine their beliefs, assumptions, ideas, and arguments in order to identify misconceptions and gaps in their reasoning. They are able to refine their thought processes over time, and they are very skilled at synthesizing information.

Many people are under the false impression that if you can hold a lot of facts or knowledge in your brain, and you are able to recall this information with ease, that you are a good critical thinker. This simply means you are able to store and retrieve information from your memory more effectively than others. It is not a guarantee that you will be a good critical thinker.

Critical thinkers are able to interpret what information really means, they are able to analyze ideas and arguments, they are able to reach accurate conclusions based on evidence, and they can assess whether people got the facts right. They can eventually sort out what is credible and true from what is not credible and not true.

Characteristics and Qualities of Critical Thinkers

Critical thinkers have the following seven characteristics:

Creative

They can see early patterns of thinking and behaviors surfacing, and they can tap into innovative ideas and solutions.

Curious

They are always interested in learning more about an idea, theory, or issue. They want to develop explanations to all their questions or for what's puzzling them, beyond a surface level.

Knowledgeable

They willing offer their analysis and conclusions, based on their expertise. Their knowledge is typically very sound.

Open-minded

They can listen to everyone's opinion and then accurately assess the strengths and weaknesses of their positions. They rarely assume they have the right answers, and they recognize many shades of grey.

Insightful

They are able to get to the core of a situation, or to an understanding of the root causes of problems, without getting paralyzed or distracted by all the details. They can tap into their intuition, and then use evidence to support their conclusions.

Thought Provoking

They are able to present their ideas or thinking in a very clear and fluid manner. They are very skilled at dialogue when discussions go back and forth about ideas, solutions, or problems. They are not afraid to disagree.

Proactive

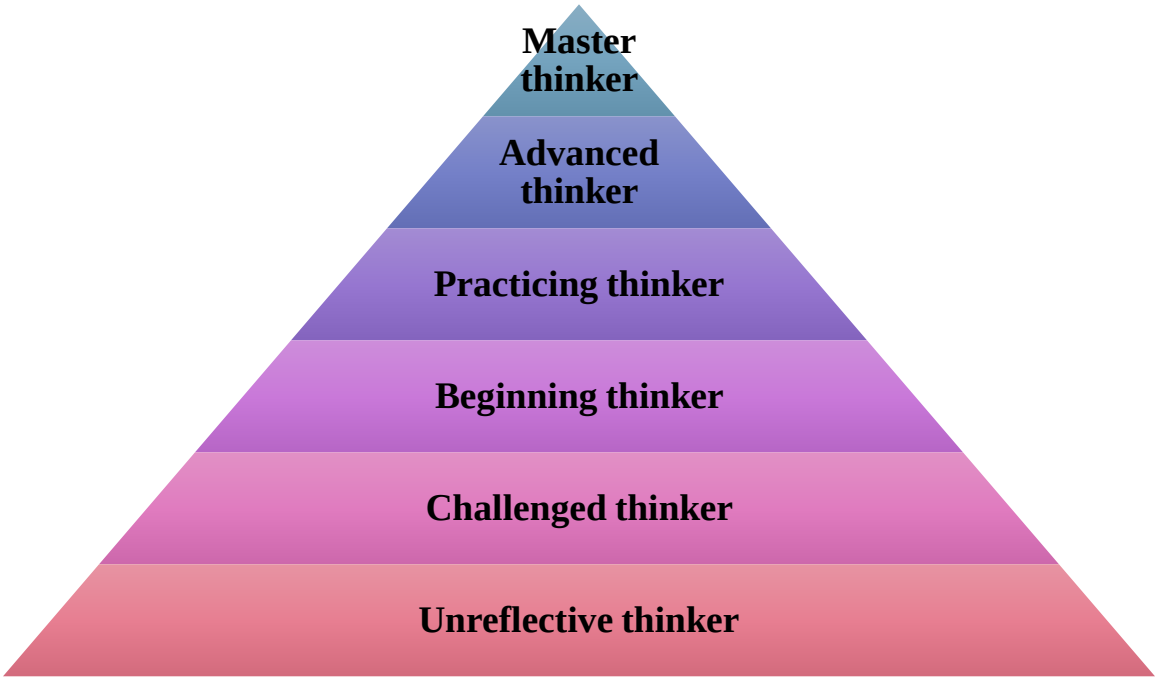
They initiate action when faced with a problem, and they use their strong thinking skills to find possible solutions. They typically don't sit back and then react.

Self-assessment of critical thinking qualities

When you are working in a group or a team, how often would others see you demonstrating these critical thinking qualities?

Creative	Rarely Sometimes Often Always
Curious	Rarely Sometimes Often Always
Knowledgeable	Rarely Sometimes Often Always
Open minded	Rarely Sometimes Often Always
Insightful	Rarely Sometimes Often Always
Thought Provoking	Rarely Sometimes Often Always
Proactive	Rarely Sometimes Often Always

Stages of development in critical thinking



Stage One: The Unreflective Thinker

Defining Features: These thinkers are basically unaware of the role of thinking in their lives and of potential problems with their own reasoning. They do not identify concepts or assumptions behind ideas, and they rarely assess the logic of their opinions or conclusions. These thinkers tend to retain biases and prejudices. Though these thinkers may be highly educated, they tend to be unable to "fix" problems in thinking or adopt new strategies to solve problems.

Stage Two: The Challenged Thinker

Defining Features: These thinkers have become aware of the role thinking plays in their lives. They have begun to understand that problems in thinking and logic can cause significant trouble for them, and they recognize thatproductive thinking requires effort and deliberate attention. They have an understanding of the basic elements of reasoning and standards for the assessment of thinking (clarity, accuracy, relevance, etc.), but they have only a superficial understanding of these concepts. They find it hard to apply these concepts consistently and deliberately in their reasoning. They may believe that they have critical thinking abilities, but they may not recognize that they apply these critical thinking abilities inconsistently in their lives, thus making it harder for them to improve their thinking skills.

Stage Three: The Beginning Thinker

Defining Features: These thinkers are actively trying to take control of the quality of their thinking in several areas of their lives. Because they realize that they sometimes experience difficulty in their reasoning or problem solving, they take deliberate measures to monitor and improve their thinking. They are aware of the need to assess and improve their thinking, but they lack a systematic plan for improving their thinking. They welcome critiques of their own thinking and know

that their thinking needs to be self-monitored, though they are sporadic at this self-monitoring.

Stage Four: The Practicing Thinker

Defining Features: These thinkers have an awareness of how our thinking tends to be flawed, have an understanding of the basic elements of reasoning and standards for assessing reasoning and know that our thinking needs to be monitored and corrected. They actively analyze their thinking across many areas of their lives, but are only beginning to assess their thinking in a systematic way. They understand that the human mind tends to be self-deceptive, and they attempt to assess and critique their own conclusions, beliefs, and opinions. However, they still have "limited insight into deeper levels of thought, and thus into deeper levels of the problems embedding thinking."

Stage Five: The Advanced Thinker

Defining Features: These thinkers have "established good habits of thought which are 'paying off'." They actively analyze, assess, and critique their own thinking in the significant areas of their lives, and they also have insight and understanding of problems at deeper levels of thought. While they are able to think well (apply elements and standards) across many areas of their lives, they may not do this at a consistently high level across all areas at all times. If they "catch" themselves displaying bias or applying a double standard, they quickly correct their thinking in an attempt to be intellectually fair. They have a developed understanding of the relationships between thoughts, desires, emotional needs, and feelings.

Stage Six: The Accomplished Thinker

Defining Features: These thinkers have established a systematic plan to assess and correct their own thinking, and are also continually critiquing this plan in order to improve their thinking. They have almost completely internalized the elements of reasoning and the standards for assessing reasoning, so that the application of the elements and standards is both conscious and deeply intuitive for them. They "regularly raise their thinking to the level of conscious realization," assessing and critiquing their own thoughts, conclusions, and opinions to uncover bias, egocentrism, and logical fallacies. They have extensively practiced critical thinking traits and skills, and are able to develop new insight into deeper levels of thought. Accomplished thinkers are deeply invested in fair-mindedness, and regularly recognize and control their own egocentric nature.

Factors influencing critical thinking ability

There are many modifiable and non-modifiable factors that influence one's critical thinking ability. They are broadly categorized into:

Personal factors

- **Moral development and fair mindedness**

It is likely that there is a positive correlation among moral development, fair mindedness and critical thinking. People with a mature level of moral development

– those with a clear, carefully reasoned sense of ‘what is right, wrong and fair’- are more likely to think critically.

- **Age**

Most of the researches find that age tends to correlate with critical thinking ability: the older you get, the better thinker you become. There are two logical reasons for this: (1) Moral development usually comes with maturity. (2) Most older people have had more opportunities to practice reasoning in different situations.

- **Dislikes, prejudices and biases**

These are subtle but powerful factors that hinder critical thinking. If we don’t recognize them it may hinder with situations where you have to function in spite of your dislikes, prejudices and biases.

- **Emotional intelligence**

This is the ability to make emotions work in positive ways, and it enhances critical thinking. How you feel about something greatly influences how you think.

- **Self confidence**

For the most part, self-confidence aids thinking. If you aren’t confident, you use much of your brain power worrying about failure, reducing the energy available for productive thinking.

- **Effective communication and interpersonal skills**

These are essential to critical thinking. You must be able to understand others, be understood by others, and gain others trust to get the facts required for sound reasoning.

- **Past experience**

Many authors view experience as an enhancing factor as we remember our experience best. However, if our past experience and current situation is incongruent, it can be an inhibiting factor.

Eg: if a mother has had a bad experience breastfeeding her firstborn child, it may be difficult to think about breastfeeding her subsequent children.

- **Effective writing skills**

These promote critical thinking. Once we learn to write clearly, applying critical thinking principles is also learnt. This includes identifying an organized approach, deciding what's relevant, and focusing on others' perspectives.

- **Effective learning and reading skills**

These are enhancing factors as critical thinking requires abilities to use resources independently. Effective reading skill doesn't mean one knows rapid reading. It means, knowing to read efficiently, identifying what's important, and drawing conclusions about what the material implies.

Situational factors

- **Anxiety, stress, fatigue:**

Mostly, these impede thinking. High levels of anxiety and stress taps brain energy, making concentration difficult. A fatigued person works on a low battery. However, a low anxiety level, like being little nervous about a test, can promote critical thinking by motivating to prepare.

- **Awareness of risks**

This is an enhancing factor, as we think more carefully when we know the risks to make sure we have taken a prudent decision before acting. But sometimes, this can increase anxiety to a level that impedes critical thinking.

For example, we remember how hard it was to think critically when we gave our first injection.

- **Knowledge of related factors**

The more knowledge about a situation helps in better reasoning.

For example, to teach a person about diabetes, just knowing about diabetes is not enough. We should know the person's lifestyle, desires, and motivations to design a plan that the person will follow.

- **Awareness of resources**

This allows to think critically, even with limited knowledge. For example, nurses frequently think critically about drug administration with limited drug specific knowledge. They check with resources like pharmacists and drug manuals before giving unfamiliar drugs on their dose range, contraindications, and possible side effects.

- **Positive reinforcement**

It promotes critical thinking by building self-confidence and focusing on what's being done right.

- **Evaluative or judgmental rights**

Conveying an evaluative or judgmental style usually impedes critical thinking. People who feel they are being evaluated or judged often spend more energy worrying about what others are thinking.

- **Presence of motivating factors**

Things that motivate to think critically connect with desires enticing to get their brain in gear. For example, knowing why you are asked to do something is a motivating factor for critical thinking. Think how much motivated one will be to learn when someone says, "You must know this because you run into it a lot and you must be able to handle it"

- **Time limitations**

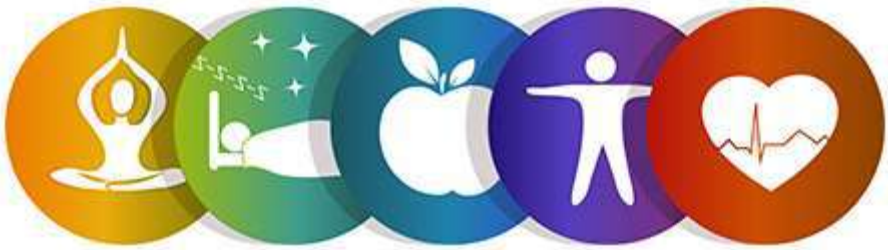
This is an enhancing or impeding factor. Time limitations can be motivating factors as deadlines stimulate us to get things done. When there is little time, we take quick decisions and get less than satisfactory answers. Courts give more leeway to decisions that were made in emergency situations than to those made with plenty of time for thinking.

- **Environmental distractions**

These impede critical thinking for obvious reasons-the more distractions; the more difficult it is to stay focused. For example, it’s better to chart in a quiet place, where there are few distractions and interruptions.

HEALTH PROMOTION

MODULE



MIMS COLLEGE OF NURSING

MODULE – 1

This module introduces you to the field of health promotion and provides an overview of key health promotion definitions and concepts.

Contents

1. Definition of Health Promotion
2. Health Promotion Logo
3. Milestones contributing to Health Promotion
4. Features of Health Promotion
5. Health promotion and other approaches

MODULE: 1

FOUNDATIONS OF HEALTH PROMOTION

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LEARNING OBJECTIVES

By the end of this module, you will:

1. Define health promotion
2. Identify the components of the health promotion logo
3. Identify the key historical milestones contributing to the development of health promotion
4. Understand how health promotion differs from related concepts, such as disease prevention and population health.

Introduction

Health, as the World Health Organization (WHO) defines, is the state of complete physical, social and mental wellbeing and not just the absence of disease or infirmity. The enjoyment of highest attainable standard of health is considered as one of the fundamental rights of every human being.[1]

Over the past few decades, there is an increasing awareness that biomedical interventions alone cannot guarantee better health. Health is greatly influenced by factors outside the domain of the health sector, especially social, economic and political forces.[2] Thus, the attainment of the highest possible standard of health depends on a comprehensive, holistic approach which goes beyond the traditional curative care, involving communities, health providers and other stakeholders.

This holistic approach should empower individuals and communities to take actions for their own health, foster leadership for public health, promote intersectoral action to build healthy public policies and create sustainable health systems in the society.[3]

These elements capture the essence of "health promotion", which is about enabling people to take control over their health and its determinants, and thereby improve their health. It includes interventions at the personal, organizational, social and political levels to facilitate adaptations (lifestyle, environmental, etc.) to improve or protect health.

Definition of Health Promotion

There are many definitions for health promotion developed by many institutions. But the widely accepted definition is the Ottawa Charter for Health Promotion, 1986. According to this Health promotion is defined as **"the process of enabling people to increase control over, and to improve, their health"**

This definition states that to reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.

According to Michael P O'Donnell **"health promotion is the science and art of helping people change their life style to move toward a state of optimal health."**

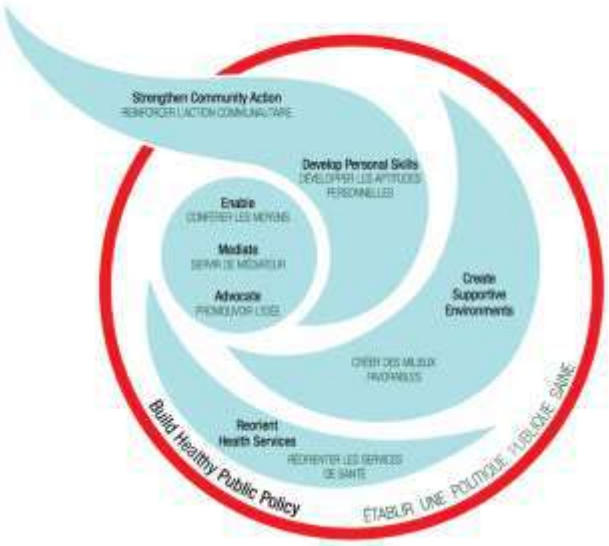
The focus of this definition is lifestyle and behavior, because the health will improve only when people take action and change their behavior. Health enhancing behavior include obvious immediate behavior that affect physical and emotional health such as exercising regularly, eating nutritious food, managing stress well etc. it also include more encompassing behaviors that affect social, intellectual and spiritual health such as deciding to work in an institution that encourages healthy life style and provides challenging work, fulfilling relationships with friends and family, living in a community that has clean air and water supply and having a purpose in life.[5]

Historical evolution

Health promotion is not a new concept. The term 'Health Promotion' was coined in 1945 by Henry E. Sigerist, the great medical historian, who defined the four major tasks of medicine as

promotion of health, prevention of illness, restoration of the sick and rehabilitation.[3] Health promotion began to gain acceptance worldwide after the launching of the Ottawa Charter for Health Promotion at the first international health promotion conference held in Ottawa, Canada 1986.

Health Promotion Logo



A brief explanation of the logo used by WHO since the First International Conference on Health Promotion.[6]

The main graphic elements of the HP logo are:

a) One outside circle

The red outside circle represents the goal of "Building Healthy Public Policies", therefore symbolizing the need for policies to "hold things together". This circle is encompassing the three wings, symbolizing the need to address all five key action areas of health promotion.

b) One round spot within the circle

The round spot within the circle stands for the three basic strategies for health promotion, "enabling, mediating, and advocacy ", which are needed and applied to all health promotion action areas.

c) The three wings

The Three wings that originate from this inner spot, one of which is breaking the outside circle represent the five key action areas of Health Promotion such as

- Build healthy public policy
- Create supportive environments for health
- Strengthen community action for health
- Develop personal skills and
- Re-orient health services

Milestones in health promotion

The WHO conferences so far held regarding Health Promotion.[7]

Conference	Theme	Place and date	Main decisions
1.	Charter for Health Promotion	Ottawa, Canada, November 1986	It launched a series of actions among international organizations, national governments and local communities to achieve the goal of "Health For All" by the year 2000 and beyond through better health promotion.
2.	Healthy Public Policy	Adelaide, South Australia 5^{th} – 9^{th} April1988	This Conference strongly recommended that the World Health Organization continue the dynamic development of health promotion through the five strategies
3.	Supportive Environment for Health	Sundsvall, Sweden 9^{th} -15^{th} June1991	This Conference emphasized that the issues of health, environment and human development cannot be separated. Development must imply improvement in the quality of life and health while preserving the sustainability of the environment.
4.	Leading Health Promotion into the 21^{st} Century	Jakarta, Indonesia 21^{st} 25^{th} July1997	This declaration included five priorities for health promotion in 21st century such as promote social responsibility for health, increase investments for health development, consolidate and expand partnerships for health, increase community capacity and empower the individual and secure an infrastructure for health promotion
5.	Promotion of Health: From Ideas to Action	Mexico City 5^{th} –9^{th} June 2000	This conference differed from the four previous international health promotion conferences in that it included a Ministerial Programme, enabling Ministers and Ministerial Delegations to share experiences and challenges they faced in the promotion of health.

Conference	Theme	Place and date	Main decisions
6.	Health Promotion in a Globalized World	Thailand 7^{th} -11^{th} August 2005	This Charter identified actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion.
7.	Promoting health and development: closing the implementation gap	Nairobi 26^{th} -30^{th} October 2009	The main theme of the conference aimed to clarify key strategies and commitments of each country in order to narrow its major implementation gaps in health and development through health promotion.
8.	Health in All Policies	Helsinki 2013	This conference emphasized the governments to ensure that health considerations are correctly taken into account in policy-making.
9.	Promoting health, promoting sustainable development	Shanghai, China November 21^{st} - 24^{th}, 2016	The conference was a chance to gather an international crowd of health promoters to witness the signing of the Shanghai Declaration on promoting health in the 2030

Features of health promotion[8]

Health promotion has a number of unique features to ensure the health and well-being of individuals and communities that distinguish it from other approaches such as population health and disease prevention. These include:

1. a holistic view of health
2. a focus on participatory approaches
3. a focus on the determinants of health, the social, behavioral, economic and environmental conditions that are the root causes of health and illness;
4. building on existing strengths and assets, not just addressing health problems and deficits; and
5. using multiple, complementary strategies to promote health at the individual and community level.

A Holistic View of Health

Health promotion views health as a positive concept emphasizing social and personal resources as well as physical capabilities.

A Focus on Participatory Approaches

The use of participatory approaches that enable people to take greater control over the conditions affecting their health is perhaps the most important feature of health promotion

A Focus on the Determinants of Health

- income and social status
- social support networks
- education
- employment and working conditions
- physical environments
- social environments
- biology and genetic endowment
- healthy child development
- health services

These factors, in combination, create the conditions determining health status at the individual and community level.

Building on Strengths and Assets

Wherever possible, health promotion practice builds on positive factors promoting the health of individuals and communities. Examples of these strengths and assets include community leaders, existing programs and services, strong social networks, or institutions and events in the community that bring people together.

Using Multiple, Complementary Strategies

Health promoters use multiple strategies focused on individuals, families, groups, communities and entire populations (e.g., a region, province or nation).

The Ottawa Charter for Health Promotion encourages the use of multiple strategies by identifying five action areas for health promotion practice. They are

1. ***Build Healthy Public Policy***

Building healthy public policy is the first of the health promotion action areas listed by the World Health Organization in the Ottawa Charter. Building healthy public policy is about the development of legislation, fiscal measures, taxation and organizational change that promotes health.

2. ***Create Supportive Environments***

Supportive environments offer protection of people from factors that can threaten good health. Supportive environments are sometimes referred to as supportive settings. Settings refer to environments where people live, learn, work and play, such as schools, hospitals, workplaces and cities.

3. ***Strengthen Community Actions***

Strengthening community action is all about community involvement in the health promotion process. It draws on community resources in order to provide social support and self-help for the community.

4. ***Develop Personal Skills***

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By doing this, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

5. ***Reorient Health Services***

Reorienting health services is primarily about changing the focus health sector from clinical and curative services to more on health promotion and prevention.

The above action areas are explained with an example.

Example: The National Tobacco Strategy

Goal: to significantly improve health and reduce the social costs caused by, and the inequity exacerbated by tobacco in all its forms.

Target group: 18 – 40 years.

Step 1: Building Healthy Public Policy:

- High levels of taxation on tobacco ensure cigarettes are less affordable, reducing access for younger people in particular
- Imposition of laws that prevent smoking in most public and indoor environments i.e. no smoking in pubs and clubs

Step 2: Creating Supportive environments

- Promotion of smoke free messages and regulation of place
- Frightening media campaigns
- Most indoor and public places are smoke free, providing safe physical and social environments for people to work and interact socially.
- Employment and training programs to reduce boredom associated with unemployment—address socio-cultural and socioeconomic determinants which influence tobacco use.
- Regulation of place of sale aims to eliminate the sale of tobacco products to minors and make them less visible.

Step 3: Strengthening Community action

- Local educational strategies such as peer support and mentoring programs improve self-esteem and the sense of worth among students which can be protective factors against harm from tobacco use.
- Families and parents provided with safe places for children to avoid tobacco smoke—parks

Step 4: Developing personal skills

- By regulating packaging and providing information to help smokers in making the decision to quit.
- Facts about harm associated with tobacco and contact information for quit programs
- School education programs that focus on assertiveness skills, academic success and developing a negative attitude to smoking and enhance skills that will be protective against smoking in future

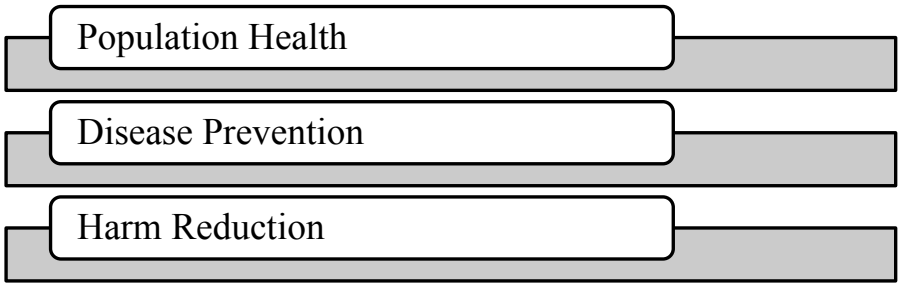
Step 5: Reorienting Health services

- Doctors can initiate discussions with patients about lifestyle behaviors
- Help doctors introduce preventative messages and recommendations for improving lifestyle behaviors.

Health promotion and other approaches

Health promotion is not the only approach to address issues affecting the health of individuals and communities. There are a number of other approaches used to guide the development of interventions, policies and programs addressing health-related issues.

The following content defines three of these approaches and describes how they are both similar to, and different from, health promotion.



Population Health

Population health aims to improve health inequalities among population groups by examining and acting upon a broad range of factors and conditions that determine health. The main interventions used by population health are societal-level policies affecting the health of entire populations (e.g., increasing tobacco taxes). The impact of these policies is monitored through the use of large-scale data sets. Unlike health promotion, population health does not place as much emphasis on strategies promoting individual and community level change, such as education, organizational change and community mobilization.

Disease Prevention

Disease prevention is the branch of public health practice concerned with the prevention of chronic diseases contributing to premature mortality (e.g., heart disease, cancer, stroke, diabetes).Health promotion also focuses on the prevention of disease and shares many of the same strategies as disease prevention. However, health promotion has a number of features and values that distinguish it from traditional disease prevention efforts. These include a focus on assets and strengths as well as risk factors and conditions; a commitment to participatory approaches that build the capacity of individuals and communities to address their health concerns; and a greater

focus on the social, economic and environmental causes of health and illness. Disease prevention initiatives, by contrast, focus mainly on modifying the health behaviors of individuals.

Harm Reduction

Harm reduction can be defined as actions which decrease the adverse health, social and economic consequences of engaging in HIGH-RISK behaviors without requiring abstinence (e.g., smoking, alcohol and drug use). While health promotion utilizes many of the same actions and strategies employed by harm reduction, its focus is much broader than high-risk behaviors.[9]

Conclusion

Health is not just the absence of disease but includes social, emotional, psychological and spiritual elements. Promoting health is about activities that enable a person to live well, even with a diagnosed condition. Promoting health is also about a way of working that is empowering and participatory. It includes many different activities at different levels of intervention.

EXERCISES

MUTIPLE CHOICE QUESTIONS

Each question in this section is a multiple-choice question with four answer choices. Read each question and answer choice carefully and choose the ONE best answer.

1. The number of wings in the health promotion logo
    a) 5
    b) 7
    c) 3
    d) 4
    Answer: ( )
2. The number of key actions mentioned in the logo
    a) 5
    b) 4
    c) 6
    d) 2
    Answer: ( )
3. Among the following key actions which action is not represented in the logo
    a) Build healthy public policy
    b) Create supportive environments for health
    c) Strengthen community action for health
    d) Prevention of disease
    Answer: ( )
4. The colour of the outside circle
    a) Red
    b) Orange
    c) Black
    d) Blue
    Answer: ( )

5. The reconfirmation of the five key actions presented in the logo was done in
    a) Jakarta Declaration
    b) Sundsvall Declaration
    c) Adelaide Declaration
    d) Bangkok Declaration

    Answer: ( )
6. The First International Conference on Health Promotion was held in
    a) 1986
    b) 1996
    c) 1976
    d) 1987

    Answer: ( )
7. The Health promotion conference which insisted the support to the developing countries was
    a) Jakarta conference
    b) Sundsvall conference
    c) Adelaide conference
    d) Bangkok conference

    Answer: ( )
8. Among the following which are the features of health promotion. Note: More than one answer may be correct.
    a) Holistic view of health
    b) Participatory approaches
    c) Disease prevention
    d) Determinants of health

    Answer: ( )

MATCH THE FOLLOWING

Match the following themes with their respective conference

1. Health Promotion in a Globalized World	a) Shanghai conference
2. Promoting health, promoting sustainable development	b) Bangkok conference
3. Health in All Policies	c) Mexico conference
4. Promotion of Health: From Ideas to Action	d) Adelaide
5. Healthy Public Policy	e) Helsinki

SHORT ANSWERS

Answer each question in 1-2 sentences in the space provided.

1. Define health promotion according to Ottawa Charter for Health Promotion?
2. What is the main distinguishing feature between health promotion and population health?
3. What are the main distinguishing feature between health promotion and disease prevention?

ANSWE KEY

MULTIPLE CHOICE QUESTIONS

1. c
2. a
3. d
4. a
5. a
6. a
7. c
8. a,b,d

MATCH THE FOLLOWING

1. b
2. a
3. e
4. c
5. d

SHORT ANSWERS

1. Health promotion is defined as "the process of enabling people to increase control over, and to improve, their health" (Ottawa Charter for Health Promotion, 1986).
2. Population health does not place as much emphasis on strategies promoting individual and community level change, such as education, organizational change and community mobilization.
3. Disease prevention focuses on assets and strengths as well as risk factors and conditions, commitment to participatory approaches and greater focus on the social, economic and environmental causes of health and illness.

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MODULE 2

This module gives an understanding to the components of health promotion model and helps you to practice it in day to day life

Contents

1. **Definitions of components of health promotion model**
2. **Assumptions of health promotion model**
3. **Prerequisites of health promotion model**
4. **The Ottawa Charter for Health Promotion**
5. **Health promotion Models**
6. **Population Health Promotion Model**
7. **Clinical assessment activities**

GLOSSARY OF HEALTH PROMOTION MODEL

Individual Characteristics and Experiences

Prior related behavior – frequency of similar health behavior in the past Personal factors (biological, psychological, sociocultural) general characteristics of the individual that influence health behavior such as age, personality structure, race, ethnicity, and socioeconomic status.

Behavior-Specific Cognitions and Affect

Perceived benefits of action – perceptions of the positive or reinforcing consequences of undertaking a health behavior– perceptions of the blocks, hurdles, and personal costs of undertaking a health behavior

Perceived self-efficacy – judgment of personal capability to organize and execute a particular health behavior; self-confidence in performing the health behavior successfully

Activity-related affect – subjective feeling states or emotions occurring prior to, during and following a specific health behavior

Interpersonal influences (family, peers, providers): norms, social support, role models – perceptions concerning the behaviors, beliefs, or attitudes of relevant others in regard to engaging in a specific health behavior

Situational influences (options, demand characteristics, aesthetics) – perceptions of the compatibility of life context or the environment with engaging in a specific health behavior

Commitment to a plan of action -- intention to carry out a particular health behavior including the identification of specific strategies to do so successfully

Immediate competing demands and preferences – alternative behaviors that intrude into consciousness as possible courses of action just prior to the intended occurrence of a planned health behavior.

Behavioral Outcome- Health Promoting Behavior

Health promoting behavior – the desired behavioral end point or outcome of health decision-making and preparation for action.

MODULE II

HEALTH PROMOTION MODEL

Learning Objectives

At the end of this module, the individual will be able to,

- **Identify and develop the personal skills to improve the health**
- **Create supportive social environment**
- **Understand the components in Health promotion Model**
- **Make health promotion models**
- **Focus individual, group and community health promotion behaviors of HP Model.**
- **Empower one's own individual health**
- **Gain skills to apply these models to modify specific individual behaviors.**

INTRODUCTION

The health promotion model (HPM) proposed by Nola J Pender (1982; revised, 1996) was proposed to be a "complementary counterpart to models of health protection." It defines health as a positive dynamic state not merely the absence of disease. Health promotion is directed at increasing individual level of well- being. [1]

Each person has unique personal characteristics and experiences that affect in subsequent actions. The behavioral specific knowledge and affect have important motivational significance. Health promoting behavior is the desired behavioral outcome and is the end point in the HPM. Health promoting behaviors should result in improved health, enhanced functional ability and better quality of life. The final behavioral demand is influenced by the immediate competing demand and preferences, which can derail an intended health promoting actions.

The model focuses on following three areas:

- Individual characteristics and experiences
- Behavior-specific cognitions and affect

- Behavioral outcomes

Definitions of Components of Model

Individual Characteristics and Experience

- Prior related behavior

Frequency of the similar behavior in the past have direct and indirect effects on the likelihood of engaging in health promoting behaviors.

- Personal Factors

Personal factors categorized as biological, psychological and socio-cultural.

- Personal biological factors

Include variable such as age, gender, body mass index, pubertal status, aerobic capacity, strength, agility, or balance.

- Personal psychological factors

Include variables such as self-esteem, self-motivation, personal competence, perceived health status and definition of health.

- Personal socio-cultural factors

Include variables such as race ethnicity, acculturation, education and socioeconomic status.

Behavioral Specific Cognition and Affect

- Perceived Benefits of Action

Anticipated positive outcomes that will occur from health behavior.

- Perceived Barriers of Action

Anticipated, imagined or real blocks and personal costs of understanding a given behavior

- Perceived Self- Efficacy

Judgment of personal capability to organize and execute a health-promoting behavior. Perceived self-efficacy influences perceived barriers to action, higher efficacy result in lowered perceptions of barriers to performance of the behavior.

- Activity related Affect

Subjective positive or negative feeling that occur before, during and following behavior based on the stimulus properties of the behavior itself. Increased feelings of efficacy can generate further positive affect.

- Interpersonal Influences

Interpersonal influences include: norms (expectations of significant others), social support (instrumental and emotional encouragement) and modelling (vicarious learning through observing others engaged in a particular behavior). Primary sources of interpersonal influences are families, peers, and healthcare providers.

- Situational Influences

Personal perceptions and cognitions of any given situation or context that can facilitate or impede behavior. Situational influences may have direct or indirect influences on health behavior.

Behavioral Outcome

- Commitment to Plan of Action

The concept of intention and identification of a planned strategy leads to implementation of health behavior.

- Immediate Competing Demands and Preferences

Competing demands are the alternative behavior over which individuals have low control because these environmental contingencies are work or family care responsibilities. Competing preferences are alternative behavior over which individuals exert relatively high control, such as choice of ice cream or apple for a snack

- Health Promoting Behavior

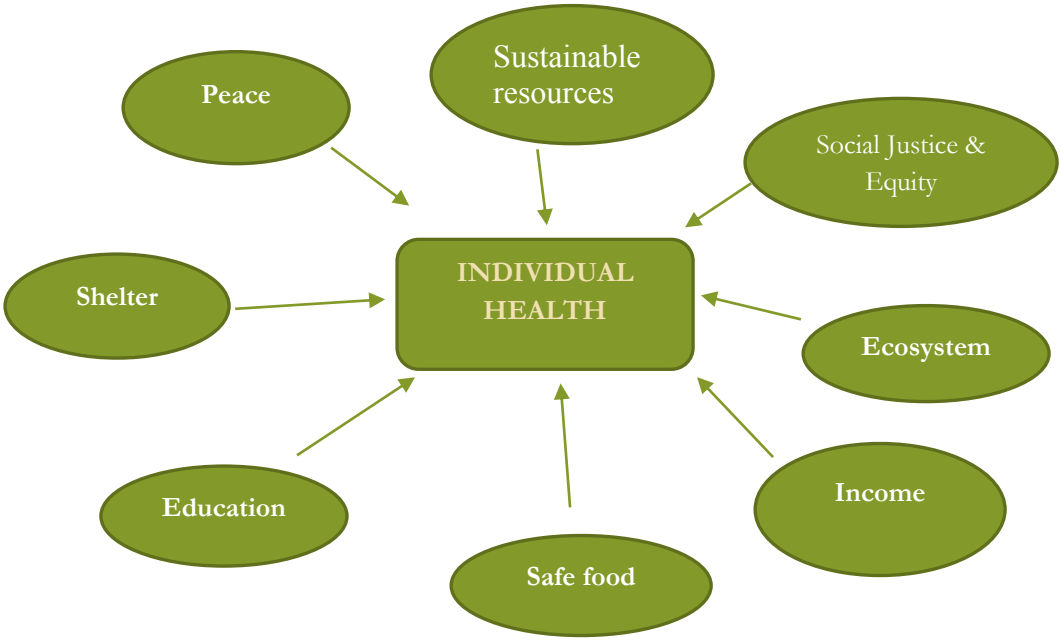
Endpoint or action outcome directed toward attaining positive health outcome such as optimal well-being, personal fulfillment, and productive living.

HPM Assumptions

The HPM is based on the following assumptions, which reflect both nursing and behavioral science perspectives:

1. Persons seek to create conditions of living through which they can express their unique health potential.
2. Persons have the capacity for reflective self-awareness, including assessment of their own competencies.
3. Person's value growth viewed as positive and attempt to achieve a personally acceptable balance between change and stability.
4. Individuals seek to actively regulate their own behavior.
5. Individuals in all their bio psychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time.
6. Health professionals constitute a part of the interpersonal environment, which influence on persons throughout their lifespan.
7. Self-initiated reconfiguration of person-environment interactive patterns is essential to behavior change.

PRERQISITES FOR PROMOTION OF INDIVIDUAL HEALTH



The Ottawa Charter identified eight prerequisites for adult health: These 8 resources are the basic prerequisites for improvement in health. [2]

- Peace
- Shelter
- Education
- Safe and Adequate food supply
- Adequate income
- A stable ecosystem- a balance between plants and animals on the environment which is important for many health resources such as food, water, and air.
- Sustainable resources- the need to sustain many resources needed for health (food, water, income- funding, building supplies, oil) for future generations to benefit.
- Social justice and equity- all people being valued and receiving fair treatment, so all people share the benefit of society

The Ottawa Charter for Health Promotion.

Ottawa was the venue for an international conference on health promotion in 1987. The resulting Ottawa Charter proposed action "to achieve health for all" by the year 2000. [3] It included the following strategies:

- Building healthy public policy.
- Creating supportive environments.
- Strengthening community action.
- Developing personal skills.
- Reorienting health services. .

Values in Ottawa Charter for Health Promotion

Health promotion is implicitly based on several values:

- Equity and social justice
- A holistic definition of health
- Covers the full range of health determinants
- Recognizes the influence of environment on health
- Empowers people and builds individual and collective capacity
- Seeks to enhance people's social participation
- Involves intersectorial collaboration.

Health Promotion Models are:

1. **Holistic Models of Health and Wellness**

Holistic approaches to health and wellness consistent with the holistic definition of health put forward by the WHO, include the beliefs that the bio-psycho-social-spiritual person is in the state of constant dynamic interaction with the environment;

changes occurring in any of these aspects create change in all the other aspects of the person and the environment within which the client is.

2. **Adaptation Models**

Adaptation models and theories of health define health as how well able the client is to adapt and cope with changes. Disease and illness occur when the person is maladapting to the change; and health is promoted when client is able to cope successfully and in a healthy manner.

3. **Role Performance Models**

A person is considered in good health and healthy when they are able to fulfill multiple roles without disruption; and a person is considered ill when they cannot fulfill their roles and responsibilities. For example, a client who is able to continue to work and to perform their role as a parent is considered healthy and not ill as they manage a chronic disorder such as heart disease or diabetes.

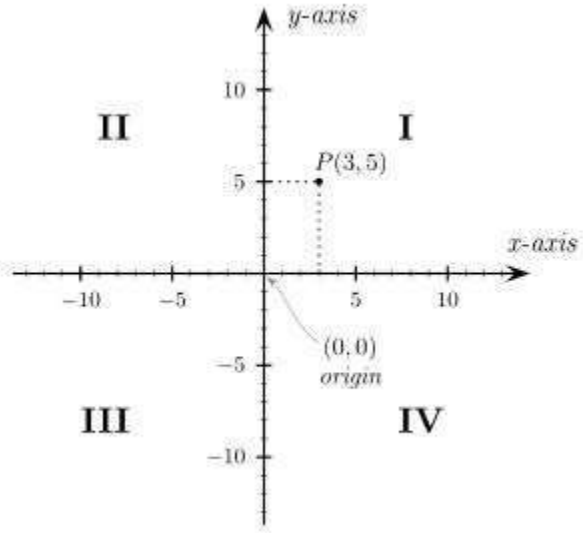
4. **The Health-Illness Continuum**

The Health-Illness Continuum, put forth by Ryan and Travis, describes health and illness along a continuum with high level health and wellness at one extreme end of the continuum and high levels of illness and poor health, including death itself, at the other extreme end of continuum. Neither health nor illness is depicted in the middle of continuum which is sometimes referred to as the neutral zone.

Clients move along the continuum from illness toward health when they are successfully treated; and clients move along the continuum from health to illness as the result of an infection or trauma.

5. **The High Level Wellness Model**

The High Level Wellness Model of Halbert Dunn is somewhat similar to the Health-Illness Continuum. High Level Wellness Model has 2 axes - horizontal axis and vertical axis. As these axes cross each other as shown below, four quadrants are formed.



The four resulting quadrants are:

- Poor health in an unfavorable environment quadrant
- Protected poor health in a favorable environment
- High level wellness in a very favorable environment and
- Emergent high level wellness in an unfavorable environment

Poor health in an unfavorable environment is present when an ill person is in an unhealthy environment. An example of poor health in an unfavorable environment is when a person with severe immunosuppression is subjected to unsanitary conditions and contaminated drinking water; an example of protected poor health in a favorable environment occurs when a client or a family, has support systems and accessibility to health care services when they are impacted with an illness, disease or disorder; emergent high level wellness in an unfavorable environment can occur when a client is committed to a regular exercise regimen, they are unable to do so because of their multiple roles and responsibilities; and poor health in an unfavorable environment occurs when a client with illness does not have the resources and services that they need to manage and correct their poor health.

6. The Agent - Host - Environment Model

The Agent - Host - Environment Model, developed by Leavell and Clark, describes disease and illness as a function of the dynamic interactions and interrelationships among the agent, the host and the environment. The Agent - Host - Environment Model is helpful for getting a fuller understanding of diseases and illnesses; it is not helpful in terms of health and health promotion.

The agent is the factor or force that leads to the disease or disorder. The agent can be a physical, psychological, social, chemical or mechanical force or factor. For example, bacteria, an agent can lead to an infectious disease when the host and the environment interact with it and each other;

and toxic chemicals can lead to a disease or disorder when the host and the environment interact with it and each other.

The host is the person could be affected with a disease or disorder when the client interacts with agent and environment interacts with client and each other. Some clients are more susceptible hosts than other clients. For example, a client's vulnerability and susceptibility to illnesses and diseases increase when they are affected by risk factors associated with the disease or disorder such as gender, age and life style choices.

The environment consists of all factors that are external to the client. Some elements of the environment can place a person at risk for a disease or illness; other environmental factors predispose the person to wellness. For example, a social stressor, such as the loss of a loved one, predisposes the host for disease and illness; and a physical environmental force, such as healthy noise levels and adequate living conditions can facilitate health.

7. The Systems Model of Neumann

The Systems Model of Neumann is based on the human being, which is an open system within the environment, has natural boundaries to protect it against the stressors in the environment.

These protective boundaries include the lines of resistance, the normal lines of defense, and the flexible lines of defense which protect the open system from environmental stressors and penetration of the open system. Health promotion includes the nurses' fortification of these lines of defense to maintain health and prevent diseases and illnesses.

When the lines become penetrated, as is the case with the occurrence of illness and disease, nurses in collaboration with other members of the health care team, provide care and treatments to reorganize and reconstitute open system after it has been disrupted with penetrating forces.

8. The Dimensions Model of Health

The Dimensions Model of Health includes 6 dimensions that impact on the individual client, groups of clients, families, populations and communities, is highly beneficial to nurses and others as they care for their clients.

The six dimensions of health are the:

1. **Biophysical Dimension**: includes physical risk factors for disease and illnesses such as the age of the person, their genetics, and the presence of any anatomical structure abnormalities.

2. **Psychological and Emotional Dimension**: includes the client's ability to adapt with and cope with changes, including those related to illness and disease, the client's level of cognition, and their willingness and motivation to participate in health and wellness activities.

3. **Behavioral Dimension**: includes the client's choices in terms of their behaviors and life style choices. For example, a good exercise regimen, adequate nutrition and the avoidance of

harmful substances are examples of some of the components of the behavioral dimension of health and wellness.

4. **Socio-cultural Dimension**: The Socio-cultural Dimension includes social forces such as socioeconomic status, and support systems; the cultural aspect of the Socio-cultural Dimension includes things like the beliefs, practices, and values of the client as based on their culture.

5. **Physical Environment Dimension**: includes factors and forces in the external environment that positively or negatively impact on clients' health. For example, clean air and clean drinking water in the environment facilitate health; and air pollution and contaminated drinking water negatively impact on the health of those who are exposed to it in the environment.

6. **Health Systems Dimension**: includes the clients' availability, accessibility, and affordability of health care and health related resources and services that meet their health related needs.

7. The Seven Components of Wellness

The Seven Components of Wellness, credited to Anspaugh, Hamrick and Rosato, is similar to the Dimensions Model of Health except that the Seven Components of Wellness has more components and some of these components are different.

The Seven Components of Wellness are the physical, intellectual, emotional, social, spiritual, occupational and environmental components of health.

The physical component, psychological component, social component and environmental component are closely parallel to physical dimension, psychological dimension, social dimension and environmental dimension. [4]

The other components of the Seven Components of Wellness are:

- **The Intellectual Dimension**: The Intellectual Dimension reflects the client's level of cognition and their abilities to solve health care problems, including an adequate level of health literacy in order for the client to understand, and consent to, procedures, alternatives, and treatments relating to their health care concerns.

- **The Spiritual Dimension**: In addition to a religious component if religious beliefs are held by the client, reflects the client's connectedness to God and higher power. This dimension gives the client a sense of meaning and connectedness beyond the immediate here and now.

- **The Occupational Dimension**: The Occupational Dimension includes client's ability to balance their work life with their personal and social lives and associated roles and responsibilities.

9. Pender's Health Promotion Model

Pender's Health Promotion Model emphasizes the relationship of the client's motivation and commitment to goal directed behavior and the promotion of health e.g the primary purpose of teaching is to change behaviors of students.

According to Pender's Health Promotion Model, health and health promotion is impacted with a wide variety of factors and forces including their personal characteristics, past experiences with successes and failures, perceptions, level of self-efficacy, support systems and emotions.

10. Health Belief Model

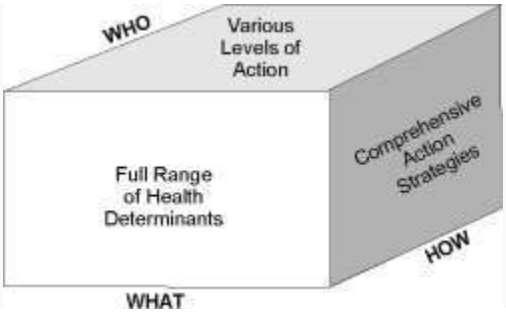
Rosenstock and Becker's Health Belief Model, addresses the relationship of the client's perceptions, beliefs and the factors related to the individuals' behaviors and their health & health promotion behaviors. This will predict whether or not a person will engage in screening tests based on their personal perceptions and beliefs. Some of the beliefs and perceptions can impact on the individual's behavior are things like demographics such as gender and culture, structural facilitators and barriers. This related to the accessibility and affordability of health care services and psychosocial factors such as support systems and economics.

Developing a Population Health Promotion Model

While developing a model to guide our actions to improve health, three questions are critical.

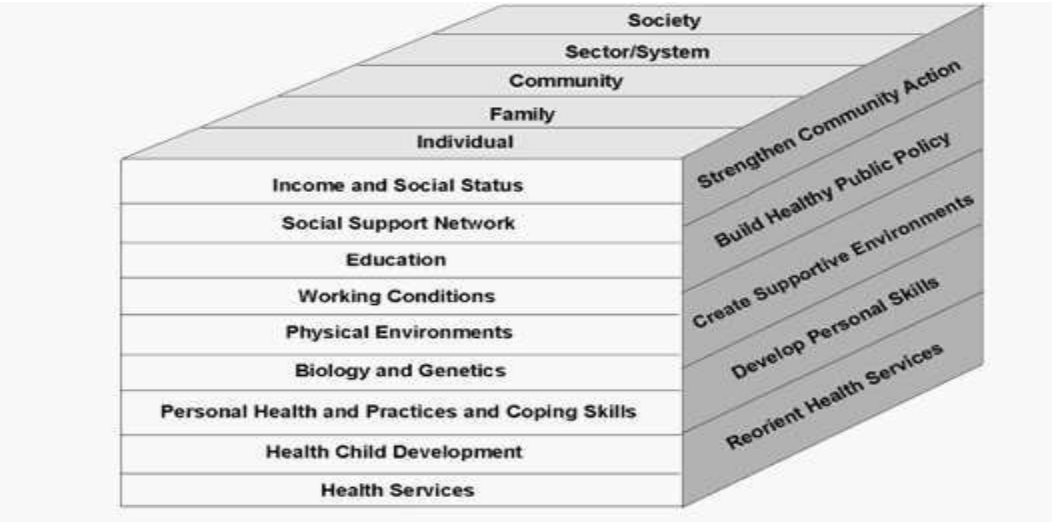
- "On WHAT should we take action?"
- "HOW should we take action?", and
- "WITH WHOM should we act?"

The answer is the Strategies for Population Health. Action must be taken on the full range of health determinants (the WHAT), A comprehensive set of action strategies to bring about the necessary change (the HOW), in order for change to be accomplished, action must be taken at various levels within society (the WHO). Taking these questions and the answers help to begin to construct an action model.



Population Health Promotion (PHP) model is a full cube shape image, which explains the relationship between population health and health promotion. This model identifies how population health approach can be implemented through action on the full range of health determinants by means of health promotion strategies.

Population Health Promotion Model



The full cube includes 12 determinants of health on the front of the cube, followed by the 5 strategies for health promotion on the side and then the levels of intervention on the top of the cube. [5]

The front of the cube outlines the social determinants of health, including:

- Income and Social Status;
- Social Support Network;
- Education;
- Working Conditions;
- Physical Environments;
- Biology and Genetics;
- Personal Health and Practices and Coping Skills;
- Health Child Development; and
- Health Services.

The strategies of health promotion are outlined on the side of the Population Health Promotion Model, which include:

- Strengthen Community Action;
- Build Healthy Public Policy;
- Create Supportive Environments;
- Develop Personal Skills; and

- Reorient Health Services.

Values and Assumptions Underlying the Population Health Promotion Model

The PHP model is based on the following assumptions:

- Comprehensive action needs to be taken on all the determinants of health using the knowledge gained from research and practice.
- It is the role of health organizations to analyze the full range of possibilities for action, to ensure their policies and programs have a positive impact on health.
- Multiple points of entry to planning and implementation are essential. There is a need for overall co-ordination of activity.
- Health problems may affect certain groups more than others. The solution to these problems involves changing social values and structures. It is the responsibility of the society as a whole to take care of all its members.
- The health of individuals and groups is a combined result of their own health practices and the impact of the physical and social environments in which they live, work, pray and play. There is an interaction among people and their surroundings. Settings, consisting of places and things, have a physical and psychological impact on people's health.
- In order to enjoy optimal health, people need opportunities to meet their physical, mental, social and spiritual needs. This is possible in an environment where relationships are built on mutual respect and caring than power and status.
- Health care, health protection and disease prevention initiatives complement health promotion. Comprehensive approaches will include a strategic mix of the different possibilities for action.

The model can be used to plan a comprehensive range of actions on emerging health issues or issues related to the health of a particular priority group.

Ancillary activities

Clinical Assessment for Health Promotion Plans are

Example: **Increasing Physical Activity**

Prior Behavior

What attempts have you made in the past to be physically active?

_____

_____

What did you learn from these experiences?

_____

_____

Personal Influences

What are the personal benefits of becoming more active?

_____

_____

What problems (barriers) might you have trying to be more active?

_____

_____

How sure are you (self-efficacy) that you can overcome these barriers to being more active?

1 2 3 4 5 6 7 8 9 10

Uncertain Very Sure

What physical activities do you enjoy most? (Activity-related affect)

_____

_____

Interpersonal Influences

Social Norms - Do any of your family members or friends expect you to be physically active? Yes No

If so, who? _____

Social Support - Who will encourage you to be active or be active with you?

_____

Role Models - Is anyone in your family or any of your friends physically active 3-5 times every week? Yes No

If so, who, and what do they do?

_____

_____

Situational Influences

Where could you be physically active doing what you enjoy?

_____

_____

Commitment to a Plan of Action

Are you ready to set goals and develop a plan to become more active? Yes No

Steps of Plan

_____

_____

_____

Competing Demands and Preferences (At Follow-up)

What problems did you encounter in trying to be more active?

_____

_____

How can you avoid these problems in the future?

_____

_____

Example: **Improving Nutrition**

Assess current stage of positive nutrition practices

Prior Behavior

What attempts have you made in the past to eat healthy foods at work and at home?

_____

_____

What did you learn from these attempts?

_____

_____

Personal Influences

What are the personal benefits of improving your eating habits?

_____

_____

What problems (barriers) might you have trying to eat healthier foods (more vegetables? more fruits, lower fat foods, and healthy grains)?

_____

_____

How sure are you (self-efficacy) that you can overcome these barriers to eating healthy?

1 2 3 4 5 6 7 8 9 10

Uncertain Very Sure

What healthy foods do you enjoy most? (Activity-related affect)

_____

_____

Interpersonal Influences

Social Norms - Do any of your family members or friends expect you to eat healthy foods? Yes No

If so, who, and what do they do?

_____

Social Support - Who will encourage you to eat healthy meals and eat them with you?\

_____

Role Models - Do any of your family members or friends eat healthy meals most of the time? Yes No

If so, who?

_____

What do they eat?

_____

_____

Situational Influences

Where can you find healthy foods to eat that you enjoy?

Work?_____

Home?_____

Other?_____

Commitment to a Plan of Action

Are you ready to set goals and develop a plan to eat healthier meals? Yes No

Steps of Plan for Healthy Eating

_____

_____

Competing Demands and Preferences (At Follow-up)

What problems did you encounter in trying to eat healthier foods?

_____

How can you avoid these problems in the future?

Interventions to Address Influences on Health Behaviors

Example: Increasing Physical Activity

Individual Characteristics and Experiences

Prior Behavior – Reinforce strengths of client and build on past successes and failures

Personal Influences

1. Benefits – Reinforce or expand vision of advantages
2. Barriers – Discuss how barriers to being more active can be worked out
3. Self-efficacy - Have try modest increase in activity to experience success, persuade of success, reinforce success, link with models of physical activity, focus on positive sensations.
4. Activity-related Affect – Help plan enjoyable activities into schedule Interpersonal Influences
5. Social norms - Encourage family and friends to increase expectations of activity
6. Social support – Help client use social support by asking family and friends to be active with Him/her or provide support to do so (encouragement, reward, family contract)
7. Role models – Plan increased interaction with persons who are physically active Situational Influences
8. Options – help select attractive, cost-effective, and safe locations for favorite Activity Commitment to a Plan of Action
9. Goal Setting – Set realistic goals for action and integrate into daily and weekly Schedule Competing Demands and Preferences
10. Unanticipated Difficulties - Work cooperatively with the client to develop a plan to avoid competing demands and preferences

Ongoing Evaluation - Follow up to see if plan worked. Readjust plan as needed.

EXERCISES

(I) MUTIPLE CHOICE QUESTIONS

Each question has four choices. Read and answer the most appropriate answer.

1). Following are the three major aspects of health promotion model, except.

a) Individual characteristics and experiences

b) Psychomotor outcomes

c) Behavior-specific cognitions and affect

d) Behavioral outcomes

Answer: ( )

2). Who proposed health promotion model

a) Virginia Henderson

b) Nola .J.Pender

c) Hildegard Peplau

d) Dorothy Vaugan

Answer: ( )

3). All these comes under the personal factor components of Health Promotion Model except,

a) Physical factors

b) Biological factors

c) Psychological factors

d) socio-cultural factors

Answer: ( )

4). What was the proposed plan of action for Ottawa Charter 1987

a) To attain health for all by 2010

b) To attain health for all by 1990

c) To attain health for all by 2000

d) To attain health for all by 2020

Answer: ( )

5). What does the Ottawa Charter Strategy "Reorienting Health Service" meant

a) Community Empowerment

b) Personal and Social Development

c) Equitable distribution of healthcare services

d) Agenda for policy making about healthcare

Answer: ( )

6). Comprehensive Model of Health Promotion refers to

a) Well defined areas of medical and psychological expertise

b) Well defined areas of medical treatment and insurance companies making payment

c) Overall health of a given population

d) Public health management plans for treating illness

Answer: ( )

7). Shape of Population Health Promotion Model

a) Square

b) Pentagon

c) Cube

d) Hexagon

Answer: ( )

8). Focus of Population Health Promotion Model

a) population health approach through health determinants

b) population health approach through health prevention

c) population health approach through health action plans

d) population health approach through health education

Answer: ( )

9). What should be the result of health promotion behaviors

a) Absence of illness

b) Desired behavior outcome

c) Free from all hazards

d) All Of The Above

Answer: ( )

10). According to Ottawa Charter, how many prerequisites are underpinned to improve healthy behavior

a) Seven

b) Eight

c) Five

d) Nine

Answer: ( )

II) FILL IN THE BLANKS

1. The health promotion model is ……. …counterpart to models of health protection
2. ……is the desired behavioral outcome and is the end point in the HPM.

3. Population Health Promotion (PHP) model explains the relationship between population health and ……
4. ……. was the venue for an international conference on health promotion in 1987.
5. Primary sources of interpersonal influences are families, peers, and……...

III) SHORT ANSWERS

Answer each question in 1-2 sentences in the space provided.

1). Explain the domains of behavioral outcomes in Health Promotion Model?

2). Write any three assumptions of Health Promotion Model?

3) Explain the core concept in Population Health Promotion Model?

4). What are the interpersonal factors influencing Health Promotion Behavior of an individual?

5). What are the strategies involved in Ottawa Charter for Health Promotion?

ANSWER KEY

(I) MUTIPLE CHOICE QUESTIONS

1) b
2) b
3) a
4) c
5) c
6) c
7) c
8) a
9) d

10) b

(II) FILL IN THE BLANKS

1. Complimentary
2. Health promoting behavior
3. Health Promotion
4. Ottawa
5. Health Care Providers

(III) SHORT ANSWERS

1) Explain the domains of behavioral outcomes in Health Promotion Model?

The domains of behavioral outcomes in Health Promotion Model include Commitment to Plan of Action, Immediate Competing Demands and Preferences, Health Promoting Behavior.

2). Write any three assumptions of Health Promotion Model?

The HPM is based on the following assumptions, which reflect both nursing and behavioral science perspectives:

a) Persons seek to create conditions of living through which they can express their unique human health potential.
b) Persons have the capacity for reflective self-awareness, including assessment of their own competencies.
c) Person's value growth in directions viewed as positive and attempt to achieve a personally acceptable balance between change and stability.

3) Explain the core concept in Population Health Promotion Model?

Population Health Promotion (PHP) model is a full cube shape image, which explains the relationship between population health and health promotion. This model identifies how population health approach can be implemented through action on the full range of health determinants by means of health promotion strategies. Strategies for Population Health points out that action must be taken on the full range of health determinants (the WHAT).

4). What are the interpersonal factors influencing Health Promotion Behavior of an individual?

Cognition concerning behaviors, beliefs, or attitudes of the others. Interpersonal influences include: norms (expectations of significant others), social support (instrumental and emotional encouragement) and modelling (vicarious learning through observing others engaged in a particular behavior). Primary sources of interpersonal influences are families, peers, and healthcare providers.

5). What are the strategies involved in Ottawa Charter for Health Promotion?

The strategies include building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services.

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MODULE 3

IMPLEMENTATION OF HEALTH PROMOTION MODELS

This module gives an understanding to the components of health promotion model and helps you to practice it in day to day life

Contents

LEARNING OBJECTIVES:

- **Discuss the various action plans, logic models, and timelines**
- **Describe their application to program implementation**
- **Enumerate on approaches to recruiting, hiring, and retaining program staff with the necessary skills**
- **Discuss the relationship between income and expenses**
- **Describe the role of program staff, their rights, and their responsibilities to program funders**

Introduction:

Implementation is a process that happens over time, not an event that occurs at a specific moment. The programs that are planned and outlined effectively by the staff and stakeholders must be now implemented so as to achieve the goal. The creation of practical and specific action plans is one of the most critical steps in health promotion planning process which would be based on program goals, objectives, and interventions.

A good action plan provides a summary of how the program needs to progress. The plan links the specific activities that will be undertaken with the outcomes desired. Once developed, the action plan helps staff members track progress, adapt to changes, and document accountability as the program unfolds. It can also serve as a key document in process evaluation — ongoing review of the process by which the program is implemented and of the impact that the process has on the outcomes.

LOGIC MODEL

A logic model is a visual depiction of the underlying logic of a planned initiative. It shows the relationship between the program's resources (inputs), its planned activities (outputs), and the changes that are expected as a result (outcomes). They are designed to provide a simple graphic illustration of the relationships assumed between the actions that will be initiated and the results anticipated.

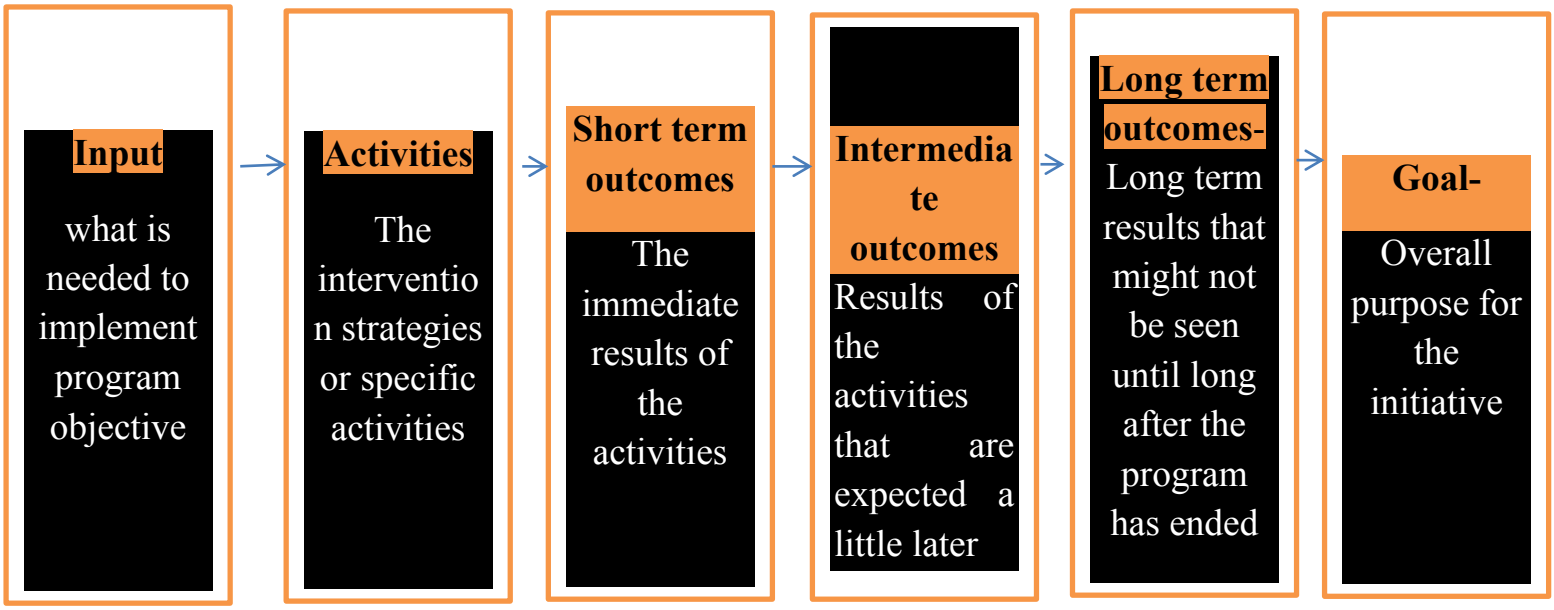
Construction of action plan – Components

Goal: statement of the outputs to be achieved			
Short term objectives:			
Objective 1 Objective 2			
Interventions:	Activities:	Personnel:	Time Frame:
What will facilitate achieving the specific objective?	What are the action steps to implement the intervention strategy?	Who will ensure that each action step is completed?	By what date does the action step need to be completed?

Characteristics of a Logic Model

- A logic model reads from left to right. Each column flows into the next, indicating that what is in each column depends on the column before it in order to be successful.
- The logic model shows what the planners are assuming which will happen as the program progresses.
- It also allows the staff and stakeholders to track any changes from what was assumed and analyze the impact of those changes on program outcomes.
- Help the stake holders and staff in communication.
- A clear and simple logic model will explain in a single page about the difference in the health behaviour or health status of a population.

COMPONENTS OF A SCHEMATIC LOGIC MODEL:



Program Inputs and Activities:

In the first column (Inputs), the major resources from the state public health department, along with its partners, are represented. Resources could be staff, locations to hold program events, organizational resources, appropriate supplies, equipment, technology, curricula, or instructional resources.

Activities brings into focus the specific strategies and interventions that were selected during the planning process on the basis of the staff and stakeholders' understanding of the underlying problem, its context, the program's theoretical framework, and the desired outcomes.

Outcomes:

The **Short-Term Outcomes**, lists the things that we expect will happen as an immediate result of each of the planned activities. The key is making sure that there is a logical link between the items that are specified in the activities column and what is assumed will happen if these are properly implemented.

The **Intermediate Outcomes** refers to results that may not be seen after a single activity but can be measured or verified at some future point.

The **Long -Term Outcomes** depicts the ultimate extension of the program's impact.

Most health promotion programs are designed to achieve a very long – term outcome that is health - or disease - related. The ultimate very long-term outcomes that are envisioned are the program's goals .Not all programs achieve their desired outcomes; others achieve the outcomes but not at the levels anticipated. Working backward and forward within a logic model throughout the action phase of a program provides valuable checks that can greatly enhance the program's effectiveness if the project manager is able to learn through analysing what has happened and why.

GANTT CHART

A Gantt chart is a visual depiction of a schedule for completing a program's objectives. This particular method of charting project activities and phases over time was developed in the early 1900s by a mechanical engineer, Henry Gantt. Originally drawn by hand on graph paper, Gantt charts and other project management planning tools are now easily developed with software such as Microsoft's Excel or Project. Ideally, a Gantt chart should be no more than a single page, even for a complex project. The goal is to show in clean and simple lines the development of the project across time and on time.

Advantages:

- A Gantt chart will help program staff to organize all of those people and activities across the time that is available to complete the program.
- It will also help communicate this calendar to all of the program staff and stakeholders. A good Gantt chart can quickly become one of the most useful tools available to program staff.
- A good Gantt chart also includes critical evaluation and reporting deadlines.
- Each period concludes with an evaluation report. However, the funder or stakeholders may require progress reports on a regular basis. If so, these need to be added to the Gantt chart. If the process

evaluation plans call for ongoing monitoring of program activities for fidelity to the original design, that monitoring also needs to be added to the chart.

Difference between Action plan and Gantt chart:

While an action plan lists everything that must be accomplished by date and by the person responsible, the items are presented in order of the program's goals and objectives. The action plan does provide the staff with useful information, but completing a Gantt chart that puts all activities on a common calendar allows the staff to make sure that nothing is overlooked and to see at a glance what activities need to be accomplished — and by when.

Queries to be answered prior to preparation of Gantt chart

- Which activities need to be done before others?
- What are the critical deadlines for each activity?
- How much time will be needed for each activity?
- Are there any scheduled holidays, vacations, or other predictable periods in which less work might get accomplished or activities won't be successful?
- When are our evaluation and progress reports due?

IMPLEMENTATION CHALLENGES

- Lack of attention to details is hampering execution of the program.
- The realities of actual program operations are more difficult than program planners anticipated.
- Staff and stakeholders do not follow the action plan or Gantt chart as closely as they should.
- Conflicts
- Unanticipated staff turnover leaves vacancies in positions that are critical to accomplishing the plan.
- Crisis occurs in the organization or community, and the program has to be put on hold.
- Unrealistic timeline
- Unsatisfied employees
- Staff members are challenged by working in teams.

HIRING AND MANAGING HIGH - QUALITY PROGRAM STAFF

Hiring Considerations

A number of strategies can be used in order to make effective hiring decisions. In general, seek to hire staff who…

Have skills and experience that are specifically matched to program goals. If a youth development program is to be implemented, seek staff who have experience in working with young people.

Have interpersonal qualities that are desirable for the program. If the program's work is highly collaborative, seek staff who value compromise and working in teams.

Are culturally competent. Cultural competence should be a requirement for program staff. Staff diversity and cultural competence contribute to supportive and caring relationships with stakeholders and participants as well as among the staff members. These relationships are critical to participants' participation in a program and their motivation to address a health concern.

Have an interest in the organizational mission. If the organization's mission is to help eliminate health disparities, seek staff who are committed to this work.

Techniques to improve the Hiring Process:

Create high - quality job announcements. An effective job announcement will describe the organization, program, minimum qualifications, and desired skills and experiences in an easy - to - understand and attractive format. Interested candidates will know how to apply, to whom, and by what deadline.

Distribute job announcements widely. Circulate the job announcement in multiple formats and places, including Internet career sites, electronic mailing lists, professional journals, and local bulletin boards. The object is to generate the largest possible pool of qualified applicants.

Screen applicants systematically. Identify leading candidates by using a grid that rates each applicant on qualifications, skills, and experience. Such grids help clarify which traits are applicants' strengths and which are most important to the project. Augment this rating process with brief telephone interviews of ten to fifteen minutes as necessary. The object is to create a short list of three to five candidates who will be interviewed.

Interview Leading Candidates

Conduct in - person interviews with the short list of candidates. Ask interview questions that will help clarify candidates ' relevant skills, experiences, and potential fit with the rest of the program staff and your organization 's mission One way to identify the best candidates is by asking them to describe potential approaches to program - specific scenarios.

Training, Coaching, Managing, and Evaluating Staff:

After making good hiring decisions, effective leaders retain qualified staff by investing in staff development: training, coaching, management, and evaluation. Staff development focuses on supporting staff so that they can (1) perform their work effectively, (2) contribute meaningfully to the organization's mission, (3) achieve high levels of satisfaction with their job, and (4) continue to expand the depth and breadth of their knowledge of health promotion.

The best staff development programs are concrete, tailored to staff needs, and ongoing. Initial sessions cover the organization's mission, policies, and procedures. Orientation sessions often match new staff members with more experienced ones in a shadowing or mentoring relationship. The new staff member learns from the established staffer through a series of observations, initial implementation efforts, and debriefing sessions. Ideally, the relationship develops on a basis of trust, understanding, and mutual respect. If so, the new staffer then has a person to consult for discussion and support about implementation challenges as they are encountered. The initial sessions will be followed closely by training sessions on the program and its implementation. Professional development does not stop once staff members are grounded in program implementation. Rather, training includes ongoing supervision. In most program structures, staff members report to a specific program director. The best programs provide time and space for these directors to meet regularly with their staff in supervisory meetings that focus on problem solving. The process of learning from a mentor continues with supervisors, who coach their staff members, using the same process (observations, debriefing, and discussion). Supervisors may also demonstrate skills and work directly with staff members on tasks, helping to strengthen the staff skills. Furthermore, good supervisors will help their staff identify areas for additional training, which may include technical skills (such as techniques for

designing program materials) or process skills (such as techniques for motivational interviewing). These training sessions might be provided by the organization or via external professional development opportunities.

Effectively trained staff should be pleasant to manage because they understand their job responsibilities, have the skills to fulfil them, and are supported through mentoring and supervision. Strong leaders are effective managers who understand the importance of structuring programs so that staff members will be poised for success. Preparing staff members for success means matching staff skills and experience with job functions while providing opportunities for growth and learning. Staff members must feel comfortable approaching their managers with concerns and requests for additional professional development opportunities. In turn, managers must create work environments that allow these requests while ensuring that all staff members perform in ways that are beneficial to both the program and the organization.

The primary method that effective leaders use to manage for staff success is performance evaluation. Workplace performance evaluation is often thought to mean year - end reviews that determine raises, bonuses, or even job cuts. While annual reviews play a role in performance evaluation, the best leaders evaluate their staff on a continual basis. Such ongoing evaluation starts with staff goals that are formulated in partnership with supervisors and that meet staff, program, and organizational needs. These goals provide the blueprint for staff work, are discussed in regularly scheduled meetings with the primary supervisor, and are adjusted as necessary on the basis of changes at the staff, program, or organizational level. In this manner, the year - end review becomes a culminating event that synthesizes and summarizes staff performance instead of providing a single high - stakes, make - or - break performance rating

BUDGETING AND FISCAL MANAGEMENT

The extent to which staff members of a health promotion program need specialized training in finance, accounting, and funding and resource development depends, to some degree, on the size and complexity of the health promotion program for which they work. Generally, the larger or more complex the organization is, the greater the likelihood that the program uses special financial management expertise.

A budget is simply a detailed statement of the resources available to a program (income) and what it costs to implement it (expenses). In the planning phase, the budget is a reasoned prediction; in the implementation phase, the budget is a living document, changing as resources come in and funds are spent. Budgets for small programs are simple and fairly straightforward; they often have a limited number of expense categories and a single funding source. But the principles regarding the basics of budgeting is same for both small and complex programs

Despite the increased presence of trained financial specialists in organizations that operate health promotion programs, it is important to understand that almost all decisions made by program directors and program staff — no matter what their role in the organization — have financial implications. Even in organizations in which staff members take on specialized roles in direct services (for example, health educators, social workers, physical therapists, physicians, or nurses), it is critical for those individuals to understand how their decisions affect and are affected by available funds, cash flow considerations, project revenue streams, and budget constraints. Therefore, it is extremely important for any person who is working or aspires to work in a health promotion program and organization to develop skills in basic accounting, financial analysis and planning, funding and resource development, and budgeting.

At the minimum, a well - prepared health promotion staff member should have the ability to interpret three basic financial documents:

- ✓ Balance sheet- A balance sheet shows what an organization owns and how it is financed
- ✓ Income statement- shows the financial performance of an organization over a specified time period — typically, a year
- ✓ Cash flow statement- shows how an organization's operations have affected its cash position.

Effective interpretation of these three documents is crucial to making sound business decisions. These documents equip health educators with information that is essential to analysing, controlling, and improving their organization ' s day - to - day operations and long - term prospects. In addition to acquiring basic skills in financial and managerial accounting, students who are contemplating senior executive roles in health promotion organizations should gain knowledge of the fundamental concepts of corporate and public sector finance.

Resources

Certain programs which are intended to complete within a stipulated time have fixed income, while in multiple year funding, budget is allocated according to the previous year annual reports. Some health promotion program budgets are based on variable factors, such as the number of people who enrol, the number of clients who complete a series of program activities, matching funds, revenue from services, fundraising, or in - kind contributions from other sources.

Expenses

Most program budgets have four primary expense categories:

Personnel - this include the compensation for the paid staff which include wage and benefit

Supplies – this include the items needed such as office supplies, printing, copying and so on.

Services – this is for those who are hired for special services for a short period like kitchen staff or translators.

Travel, training and dissemination of results

It is very essential that the program staff must know in advance what can or cannot be claimed against the budget approved.

Monitoring the fiscal budget

The expenses and resources could be monitored easily by a program director, who is solely responsible for the budget, using Microsoft applications. Receipts for reimbursement must be scrutinized and timely submission of receipts, instigated by the program director

SKILLS TO BE INSTIGATED IN IMPLEMENTATION

ADVOCACY

Advocacy is action in support of a cause or proposal. It can be political, as in lobbying for specific legislation, or social, as in speaking out on behalf of those without a voice. This is an inevitable skill a health professional need to acquire, in case of divulging into political and legal issues.

COMMUNICATION

The advent of newer technologies have wavered the means of communication among health professional as well as with public. During program implementation, effectively communicating health information to program participants, stakeholders, and staff is an important part of a health promotion program.

Development of a communication plan:

Step 1: understand the problem and the priorities of public or the stakeholders.

Step 2: define communication goals that the staff intends to communicate in the program. It may be a talk to the public, or with fellow staff or to the funding agencies and stakeholders.

Step 3: know the intended learners or audience

Step 4: section of the channels of communication

Step 5: development of partnerships with other organizations

Step6: conduct market research to refine message and materials

Step 7: implementation of the communication plan

Step 8: review task and timeline

Step 9: evaluate the plan

Having a communication plan strengthens a health promotion program. Developing and pretesting concepts, messages, and materials with the intended audience is a critical step in the communication process. Pretesting processes includes developing and testing concepts, deciding what types of materials need to be developed, testing the materials with the target audience, revising them as necessary, and implementing them. Understanding the role that health communication plays in health promotion will help staff develop effective programs in any setting by understanding the audiences ' needs and ensuring that information is provided in a meaningful and appropriate manner.

SUMMARY

Action plans, logic models, and Gantt charts are tools that program staff and stakeholders can use to implement a program and reach the desired program objectives and goals. All should be thoughtful, living documents that help program staff and stakeholders accomplish the program's objectives on time and as intended. Program staff and stakeholders should be prepared for changes and challenges during a program ' s implementation period; programs take place in schools, workplaces, health care organizations, and

communities, where change and challenge are to be expected. During implementation, staff and stakeholders also need to attend to managing the program's human and fiscal resources.

PRACTICE QUESTIONS

1) The financial performance of an organization over a specified time period is known as
    a) Balance sheet
    b) Income statement
    c) Cash flow statement
2) A …… is a visual depiction of the underlying logic of a planned initiative.
3) A …….. is a visual depiction of a schedule for completing a program's objectives

Short Notes:

4) Describe a planning model for reducing obesity among school going children and discuss its approach to program implementation.
5) Difference between Action plan and Gantt Chart
6) Characteristics of logic model.

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MODULE 4

On completion of the session, the student attains knowledge regarding the health promotion interventions and use this knowledge in their day to day life with a positive attitude.

Content outline

- Definition
- Modes of intervention
- Health promotion intervention
- The major change areas in intervention

Specific objectives: On completion of the session, the student

- defines health promotion activities
- describes the modes of interventions
- enlists the health indicators
- lists down the health promotion interventions
- explains health education
- describes the environmental modification
- describes the nutritional interventions
- explains the lifestyle and behavioral modifications

MODULE III

HEALTH PROMOTION ACTIVITIES

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Introduction

The concept of health promotion began to shape at the beginning of 20th century. The public health had neglected the citizen as an individual, and the state had a direct responsibility for the health of the individual. Consequently in addition to disease control activities, one more goal was added to public health, i.e. health promotion of the individuals.[1]

The purpose of health promotion is to focus on the person's potential for wellness and to encourage appropriate alterations in personal habits, lifestyle and environment. The public demand for health information has increased, and health care professionals and agencies have responded by providing this information. Health promotion programs, once limited to hospital settings, has now moved in to community settings such as clinics, schools, workplace etc.[2]

During the natural course of any disease five modes of intervention have been described which forms a continuum.[3] They are

1. Health promotion
2. Specific protection
3. Early diagnosis and treatment
4. Disability limitation
5. Rehabilitation

Health promotion:

"The process of enabling people to increase control over, and to improve, their health".[3]

WHO, 1986

It represents a comprehensive approach to bringing about social change in order to improve health and wellbeing. It is not directed against any particular disease, but intended to strengthen

the host.[1] To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Specific protection:

It is the provision of conditions for the normal mental and physical functioning of the human being individually and in the group. It includes the promotion of health, the prevention of sickness, and curative and restorative medicine in all its aspects. Currently available interventions aimed at specific protection are immunization, use of specific nutrients, chemoprophylaxis, protection against occupational hazards, protection against accidents, protection from carcinogens, avoidance of allergens, the control of specific hazards in the general environment, control of consumer product quality and safety of foods, drugs, cosmetics etc.[3]

Early diagnosis and treatment:

It refers to the detection of disturbances of homeostatic and compensatory mechanism while biochemical, morphological and functional changes are still reversible. Though it is not as effective and economical as "primary prevention" may be critically important in reducing the high morbidity and mortality in certain diseases such as hypertension, cancer cervix and breast cancer.[3]

Disability limitation:

When a patient reports late in the pathogenesis phase, the mode of intervention is disability limitation. The objective of this intervention is to prevent or halt the transition of the disease process from impairment to handicap.[3]

Rehabilitation:

It is the combined and coordinated use of medical, social, educational and vocational measures for training and retraining the individual to the highest possible level of functional ability. It includes all measures aimed at reducing the impact of disabling and handicapping conditions and at enabling the disabled and handicapped to achieve social integration. Social

integration has been defined as the active participation of the disabled and handicapped people in the mainstream of community life. Health for All by 2000 AD aims at providing "rehabilitation for all".[3]

Health promotion activities

Health promotion activities are those activities that assist people in developing resources that maintain or enhance well-being and improve their quality of life. These activities involve people's efforts to remain healthy in the absence of symptoms and do not require the assistance of a health care team member.[1]

Health promotion interventions

- Health education
- Environmental modification
- Nutritional interventions
- Life style and behavioral changes

Health education:

This is one of the most cost effective interventions. A large no: of disease could be prevented with little or no medical interventions. If people are adequately informed about the and if they are encouraged to take necessary precautions in time "the extension to all people of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health". The target of educational efforts may include the general public, patients, priority groups, health providers, community leaders and decision makers.[1]

Environmental modification:

A comprehensive approach to the health promotion requires environmental modification such as provision of safe water, installation of sanitary latrines, control of insects and rodents, improvement of housing etc. the history of medicine has shown that many infectious diseases have been successfully controlled in many countries through environmental modifications, even prior to the development of the specific vaccines or chemotherapeutic drugs. Environmental interventions are non-clinical and do not involve any physician.[1]

Nutritional intervention:

These comprise food distribution and nutrition improvement of vulnerable groups, child feeding programs, food fortification, nutrition education etc.[1]

Life style and behavioral changes:

The conventional public health measure and interventions have not been successful in making inroads into life style reforms. The action of prevention in this case is one of the individual and community responsibilities for health. The health care team workers act as an educator than a therapist. The lifestyle choices we make can have a direct impact on our physical and mental well-being. These choices and ultimately behaviors can be influenced or determined by many factors such as age, sex, social class, income, education, peer group pressure, work and living conditions, mental health and access to information.[1] The major areas of change should include

1. **Smoking**

Cigarette smoking is the most important single preventable cause of death in human society.[4] Enhancement of smoking cessation should include the following

- Enforcement of law
- Bans on public smoking
- Pharmacological therapy
- Relapse prevention
- Cessation clinics
- Acupuncture
- Hypnosis
- Aversive conditioning

2. **Food and nutrition**

It is important to understand that the role of food and nutrition in the promotion of health and well-being is unique. Defining a healthy diet is difficult. Most people have their own vision of what constitutes a healthy diet, even if they don't always follow it.[4] Comments from participants

Dietary Guidelines

3. To maintain a healthy body weight, balance calories taken in with calories expended.

4. To reduce the risk of chronic disease in adulthood, engage in a moderate intensity physical activity at least thirty minutes a day on most days of the week.
5. To prevent gradual weight gain in adulthood, engage in about sixty minutes of moderate to vigorous activity on most days of the week while keeping calories constant.
6. To maintain weight loss in adulthood, do sixty to ninety minutes of daily moderate intensity physical activity while keeping calories constant.
7. Limit intake of saturated and trans fats, cholesterol, added sugar, salt, and alcohol.
8. On a 2,000-calorie diet, eat two cups of fruit and two and one-half cups of vegetables each day.
9. Eat three or more one-ounce equivalents of whole-grain products each day, with the rest of the recommended grains coming from enriched or whole-grain products.
10. Consume three cups a day of fat-free or low-fat milk or equivalent milk products.
11. Consume less than 10 percent of total calories from saturated fatty acids and less than 300 milligrams a day of cholesterol, while keeping trans fatty acid consumption as low as possible.
12. Keep total fat intake between 20 percent and 35 percent of calories, with most fats coming from sources of polyunsaturated and monounsaturated fatty acids.
13. Eat lean, low-fat, or fat-free meat, poultry, dry beans, and milk or milk products.
14. Consume less than 2,300 milligrams of sodium—about one teaspoon of salt per day.
15. Increase potassium intake with fruits and vegetables

3. Alcohol

Alcohol consumption that increases the chances for a person to develop problems and complications is called *at-risk* drinking. Women who consume more than seven drinks per week, men who consume more than fourteen drinks per week, and persons who drink in risky situations are considered to be at-risk drinkers. Individuals who engage in *problem* drinking consume alcohol at a level that has already resulted in adverse medical, psychological, or social consequences. Potential consequences can include accidents and injuries, legal problems, sexual behavior that increases the risk of HIV infection, and family problems. All the alcohol-related brief interventions include the use of assessment and direct feedback, contracting and goal setting, behavioral modification techniques, and written materials such as self-help manuals. Strategies for cessation of alcohol have ranged from relatively unstructured counseling and feedback to more formal

structured therapy and have relied heavily on concepts and techniques from the behavioral self-control training. Drinking goals of brief treatment interventions are flexible, allowing the individual to choose drinking in moderation or abstinence. The overall goal of brief counseling is to motivate the problem drinker to change his or her behavior.[4]

4. Physical activity

Regular physical activity works to maintain psychological and physical well-being and prevents chronic diseases including obesity, certain types of cancer, diabetes, heart attack and hypertension and premature death. Every adult should accumulate 30 minutes or more of moderate-intensity physical activity on most, preferably all, days of the week. Regular, moderate-intensity physical activity, done at once or broken up into two or three shorter bouts of activity during the course of the day, is associated with lower death rates and other general health benefits. Researchers suggest that beginning physical activity programs early in life is the best way to prevent adolescent and later adult obesity. Current physical activity recommendations for adolescents include at least sixty minutes of moderate to vigorous physical activity daily. For older adults brisk walking, gardening, and some forms of housework can lead to health benefits. Living independently is very important to this age group. Strength training exercises can help older adults maintain independence by increasing their muscle strength and thus their ability to perform activities of daily living as maintaining personal hygiene, maintaining a household, and managing transportation. [4]

5. Dental care

The term *oral health* is used to indicate a broad view of health of the entire oral-facial complex, rather than only the health of the teeth. Health care professionals must realize the critical, interrelated role of oral health care within general health care and health promotion. For many clients, oral health issues often take a primary role in their perception of their quality of life and ideal health image. Understanding the connection between a client's oral health status and his or her perceived health status becomes even more important in light of the many health conditions that have manifestations in the mouth and face. Lack of access to oral health promotion strategies and dental treatment has become a major health issue for many individuals and is reflected in the uneven distribution of the prevalence of both caries and periodontal diseases.[4]

Interventions for dental problems

Dental Caries

Fluoride applied to the tooth, either topically or through systematic ingestion, will be a source of minerals to help reverse the decay process through remineralization Fluoride has its greatest anticaries effect on the smooth surfaces of teeth. Dental sealants can be used to physically block the minute grooves from acid penetration but can be used only on the chewing surfaces of teeth. [4]

Periodontal Diseases

Effective preventive activities need to include the recognition, identification, and elimination or minimalization of both the etiologic factors and the risk factors associated with the diseases. To clean the difficult areas in between the teeth (*interproximal* areas), dental floss, interproximal brushes, or appropriately shaped wooden picks are necessary. Twice per day rinsing with approved antimicrobial rinses will also aid in the reduction of plaque and gingivitis.[4]

Oral Trauma

Use of oral-facial protective devices (head, face, eye, and mouth protection) in sporting and recreation events that present risks of injury. Clients seeking school or sports physicals may need guidance in determining ways to keep their face and mouth intact and not altered by injury. Health care professionals can counsel clients in the use of mouth guards, helmets, face shields, and seat belts.[4]

Oral candidiasis

Oral candidiasis is associated with immunocompromised status and is commonly seen in older clients because of prolonged wearing of dentures. Oral candidiasis is best treated with a wide range of antifungal medications; however, there is no clear-cut treatment for dry mouth, with symptom relief forming the basis for recommendations for clients.[4]

Oral cancer

The use of smokeless, or spit, tobacco has especially severe negative effects in the oral facial complex and is a habit often overlooked by health care professionals. Limiting exposure to the sun, always wearing sunscreen and lip protection, and limiting alcohol ingestion are also specific behaviors that decrease the risk of oral and pharyngeal cancers. Early detection of any cancerous lesions is critical to ensure prompt care, and clients can be taught to examine their face, mouth, and neck for common signs of early oral lesion.[4]

6. Sexual behavior

The first aim of sexual behavior is the prevention of harm. Preventive action aims not only at preventing the first occurrences of negative events or outcomes, such as unwanted pregnancies, STIs, and sexual violence. Preventive action can also be aimed at the avoidable reoccurrence of negative events, such as consequent infections of other people; screening can be a relevant tool for such preventive action. Instead of focusing on prevention, sexual health promotion can also aim at enhancing positive health, which would mean increasing people's capacity to achieve sexual intimacy and have a joyful sexual life. The targets of sexual health promotion vary from individuals, families, and groups to communities. Individuals are the target of health promotion in a variety of settings, including health care interactions. Sometimes parents are targeted to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction, with the ultimate goal being to reduce sexual risk behavior among adolescents. Sexual health interventions sometimes involve schools or broader communities. One remarkable community prevention program used peer outreach, peer-led small groups, a publicity campaign, and a young men's center to promotes safer sex among young gay men[4]

Sexual Health Interventions

- Prevention of Unwanted Teen Pregnancies
- HIV Prevention
- Prevention of sexual abuse
- Sex education and counselling
- Support and motivation
- Peer education

7. Disaster preparedness

Develop the emergency plan

• Develop and provide training, based on the plan

• Test the plan (series of drills and exercises)

• Often, a graduated exercise sequence is used (tabletops/facilitated discussions, functional drills, full-scale drills)

• Use lessons learned to revise plans and training

• Repeat cycle[4]

EVALUATION

a. When a patient reports late in the pathogenesis phase, the mode of intervention is disability limitation.

b. The combined and coordinated use of medical, social, educational and vocational measures for training and retraining the individual to the highest possible level of functional ability is called rehabilitation.

c. Health for All by 2000 AD aims at providing rehabilitation for all.

d. ……. Is a health promotion intervention.

e. The health promoting intervention that is non-clinical and does not involve any physician is called as Environmental interventions.

f. Cigarette smoking is the most important single preventable cause of death in human society.

g. Alcohol consumption that increases the chances for a person to develop problems and complications is called *at-risk* drinking.

h. Alcohol consumption at a level that has already resulted in adverse medical, psychological, or social consequences are called as *problem* drinking.

i. Fluoride has greatest anticaries effect on the smooth surfaces of teeth.

j. The daily recommended consumption of sodium should be less than 2300 mg.

MIMS

HEALTH PROMOTION

MUTIPLE CHOICE QUESTIONS

Each question in this section is a multiple-choice question with four answer choices. Read each question and answer choice carefully and choose the ONE best answer.

1. Who introduced the term health promotion?
   a) Henry E. Sigerist
   b) Abraham Maslow
   c) Joseph M Juran
   d) Michael P O'Donnell
2. Where was the first international conference on health promotion held
   a) Canada
   b) China
   c) Australia
   d) Russia
3. How many key actions are mentioned in the health promotion logo
   a) 5
   b) 4
   c) 6
   d) 2
4. Among the following which are the features of health promotion. Note: More than one answer may be correct.
   a) Holistic view of health
   b) Participatory approaches
   c) Disease prevention
   d) Determinants of health
5. The colour of the outside circle of the health promotion logo is
   a) Red
   b) Orange
   c) Black

d) Blue

6. Following are the three major aspects of health promotion model, except.
   a) Individual characteristics and experiences
   b) Psychomotor outcomes
   c) Behavior-specific cognitions and affect
   d) Behavioral outcomes
7. Who proposed health promotion model
   a) Virginia Henderson
   b) Nola .J. Pender
   c) Hildegard Peplau
   d) Dorothy Vaugan
8. Among the following which is NOT a personal factor components of Health Promotion Model
   a) Physical factors
   b) Biological factors
   c) Psychological factors
   d) socio-cultural factors
9. What is the shape of Population Health Promotion Model
   a) Square
   b) Pentagon
   c) Cube
   d) Hexagon
10. The main focus of Population Health Promotion Model is population health approach through
    a) health determinants
    b) health prevention
    c) health action plans
    d) health education
11. According to Ottawa Charter, how many prerequisites are underpinned to improve healthy behavior
    a) Seven

b) Eight
c) Five
d) Nine

12. These are the approaches of health promotion, except
    a) Healthy population
    b) Healthy life style
    c) Healthy Relationship
    d) Healthy environment
13. All these are the principles of health promotion, except
    a) Peace
    b) Shelter
    c) Education
    d) Morality
14. What is the major problem facing health promotion in developing countries?
    a) Population
    b) Poverty
    c) Environment
    d) Democracy
15. Gantt chart developed on
    a) Early 1900
    b) Early 1910
    c) Early 1920
    d) Early 1930
16. The daily recommended intake of fat should be
    a) 20%
    b) 30%
    c) 25%
    d) 35%
17. Alcohol consumption that increases the chances for a person to develop problems and complications is called
    a) At-risk drinking.

b) Problem drinking
c) Problematic drinking
d) Risk drinking

18. The daily recommended consumption of sodium should be less than
    a) 2300 mg.
    b) 2500 mg
    c) 3000 mg
    d) 2100 mg
19. The recommended duration of moderate intensity physical activity to reduce the risk of chronic disease in adulthood is
    a) 20-30 minutes per day
    b) 10 minutes per day
    c) 10-20 minutes per day
    d) 1 hour per day
20. The specific behaviors that reduces the risk of oral and pharyngeal cancer includes all the following, except
    a) Limiting exposure to sun
    b) Wearing sunscreen and lip protection
    c) Limiting alcohol ingestion
    d) Use of smokeless tobacco

GERIATRIC CARE

MODULE

MIMS COLLEGE OF NURSING

MIMS
College of Nursing

CERTIFICATE COURSE

ON

GERIATRIC CARE

Prepared by:

MIMS COLLEGE OF NURSING

INTRODUCTION

The science of aging indicates that chronic disease and disability are not inevitable. As a result, health promotion and disease prevention activities and programs are an increasing priority for older adults, their families, and the health care system. Geriatrics differs from standard adult medicine because it focuses on the unique needs of the elderly person. The aged body is different physiologically from the younger adult body, and during old age, the decline of various organ systems becomes manifest. Previous health issues and lifestyle choices produce a different constellation of diseases and symptoms in different people. The appearance of symptoms depends on the remaining healthy reserves in the organs. Smokers, for example, consume their respiratory system reserve early and rapidly.

Gerontological nursing is the specialty of nursing pertaining to older adults. Gerontological nurses work in collaboration with older adults, their families, and communities to support healthy aging, maximum functioning, and quality of life. The term Gerontological nursing, which replaced the term geriatric nursing in the 1970s, is seen as being more consistent with the specialty's broader focus on health and wellness, in addition to illness.

The current course introduces you to the basic key information of geriatric care such as the basic concept, aging process, and health issues of elderly, nursing management of elderly and geriatric rehabilitation.

MODULE – 1

This module introduces you to the field of Geriatric care and provides an overview of definitions and key concepts.

Content

- Demographics
- Definitions
- History of geriatric care
- Principles of geriatric care
- Theories of geriatric care

MODULE: 1

CONCEPTS OF GERIATRIC CARE

LEARNING OBJECTIVES

By the end of this module, you will:

1. understand the demographics of old age
2. define geriatric care
3. identify the history of geriatric care
4. understand the principles of geriatric care
5. identify the theories of geriatric care

DEMOGRAPHICS OF ELDERLY

Global statistics

The world's older population continues to grow at an unprecedented rate. Today, 8.5 percent of people worldwide (617 million) are aged 65 and over. According to a new report, this percentage is projected to jump to nearly 17 percent of the world's population by 2050 (1.6 billion)"An Aging World: 2015" was commissioned by the National Institute on Aging (NIA), part of the National Institutes of Health, and produced by the U.S. Census Bureau. The report examines the demographic, health and socioeconomic trends accompanying the growth of the aging population.

- By 2050, global life expectancy at birth is projected to increase by almost eight years, climbing from 68.6 years in 2015 to 76.2 years in 2050.
- The global population of the "oldest old" — people aged 80 and older — is expected to more than triple between 2015 and 2050, growing from 126.5 million to 446.6 million. The oldest old population in some Asian and Latin American countries is predicted to quadruple by 2050.
- Among the older population worldwide, non-communicable diseases are the main health concern. In low-income countries, many in Africa, the older population faces a considerable burden from both non communicable and communicable diseases.
- Risk factors — such as tobacco and alcohol use, insufficient consumption of vegetables and fruit, and low levels of physical activity — directly or indirectly contribute to the global burden of disease. Changes in risk factors have been observed, such as a decline in tobacco use in some high-income countries, with the majority of smokers worldwide now living in low- and middle-income countries.

Status in India

- According to Population Census 2011 there are nearly 104 million elderly persons (aged 60 years or above) in India; 53 million females and 51 million males. A report released by the United Nations Population Fund and Help Age India suggests that the number of elderly persons is expected to grow to 173 million by 2026.

- Both the share and size of elderly population is increasing over time. From 5.6% in 1961 the proportion has increased to 8.6% in 20 11. For males it was marginally lower at 8.2%, while for females it was 9.0%.

Status in Kerala

- The proportion of the elderly in Kerala's population, already the highest in India, is set to go up from 12 percent to 20 percent by 2026, an expert said today.
- "By 2026, the geriatric population in Kerala will touch 20 percent due primarily to demographic transition,"
- The "demographic transition" in Kerala is characterised by increased life expectancy which stands at 74.1 years as compared to the national average of 65 years

DEFINITIONS

Aging

Aging can also be defined as a progressive functional decline, or a gradual deterioration of physiological function with age, including a decrease in fecundity

-Partridge and Mangel, 1999; Lopez-Otin et al., 2013

Gerontology /Geriatrics

- The branch of medicine concerned with the diagnosis, treatment and prevention of disease in older people and the problems specific to aging. Also called geriatrics. It was derived from the Greek "geron" meaning "old man" + "iatreia" meaning "the treatment of disease
- Geriatrics is a branch of medical and nursing science that deals with the treatment and care of disease conditions in old people including also constructive health practice and prevention of disease.

-Newton 1950

- Geriatrics is the positive approach to preserve and to restore human ability in old age

-Norton 1965

Geriatric Nursing

- Geriatric nursing is defined as the assessment of nursing needs of older people, planning and implementing nursing care to meet those needs and evaluating the effectiveness of such care to achieve and maintain a level of wellness consistent with limitations imposed by the ageing process.

-American nurses association 1970

- Geriatric nursing is defined as the specialized nursing care of the older adults that occur in any setting in which nurses use knowledge, expertise and caring abilities to promote optimal functioning.

-Lena myrtle gomez

AGE CLASSIFICATION

The old age group is classified into three .That is

Young old adults (65 to 74yrs)

Middle old (75 to 84yrs)

Old-old adults (85 and above)

HISTORY OF GERIATRIC NURSING

The history of Geriatric nursing as a profession, although the need for a Geriatric nursing specially was identified as early as 1990, formalization of the spatiality occurred only in 1966, as other specialties in nursing were being formally recognized.

The first Geriatric nursing text was published in 1950 by Newton. Like many nursing texts of the day, the material was long on aphorism and short on scientific rationale. Norton. (1962) conducted a landmark study describing the problems of hospitalized older people and the conditions under which nurses cared for them in the United Kingdom. At approximately the same time, Schwartz et al. (1964) published their study of the psychosocial needs of elderly ambulatory patients. These nursing activities, along with political action being generated to establish governmental health insurance for the aged, set the stage for the establishment of Geriatric nursing as a specially. In 1962 the ANA convened the first meeting of a Conference Group on Geriatric Nursing Practice. Four years later a Division of Geriatric Nursing Practice was established, giving nursing of the aged specialty status along with maternal child health, medical-surgical nursing, psychiatric nursing, and community health nursing.

1965-1981

The period following the enactment of Medicare and Medicaid was one of rapid growth in health care generally. Federal funding for nursing training stimulated growth in nursing practice and education in the form of "expanded roles" for nurses, rapid increases in the numbers of nurses prepared at the master's and doctoral levels, and an increased interest in theory building in nursing science.

Medicare and Medicaid spawned tremendous growth in nursing home and hospital industries. Medicare legislation provided payment for medical care for older persons.

Large scale longitudinal studies of the aging process began to nature during the 1960s and 1970s, providing the scientific base for much of the modern prospective on aging. During this era, social policy for care of the aged evolved in the form of the Older American's Act and amendments to the Social Security Act.

1981-1990

A watershed year in Gerontological nursing, 1981 marked the beginning of major public policy shifts away from Federal involvement in social programs of all types, including health care

financing. The Omni bus Reconciliation Act (OBRA) of 1981 liberalized Medicare home health benefits by removing the limit on the number of visits allowed and the requirement for prior hospitalization. This led to the rapid growth in home health and dramatically changed the acuity level of patients being cared for in the home. The Tax Equity and Fiscal Responsibility Act of 1983 changed Medicare reimbursement for hospitals from a cost-based system to a prospective payment system, creating, for the first time since 1965, an incentive for hospitals to contain costs rather than expand service costs.

Concern about the high cost of health care led to experiments in financing health care for the aged in the late 1970s, which resulted in more widespread implementation of new models for care provision, such as reimbursement for care coordination, or "case-management" service, increased use of non-physicians as gatekeepers for care, increased centralization of diverse community based service, and prepaid care.

The 1980s were characterized by an increased interest in health promotion and fitness, and a slowly growing understanding of the limitations of technology to cure all ills. During this same period, increased interest in the ethical aspects of long-term care was evident.

Fundamental changes also occurred during this period in delivery of health care services. The number of hospitals beds decreased, and new institutions for the delivery of medical care emerged, including "urgent care" centers, ambulatory surgery facilities, and outpatient rehabilitation center. These innovations have the potential to benefit older people by containing costs through decreased overhead and hospitalization and by foresting the development of new care models.

1991 to the Present

During the late 1980s, and into the present, rare experiencing some of the benefits of Gerontological educational and research initiatives. The Geriatric Research, Education and Clinical Centers (GRECCs) of the US Department of Veterans Affairs provide substantial leadership in training of other Gerontological health care providers, including nurses. Geriatric education Centers (GECs) are now widespread throughout the country in academic health sciences centers, providing multidisciplinary continuing education for health care providers.

The medical outcomes movement has focused increased attention on whether care received by older adults is appropriate and effective (Lawlor, 1992). Outcomes research is currently spearheaded by the US Agency for Health Care Policy and Research (AHCPR), under its Medical Treatment effectiveness program. One goal of this approach is to examine variability in treatment

approaches for common conditions, and determine (if a suitable scientific basis exists) a recommended set of approaches to assessment and treatment of these conditions that can reduce treatment variability and cost, improve quality and enhance patient outcomes (Kravitz et al., 1992). Cooperative studies of Intervention Techniques (FICSIT) trails jointly sponsored by the NIA and NINR and most recently with the establishment of several Older Americans independence Centers (OAICs) throughout the country. Finally, establishment of a National Institute for Nursing Research (NINR) further helps to expand the knowledge base for Gerontological nursing practice.

PRINCIPLES OF GERIATRICS

1. Aging is not a disease

Aging occurs at different rates Between individuals Within individuals in different organ systems Aging alone does not generally cause symptoms Aging increases susceptibility to many diseases and conditions ("homeostenosis")Aging people are heterogeneous - some are very healthy, some are very ill

2. Medical conditions in geriatric patients are commonly chronic, multiple, and multifactorial

Older individuals commonly suffer multiple chronic conditions, making management complex and challenging Acute illness are superimposed on chronic conditions and their management Treatment for one chronic or acute illness can influence the management of other underlying conditions Multiple factors are generally involved in the pathogenesis of geriatric conditions

3. Reversible and treatable conditions are often under-diagnosed and under-treated in geriatric patients

Older individuals, caregivers, and health professionals mistakenly attribute symptoms to "old age" Many conditions present atypically in the geriatric population Systematic screening for common geriatric conditions can help avoid undiagnosed, treatable conditions Geriatric "syndromes" are commonly undiagnosed and therefore not managed optimally, such as: delirium, gait, instability and falls, urinary incontinence, pain, and malnutrition

4. Functional ability and quality of life are critical outcomes in the geriatric population

Functional capacity, in combination with social supports, is critical in determining living situation and overall quality of life Small changes in functional capability (e.g., the ability to transfer) can make a critical difference for quality of life of older patients and their caregiver Standard tools can be used to measure basic and instrumental activities of daily living and overall quality of life

5. Social history, social support, and patient preferences are essential aspects of managing geriatric patients

Understanding the patient's life history and preferences for care are critical (place of birth, education, occupation, family relationships, spirituality, resources, willingness to take risks and utilize resources for care, etc) Living circumstances are critical to managing frail older patients

Caregiver availability, health, and resources are critical determinants of care planning for frail older patients

6. Geriatric care is multidisciplinary

Interdisciplinary respect, collaboration, and communication are essential in the care of geriatric patients and their caregivers various disciplines play an important role in geriatric care, e.g. nursing, rehabilitation therapists, dieticians, pharmacists, social workers, etc.

7. Cognitive and affective disorders are prevalent and commonly undiagnosed at early stages

Aging is associated with changes in cognitive function Common causes of cognitive impairment include delirium, Alzheimer's Disease, and multi-infarct dementia Geriatric depression is often undiagnosed Screening tools for delirium, dementia, and depression should be used routinely

8. Iatrogenic illnesses are common and many are preventable

Polypharmacy, adverse drug reactions, drug-disease interactions, drug-drug interactions, and inappropriate medications all common Complications of hospitalization, such as falls, immobility, and deconditioning can be serious and life-threatening

9. Geriatric care is provided in a variety of settings ranging from the home to long-term care institutions

There are specific definitions and criteria for admission to different types of care settings Funding for care in different settings varies and depends on many factors Transitions between care settings must be coordinated in order to avoid unnecessary duplication, medical errors, and patient injuries Integrated, multi-level systems provide the most coordinated care for complex geriatric patients

10. Ethical issues and end-of-life care are critical aspects of the practice of geriatrics

Ethical issues arise almost every day in geriatric care Advance directives are critical for preventing some ethical dilemmas Principles of palliative care and end-of-life care are essential for high quality geriatric care

THEORIES OF AGING

I. BIOLOGICAL THEORIES

Biological theories attempt to explain the physical process of aging, including molecular and cellular changes in the major organ systems and the body's ability to function adequately and resist disease. They also attempt to explain why people age differently and what factors affect longevity and the body's ability to resist disease.

Genetic Theory

According to genetic theory, aging is an involuntarily inherited process that operates over time to alter cellular or tissue structures. This theory suggests that life span and longevity changes are predetermined. Stanley, Blair, and Beare (2005) state: [Genetic] theories posit that the replication process at the cellular level becomes deranged by inappropriate information provided from the cell nucleus. The DNA molecule becomes cross-linked with another substance that alters the genetic information. This cross-linking results in errors at the cellular level that eventually cause the body's organs and systems to fail.

Wear-and-Tear Theory

Proponents of this theory believe that the body wears outon a scheduled basis. Free radicals, which are the waste products of metabolism, accumulate and cause damage to important biological structures. Free radicals are molecules with unpaired electrons that exist normally in the body; they also are produced by ionizing radiation, ozone, and chemical toxins. According to this theory, free radicals cause DNA damage, cross-linkage of collagen,
and the accumulation of age pigments.

Environmental Theory

According to this theory, factors in the environment (e.g., industrial carcinogens, sunlight, trauma, and infection) bring about changes in the aging process. Although these factors are known to accelerate aging, the impact of the environment is a secondary rather than a primary factor in aging. Science is only beginning to uncover the many environmental factors that affect aging.

Immunity Theory

Immunity theory describes an age-related decline in the immune system. As people age, their ability to defend against foreign organisms decreases, resulting in susceptibility to diseases such as cancer and infection. Along with the diminished immune function, a rise in the body's autoimmune response occurs, leading to the development of autoimmune diseases such as rheumatoid arthritis and allergies to food and environmental agents.

Neuroendocrine Theory

This theory proposes that aging occurs because of a slowing of the secretion of certain hormones that have an impact on reactions regulated by the nervous system. This is most clearly demonstrated in the pituitary gland, thyroid, adrenals, and the glands of reproduction. Although research has given some credence to a predictable biological clock that controls fertility, there is much more to be learned from the study of the neuroendocrine system in relation to a systemic aging process that is controlled by a "clock."

II. PSYCHOSOCIAL THEORIES

Psychosocial theories focus on social and psychological changes that accompany advancing age, as opposed to the biological implications of anatomic deterioration. Several theories have attempted to describe how attitudes and behaviour in the early phases of life affect people's reactions during the late phase. This work is called the process of "successful aging."

Personality Theory

Personality theories address aspects of psychological growth without delineating specific tasks or expectations of older adults. Murray and Zentner (2001) state, "Evidence supports the general hypothesis that personality characteristics in old age are highly correlated with early life characteristics" (p. 802). In extreme old age, however, people show greater similarity in certain characteristics, probably because of similar declines in biological functioning and societal opportunities. In a classic study by Reichard, Livson, and Peterson (1962), the personalities of older men were classified into five major categories according to their patterns of adjustment to aging. According to this study:

- ***Mature men***

  Matured men are considered well-balanced persons who maintain close personal relationships. They accept both the strengths and weaknesses of their age, finding little to regret about retirement and approaching most problems in a relaxed or convivial manner without continually having to assess blame.

- *"**Rocking chair**"*

  Rocking chair personalities are found in passive– dependent individuals who are content to lean on others for support, to disengage, and to let most of life's activities pass them by.

- ***Armored men***

  Armored men have well-integrated defense mechanisms, which serve as adequate protection. Rigid and stable, they present a strong silent front and often rely on activity as an expression of their continuing independence.

- ***Angry men***

  Angry men are bitter about life, themselves, and other people. Aggressiveness is common, as is suspicion of others, especially of minorities or women. With little tolerance for ambiguity or frustration, they have always shown some instability in work and their personal lives, and now feel extremely threatened by old age.

- ***Self-haters***

  Self-haters are similar to angry men, except that most of their animosity is turned inward on themselves. Seeing themselves as dismal failures, being old only depresses them all the more. The investigators identified the mature, "rocking chair," and Armored categories as characteristic of healthy, adjusted individuals and the angry and self-hater categories as less successful at aging. In all cases, the evidence suggested that the personalities of the subjects, although distinguished by age-specific criteria, had not changed appreciably throughout most of adulthood.

Developmental Task Theory

Developmental tasks are the activities and challenges that one must accomplish at specific stages in life to achieve successful aging. Erikson (1963) described the primary task of old age as being able to see one's life as having been lived with integrity. In the absence of achieving that sense

of having lived well, the older adult is at risk for becoming preoccupied with feelings of regret or despair.

Disengagement Theory

Disengagement theory describes the process of withdrawal by older adults from societal roles and responsibilities. According to the theory, this withdrawal process is predictable, systematic, inevitable, and necessary for the proper functioning of a growing society. Older adults were said to be happy when social contacts diminished and responsibilities were assumed by a younger generation. The benefit to the older adult is thought to be in providing time for reflecting on life's accomplishments and for coming to terms with unfulfilled expectations.

The benefit to society is thought to be an orderly transfer of power from old to young. There have been many critics of this theory, and the postulates have been challenged. For many healthy and productive older individuals, the prospect of a slower pace and fewer responsibilities is undesirable.

Activity Theory

In direct opposition to the disengagement theory is the activity theory of aging, which holds that the way to age successfully is to stay active. Multiple studies have validated the positive relationship between maintaining Meaningful interaction with others and physical and mental well-being. Sadock and Sadock (2007) suggest that social integration is the prime factor in determining psychosocial adaptation in later life. Social integration refers to how the aging individual is included and takes part in the life and activities of his or her society. This theory holds that the maintenance of activities is important to most people as a basis for deriving and sustaining satisfaction, self-esteem, and health.

Continuity Theory

This theory, also known as the developmental theory, is a follow-up to the disengagement and activity theories. It emphasizes the individual's previously established coping abilities and personal character traits as a basis for predicting how the person will adjust to the changes of aging. Basic lifestyle characteristics are likely to remain stable in old age, barring physical or other types of complications that necessitate change. A person who has enjoyed the company of others and an

active social life will continue to enjoy this lifestyle into old age. One who has preferred solitude and a limited number of activities will probably find satisfaction in a continuation of this Lifestyle. Maintenance of internal continuity is motivated by the need for preservation of self-esteem, ego integrity, cognitive function, and social support. As they age, individuals maintain their self-concept by reinterpreting their current experiences so that old values can take on new meanings in keeping with present circumstances. Internal self-concepts and beliefs are not readily vulnerable to environmental change; and external continuity in skills, activities, roles, and relationships can remain remarkably stable into the 70s. Physical illness or death of friends and loved ones may preclude continued social interaction (Sadock & Sadock, 2007).

EXERCISES

MUTIPLE CHOICE QUESTIONS

Each question in this section is a multiple-choice question with four answer choices. Read each question and answer choice carefully and choose the ONE best answer.

1. Which is the age classification of young old adults?
    a) 65-74
    b) 60-70
    c) 62-68
    d) 62-70
2. What is the expansion of GRECC?
    a) The General research of elderly and clinical care
    b) The Geriatric Research, Education and Clinical Centers
    c) The geriatric research of elderly and clinical care
    d) The general research of elderly and clinical care
3. Who proposed the personalities of older men?
    a) Murray and Zentner
    b) Reichard, Livson, and Peterson
    c) Sadock and Sadock
    d) Stanley, Blair, and Beare
4. What is rocking chair?
    a) well-balanced persons who maintain close personal relationships
    b) personalities are found in aggressive and suspicious individuals
    c) personalities are found in passive– dependent individuals
    d) personalities with well integrated defense mechanisms
5. Disengagement theory explains
    a) The process of withdrawal by older adults from societal roles and responsibilities
    b) the way to age successfully is to stay active of older adults
    c) Psychological growth without delineating specific tasks
    d) Age-related decline in the immune system

6. Formalization of Geriatrics was in
    a) 1986
    b) 1967
    c) 1977
    d) 1966

Answer key

1.a	**2.b**	**3.b**	**4.c**	**5.a**	**6.d**

Answer briefly

1. Define geriatrics
2. Define geriatric nursing
3. Define aging
4. Classification of aging

Answer shortly

1. Explain the principles of geriatrics
2. Explain the theories of aging
3. Explain the history of geriatric care

MODULE – 2

This module gives an understanding to the informations regarding aging process and associated changes in elderly.

Content

- Aging process
- Normal changes occurs in aging

MODULE: 2

THE AGING PROCESS AND ASSOCIATED CHANGES

LEARNING OBJECTIVES

By the end of this module, you will:

1. understand the aging process
2. identify normal changes occurs in aging

AGEING PROCESS

Ageing is a universal phenomenal old age is not in itself a disease, but is a normal part of the human life span. Ageing is normal, universal, progressive, irreversible process. It is an inevitable physiological phenomenon. The human life span follows a recognized pattern from birth to death. A peak of human growth and development is reached in the twenties as the ageing process progress mental capabilities such as memory and physical abilities further deteriorate.

TYPES OF AGEING

1. **Biologic ageing:-** refers to the changes in structure and functions of the body that occurs over the life span.
2. **Functional ageing:-** Refers to the capacities of individuals for functioning in societies as compared with that of others of the same age.
3. **Psychological ageing:** Refers to behavioural changes, changes in self-perception and reactions to the biologic changes.
4. **Sociologic ageing:-** Refers to the roles and social habits of individuals in society.
5. **Spiritual ageing:-** refers to changes in self and perception of self of relationships of self to others, of the place of self in the world and of the self's world view.

FACTORS WHICH INFLUENCING AGEING FACTOR

1. Hereditary factors

Some families live longer that others given the same environmental circumstances. This is related with genetic factors. This gene is not only the ageing but could also be a cancer gene.

2. Environmental factors

Bourlier in 1973 has given three factors

- Abiotic factor: these are the physical and chemical components of the environment such as climatic influences pollutants and radiations.

- Biotic factor: These results from the influence of the thousands of living organisms which share mans environment. Ageing processes are affected by such things as pathogens, parasites and quality and availability of food products.
- Socio economic factors: Adverse living and working conditions can increases the wear and tear of tissues to which the individual is exposed. Stressful living conditions are likely to accelerate the process of ageing. Stress factors are more prevalent in modern industrialized society. Income, poverty and chronic health problems also affect ageing.

3. Disabilities of old people

Inability to perform as expected in the socio-economic and cultural context. Eg poor self care improper family role and social role, vocational incompetence, improper interpersonal relationships, bad money management all these causes burden to family. So the care had to be planned accordingly to such as individualized needs, family needs available resources and facilities. So we have to indentify the needs of the particular person, his financial conditions and set an objective and take action and implement it. The main goal is helping the aged to reach and maintain the best level of functioning reduction or maintenance of disability or to remove the problems faced as the result of illness.

NORMAL CHANGES WHICH OCCURS IN AGEING

Changes in posture and appearance

- Lean body mass in muscle tissue is lost, whereas the proportion of the fat increases. This decline I muscle mass and increase in fat is known as Sarcopenia
- Loss of elasticity and flexibility in muscle tissue, due to increases in fiber, decrease in muscle mass
- Changes in the body composition, due to the result of their diet and life style
- Skin surface will become wrinkle, dry and tougher, due to the ultraviolet from the sun which damages the elastic fibers and is known as Photo ageing or extrinsic ageing
- Deeper layer of skin losses fat and the sebaceous and sweat glands deteriorate
- Reduction in circulation in the skin causing skin temperature regulation mechanism les functioning, due to that wound healing is delayed
- The hair becomes fine, limp and scanty or bald
- The height reduces by three inches with age in both body and extremities, due to the Lessing in production of Oestrogen and Testosterone which causes a loss of bone mineral density, causing the bone to become brittle, so that easy bending occurs and easy fractures in older people
- Posture becomes stooped forward with flexed knees, hips and elbows and head is tilted back

Changes in Musculo Skeletal system

- Old people suffer from arthritis, paralytic stroke and osteoporosis problems this produces stiffness of joint making them difficult for easy movement such as getting up from a chair, to turn their neck and to keep an erect posture
- Shoulder width is reduced due to bone loss
- Loss tone and elasticity
- Kyphosis

Changes in Central nervous system

- Decreased ability to orient
- Progressive loss of nervous and sensory system

- Delayed reaction ands responses
- Reduction in the efficiency of sensory perception
- Atrophy of the brain
- Decreased blood flow and affection of peripheral nerves

Sense of touch

Sense of touch deteriorates with age, especially in finger tips, palms and in the lower extremities. This also causes less level of painful stimulant

Changes in the respiratory system

- The aspiratory and expiratory muscle strength is reduced.
- The lungs looses elasticity, so that breathing efficiency is reduced
- Decreased vital capacity causing decline in Oxygen consumption
- Breathing may more become more difficult after strenuous exercise

Changes in Immune system

- Cells continually wear out and existing cells cannot repair damaged parts within themselves, especially in skeletal and heart muscles and throughout nervous system
- Ageing affect he immune system of the body making it defective, and attacking not just foreign proteins, bacteria and viruses but also producing antibodies against itself.

Loss of immune function

- Loss of elasticity in blood vessels, muscle tissue, skin, the lens of the eye and other organs and to slower wound healing

Changes in Cardiovascular System

- The heart muscles are replaced with fat, Myocardial hypertrophy occurs
- A loss of elastic tissues and an increases in collagen
- Deposit of fat on the walls of arteries causing atherosclerosis or weakening of the walls later cause Aneurysms
- Endocardium of the heart thickens from fibrosis and sclerosis.
- The heart valves thicken and rigid and less functional
- The BP get elevated

- The heart rate slows with age
- Stroke volume and cardiac output decreases
- Blood flow to all organs decreases
- Coronary artery blood flow decreases 35%
- Delay occurs in recovery of Myocardial contractility

Changes in blood vessel

- Arterial elasticity decreases result in increased peripheral resistance
- Superficial vessels become more prominent
- Valves in veins become less efficient causing varicose vein and
- Systolic BP is raised
- Heart work increases in response to increase peripheral resistance
- Altered distribution of blood flow

Changes in the urinary system

- The kidney decreases in volume and weight and the total number of filters effecting the functioning of the kidney
- Lose the capacity to absorb the glucose as well as concentrating and diluting ability
- Increases problems with dehydration and loss of salt in the blood
- Problem of incontinence
- In women, the common problem is the inability of the bladder to empty completely causing cystitis and UTI
- Retention of urine

Changes in the GI system

- Decrease in the contraction of muscles and more time for the cardiac sphincter to open, thus taking more time for food to be transmitted to the stomach, as a result a person always feels a fullness of stomach even before having a full meal
- Loss of appetite
- The secretions of gastric juice in the stomach diminish producing a condition called acute gastritis. This may lead to stomach ulcers and colon and stomach cancer.
- Stomach discomfort
- Smooth muscle content and ton of the wall of the colon decrease causing chronic constipation

Changes in the Endocrine system

- The secretion Oestrogen protects women from heart disease and bone demineralizing
- The other hormones are testosterone, thyroid, growth hormones and insulin, whose productions' are decreased.
- Changes in the insulin level causes high blood sugar level

Changes in reproductive system

- In men - sperm count decreases, the erection process decreases, urge for sexual intercourse gradually decreases. Enlarged prostates is another problem
- In women – the production of eggs decreases and menopause sets along with estrogen.
- Vaginal secretion decreases causing dry vagina
- Laxity in pelvic floor causes prolapsed of the uterus and bladder
- Cancer of breast, ovary and cervix are common

Changes in nervous system

- Number of neurons and nerve cells decreases
- Changes in brain tissues, flow of blood and receptor organs cause Alzheimer's and other dementias
- Brain weight is reduced by 10%, due to loss of fluids and an accumulation of Lipofuscin causes slower transmission of information from one neuron to another

Changes in sleep pattern

- Complains of less sleep
- Sleep progress over 5 stages. In the 1^{st} stage to 4^{th} sages there is no rapid eye movement. In the 5^{th} stage the rapid eye movement occurs. These cycles are repeated 4-5 times through out the night.

Changes in sensory function

- Reduction in the efficiency of sensory perception
- The ability to respond to the information is provided by the series may also be reduced
- Sensory discrimination

Changes in vision

- Loss of vision
- Changes in the visual pathway of brain and the visual cortex which blocks the transmission of stimuli from the sensory organs
- Surface of the cornea thickens and irregular in shape
- The pupil becomes smaller and more fixed in size. The opening in the pupil becomes reduced to 2/3 of the original size
- Peripheral vision become narrowed with age
- Problems in rod and cone function due to less supply of oxygen to the retina
- The muscles that stretch the lens deteriorate with age and causing difficulty in close vision
- The hardening of the lens due to changes in collagen tissue does not occur.
- The lens become more opaque and less light pass through or prevent the light from entry
- Narrowing the peripheral vision
- Macular degeneration
- Dryness of the eye due to lack of tears.

Changes in hearing

- Hearing loss the Pinna appears somewhat elongated and rigid
- The supporting wall of external auditory canal deteriorates
- The stapes become fixed and cannot vibrate (Osteosclerosis)
- Cellular deterioration and vascular changes in auditory pathways

Changes in taste and smell

- Complaints of taste difference due to the loss in taste buds as aged or their ability to appreciate taste

EXERCISES

Short notes

1. Explain the aging process
2. Explain the changes associated with aging

MODULE – 3

This module explore you to the common health problems of elderly

Content

- Common physical problems among elderly
- Common mental problems among elderly
- Common social problems among elderly

MODULE: 3

COMMON HEALTH PROBLEMS AMONG ELDERLY

LEARNING OBJECTIVES

By the end of this module, you will:

1. describe common physical problems among elderly
2. describe common mental problems among elderly
3. describe common social problems among elderly

COMMON HEALH ISSUES AMONG ELDERLY

COMMON PHYSICAL PROBLEMS AMONG ELDERLY

1. Arthritis

Arthritis is the breakdown of tissue inside the joints. It can cause pain, inflammation, restricted movement of the area and an apparent weakness within the joints affected. Arthritis is very common in the UK, affecting around 10 million people of all ages. There are two main types of Arthritis: Osteoarthritis and Rheumatoid Arthritis. When it comes to older people, the most common type of arthritis is osteoarthritis. This is caused by wear and tear; the older we are the more we have used our joints through our lifetimes. Around eight million people in the UK are affected by this type of arthritis.

Symptoms of arthritis

Joint pain, tenderness and stiffness. Restricted movement of joints. Inflammation in and around the joints. Unfortunately, there is currently no cure for the illness but there are treatments available such as painkillers and corticosteroids, which can help slow down the condition.

2. Hypertension

Hypertension is a long-term health condition whereby the blood pressure in the arteries is constantly elevated. Blood pressure is the pressure of the blood within blood vessels and is measured in ‘millimetres of mercury’ (mmHg) using two numbers; for example, 120/80mmHg.

Symptoms of hypertension

Symptoms of hypertension are rare as the only time someone will notice symptoms of hypertension will be when their blood pressure reaches dangerously high levels. This is known as hypertensive crisis and the symptoms for this include severe headaches and anxiety, chest pain and an irregular heartbeat.

- Hypertension puts lots of strain on blood vessels, the heart and other vital organs such as the kidneys. Having high blood pressure increases the risk of the following serious, and potentially life-threatening medical conditions:

  Heart Disease.Heart Attacks.Kidney Disease.Vascular dementia.Strokes.Heart Failure.

Management

Dietary management – Avoid foods high in saturated fat and sugar. Replace them with fruits and vegetables.Leading an active lifestyle – Begin adding more exercise to your day. Start by walking regularly and then move onto jogging if you can.Stop smoking – Nicotine raises people's blood pressure and heart rate. If you smoke, one of the best things you can do for your overall health is to quit.

3. Asthma

Asthma occurs when the body's airways are sensitive to allergens and become inflamed. This inflammation can cause a painful and frightening attack, which causes the airway muscles to tighten and narrow – making it hard to breathe.

Symptoms of asthma

Coughing. A tight sensation in the chest. Being out of breath regularly.

Older people are susceptible to asthma and it can worsen when people have a cold or the flu. Asthma can be disruptive to a person's life and managing it is extremely important as it can be a life-threatening condition.

Having a Personal Alarm could be a difference maker if you suffer from an asthma attack. You can press your pendant button, which will then make an alarm call through to our Care Team. They will communicate with your over the loudspeaker and arrange for help immediately. Should you collapse or fall wearing a Fall Detector, your device will send an alert call automatically.

4. Blindness

Around two million people are living with sight loss here in the UK, with 360,000 people registered as blind or partially slighted. The leading cause of blindness is age-related macular degeneration (AMB), which affects more than 600,000 people in the UK. AMD is caused by a build-up of deposits on the macula (the small area at the centre of the retina) and can also be caused by abnormal blood vessels developing under it.

Other common causes of blindness in the elderly are Glaucoma, caused by pressure on the optic nerve, and diabetes– Diabetic Retinopathy causes damage to the retina. Possible treatment options for blindness will depend on the cause, but may include:

Cataract surgery. Eye drops. Laser surgery.

Early diagnosis of potential blindness is vital so please seek medical attention if your vision is becoming an issue. Of course we should all get regular eye checks to ensure that our eyesight is healthy. Specsavers suggest that people have an eye test every two years at the very least.

5. Cancer

A third of the population will suffer from a form of cancer at some point in their lives. There are over 200 strains of this medical condition, such as breast cancer, prostate cancer and lung cancer. Cancer is a disease where cells in the body replicate abnormally and cause a mass known as a tumour. These abnormal cells multiply, causing either the tumour to grow or the cancerous cells to spread through the bloodstream.

Symptoms of cancer

Finding an unexpected lump. Unexplained weight loss. Unexplained blood in the stool, urine, when coughing or when vomiting.

The survival rate is much lower for older people, which is why it is important for symptoms to be caught earlier and treatment to begin as soon as possible. Please take a look at our guide to coping with cancer, an article we hope will help those affected by this condition.

6. Chronic Bronchitis

Chronic bronchitis is a respiratory condition. Most cases develop due to an infection irritating and inflaming the bronchi of the lungs, causing an overproduction of mucus. The body tries to shift this excess mucus via coughing. This condition causes this coughing to happen daily for prolonged periods of time.

The condition is caused by either a virus or bacteria, similar to the same viruses that cause colds and flu which can make it difficult to differentiate when diagnosing.

Symptoms of chronic bronchitis

A sore throat. Headaches. A runny or blocked nose. Fatigue. Aches and pains in your chest.The most important thing to do if diagnosed with chronic bronchitis is to quit smoking if you smoke. Cigarettes will only make the condition worse and it will take longer to disappear. Alongside this, you should also ensure that you're eating a healthy diet to help prevent lung infections in the first place.

If you have chronic bronchitis you should make sure that you get plenty of rest, drink plenty of fluids to avoid dehydration, and ensure that you treat any headaches or fever with paracetamol or ibuprofen – don't use the latter if you have asthma.

7. Coronary Heart Disease

Coronary heart disease is one of the leading causes of death here in the UK. According to the NHS, coronary heart disease (CHD) is the term that describes what happens when your heart's blood supply is blocked or interrupted by a build-up of fatty substances in the coronary arteries.

CHD can be caused by certain lifestyle choices and other medical conditions, such as:

Smoking. High cholesterol. High blood pressure. Diabetes. Obesity.

Those considered to be at risk from CHD will be put through a risk assessment by their GP. Tests such as a treadmill test, radionuclide scan and a CT scan are just a few of the options available to doctors. The main symptoms of CHD are angina, heart attacks and heart failure.

In order to reduce the risk of CHD, people are advised to make severe lifestyle changes. For example, people should take part in regular exercise, eat a balanced diet and stop smokingif they smoke. There are also several types of medication or surgery options to help treat CHD.

The knock-on affects of CHD can appear out of nowhere, and can be fatal. If you have a Personal Alarm you can raise the alarm as soon as you feel any pain or fall, and help will be on its way within a few short seconds. Remember, a Fall Detector Pendant will automatically detect a sudden fall and will raise an alarm for you. Having this technology can make a huge difference should you suffer from a heart attack.

8. Dementia

Dementia is a progressive disorder that affects the brain's memory capacity and it's overall functionality. Rather than being a condition in and of itself, dementia is a word that refers to a set of symptoms relating to someone's memory, language and understanding.

The most common cause of dementia, and most well-known, is Alzheimer's disease. Vascular dementia is another type of dementia that develops following a stroke or if there is blood vessel damage in the brain.

Symptoms of dementia

Difficulty remembering recent events. Problems in conversation – struggling to follow along or to find the right words. Difficulty judging distance. Forgetting where you are or what date it is.

Nearly one million people in the UK live with dementia, 90% of whom are 65 or over. Anybody who feels that they might be suffering from any of these symptoms should visit their GP as soon as possible. An early diagnosis can help ensure that the right treatment and support is put into place.

The symptoms of dementia can be scary, both for you and your loved ones. Personal Alarms can help in these situations. If you, or your loved one, begins to worry or becomes confused about their surroundings they can press their pendant for help.

9. Diabetes

Older people are susceptible to developing diabetes because of changes that happen as our bodies grow and age. Diabetes is a lifelong condition, caused by the pancreas not producing enough insulin. It affects an astonishing 3.9 million people here in the United Kingdom.

Among the older population, type 2 diabetes is a growing problem, and a larger proportion of newly diagnosed diabetics are from the older generation. Lifestyle changes, encouraged by the NHS, to help avoid diabetes include:

Dietary management– Increasing the amount of fibre and reducing sugar and fat intake. Losing weight – Do this by gradually reducing calorie intake and becoming more physically active. Exercising regularly – It is important to keep active by completing both aerobic and muscle-strengthening activities.

Older people are often quite frail and more susceptible to illnesses, which can lead to diabetes-related complications. Furthermore, exercising and adopting a diabetic-friendly diet can be more difficult for elderly people to manage.

10. Epilepsy

Epilepsy is a neurological condition that results in seizures. Oddly, epilepsy is commonly diagnosed in those at polar opposites of the age spectrum. It is most common in young children and people aged over 65. In fact, one in four people diagnosed are over 65.

Epilepsy can be either symptomatic, meaning it has a clear cause, or idiopathic, meaning its roots are most likely genetic. Symptomatic epilepsy can be caused by head injuries, strokes, tumours or certain serious infections. The condition is commonly diagnosed after somebody has suffered from more than one seizure – as many people have a one-off epileptic seizure during their lifetime.

Epilepsy can be controlled with the help of medications, which help eight out of every 10 people with epilepsy to control their seizures. People should act upon the following guidelines to help make living with the condition a little easier:Stay Healthy – Take part in regular exercise and

eat a balanced diet.Sleep – Ensure that you're getting enough sleep.Avoid Alcohol – Avoid excessive drinking.

Please remember that if you have a seizure, you have a legal responsibility to inform the Driving and Vehicle Licence Authority.

11. Motor Neurone Disease

Motor neurone disease is a rare condition where the nervous system progressively degenerates, leading to muscle weakness often visible by the wasting away of muscle tissue. Motor neurone disease, also known as ALS (Amyotrophic Lateral Sclerosis), occurs when motor neurones that control important muscle activities such as walking and speaking in the brain and the spinal cord stop working.

Symptoms include:

Difficulty swallowing (and sometimes excessive drooling).A weakened grip, usually first noticed in one hand. Small twitches and flickers of movement, known as 'fasciculations'.Difficulty speaking or slurred speech, known as 'dysarthria'.

The causes of the disease are still unknown, but we do know that it commonly affects men more than women and that it occurs most often in people between the ages of 50 and 70-years-old.

12. Multiple Sclerosis

Multiple sclerosis is a neurological condition that affects the brain and spinal cord. Multiple sclerosis can cause serious disability, but the main symptoms are a wide range of problems with vision, movement and even balance.

There are more than 100,000 people in the UK living with the condition. The MS Society estimates that each year 5000 more people are diagnosed – that's approximately 14 people every day. They go on to say that around one in every 600 people has multiple sclerosis (MS).

Symptoms of MS include: Blurred vision. Muscle stiffness. Balance problems. Difficulty walking. Fatigue.

Currently there is no cure for multiple sclerosis, but there are a number of treatments out there which can help to control the condition. The treatments available will depend on the specific symptoms of the condition.

13. Osteoporosis

Osteoporosis affects over three million people across the UK, with more than 500,000 people receiving hospital treatment for fragility fractures every year as a result. This condition develops slowly over time and is often left undiagnosed until a fall or impact causes a bone fracture.

This is because osteoporosis is a condition that weakens the bones. Losing bone mass is a natural part of the ageing process, however some people do lose density faster than normal which leads to Osteoporosis and an increased risk of fracture injuries.

Women are more at risk of the condition because they lose bone density rapidly in the first few years after going through menopause. Medication can help strengthen bones or, alternatively, calcium and vitamin D supplements can be taken as both are very important when it comes to the well-being of bones.

According to the National Osteoporosis Foundation, there are types of exercise that can help combat the condition. These are split into two groups:

- **Weight-bearing exercises –** Activities which involve moving against gravity whilst staying upright. High-impact examples such as skipping and tennis help to build bones and keep them strong. Low-impact examples such as using a stair-step machine and a treadmill are a safer alternative if you have bone problems.
- **Muscle-strengthening exercises –** Activities which involve moving the body, weights or other forms of resistance against gravity. Examples include lifting weights, using weight machines and elastic exercise bands.

Suffering from a fall is very common for those who suffer from osteoporosis. Should you suffer from a fall, you may be unable to get back up or reach for your phone. Having a pendant button around your wrist or neck allows you to call for help in event such as this.

14. Paget's Disease of the Bone

Paget's disease of the bone disrupts the normal cycle of bone renewal. It's triggered by a flaw in the bone cell regeneration system, which causes bones to become weakened and possibly deformed.

Paget's disease is a common bone condition that affects the pelvis, spine and other areas of the body. It is a very common condition in the UK and is most common in people over the age of 50. The condition can be seen in 8% of men and 5% of women by the age of 80.

Symptoms of the condition include the following: Constant, dull bone pain. Shooting pain that travels along or across the body. Numbness and tingling. Loss of movement in a part of the body.

The symptoms of this condition can trigger a fall, which can be fatal if there is nobody around to help you. Having a Personal Alarm can help should you suffer from any of the symptoms above, or from a fall. Simply press the red button on your pendant and our Care Team will respond, assess your situation and arrange for help to come to you.

15. Parkinson's Disease

Parkinson's disease is a chronic and progressive condition which damages and affects parts of the brain.

Parkinson's is caused by a loss of nerve cells in a part of the brain called in the substantia nigra, which leads to a reduction in a chemical in the brain called dopamine. The condition is most common in middle-aged and elderly people. The most common symptoms to look out for are:

Involuntary shaking of particular parts of the body (tremor).Slow movement. Stiff and inflexible muscles.

Currently, there is no cure for Parkinson's disease. There are treatments available which can help to reduce the main symptoms and allow those affected to maintain their quality of life for as long as possible.

16. Stroke

Having a stroke is very serious and it can be life-threatening if you don't seek medical attention straight away. A stroke will occur when the blood supply to a part of your brain is cut off. Without your blood, brain cells can be damaged and may even die.

Strokes a particularly common among older people, with the average age for men to suffer one being 74 in England, Wales and Northern Ireland. For women, this age is slightly higher, with the average being 80-years-old. .

It's very important to know the signs and symptoms of a stroke, as the sooner you and your loved ones react, the less complications there will be afterwards. As mentioned, strokes can be life-threatening so it's important for treatment to begin as soon as possible. The most common signs of a stroke can be memorised by using the word F.A.S.T:

Face – The person affected may be unable to smile and their face may have dropped on one side, with their mouth or eye drooping. **A**rms – The person affected may be unable to life both arms and keep them there due to weakness in one arm. **S**peech – The person affected may suffer from slurred or garbled speech, or may be unable to talk at all. **T**ime – Don't waste any time! Dial 999 immediately if you notice any of these symptoms.

Paramedics are trained to deal with strokes, so if you notice any signs at all you need to call for an ambulance. Wearing an alarm pendant ensures that you can call for help even if you're unable to reach for the phone. Our Care Team will take care of everything, by calling for your loved ones and the emergency services.

17. Chronic Kidney Disease

Chronic kidney disease (CKD) is often associated with the aging process and is therefore quite common among older people here in the UK. The disease is commonly caused be other medical conditions which have an affect on your kidney, such as kidney infections, high blood pressure, diabetes and kidney inflammation.

Unfortunately, symptoms for the early stages of the condition are quite rare and may only be picked up during a blood or urine test carried out for other medical conditions. As the condition gets worse, you may suffer from:

Shortness of breath. Feeling sick. Blood in your urine. Swollen ankles, feet or hands. Tiredness.

If you suffer from any of the symptoms above or notice any other worrying changes to your body, you should see your GP as soon as possible.

There is no cure for CKD right now, but there are methods of treatment which can relieve the symptoms and prevent it from getting any worse. Options include medication, living a healthy lifestyle, dialysis or a kidney transplant in severe cases.

18. Deep Vein Thrombosis

Deep vein thrombosis is caused by a blood clot in your deep veins, which are commonly found in your legs. This condition is most common in people over the age of 40, and can also lead to further complications, including pulmonary embolism.

There are a number of risk factors which could increase your risk of suffering from such a blood clot, including being inactive for longer periods of time, obesity, blood vessel damage and a family history of blood blots.

Blood vessel damage can be caused by smoking, so in order to lower your risk of deep vein thrombosis and several other medical conditions you should seriously consider quitting.

The most common symptoms to look out for include:

Pain, swelling and tenderness in one of your legs. A heavy ache in the affected area. Red skin – particularly at the back of your leg, below the knee. Warm skin in the area of the clot. A mild fever.

Medication which thin your blood and therefore reduce the blood's ability to clot and prevents existing clots from increasing in size, are is commonly used as treatment. Alongside your medication, you will also be told to make some lifestyle changes.

19. Varicella zoster

Varicella zoster is a skin condition which is very common among older people, especially those over the age of 70. This is due to the fact that your body's immune system becomes weaker as you age.

This medical condition is caused by the same virus which causes chickenpox, and only those who have had chickenpox can develop Varicella zoster. The infection will cause a painful rash or blisters to form on your skin, which may become extremely itchy.

If you have Varicella zoster, the affected area will feel quite tender and you may experience sharp stabbing pains every now and then. Other symptoms include a burning and tingling feeling in the affected areas, as well as a high temperature and a general feeling of being unwell.

The earlier that you see your doctor, the sooner treatment can begin which means the severity of your condition may be reduced. The NHS suggest using Calamine Lotion as this has a cool, soothing effect on the skin and can relieve the itchy feeling. If your blisters are weeping, you can use a cloth or flannel which has been cooled with tap water.

20. Cholesterol

Cholesterol is a fatty substance which is created by your liver and is also found in some foods. It is then carried around your body by proteins in your blood, with the combination of the two being known medically as lipoproteins. There are two types of lipoproteins; low density and high density, with the latter being classed as good cholesterol.

Having high cholesterol is bad for your body and can be caused by a number of lifestyle choices and medical conditions, such as:

Smoking. An unhealthy diet. Diabetes. High blood pressure. A family history of stroke or heart disease.

Being old can also increase your chances of having high cholesterol, as the risk of your arteries narrowing is much higher. The best way to lower or avoid high cholesterol in the first place is by living as healthily as possible.

This includes staying as active a possible by exercising or taking part in sporting activities, eating healthy foods, lowering your alcohol intake and trying to stop smoking.

COMMON MENTAL PROBLEMS AMONG ELDERLY

While mental illness in the elderly is often overlooked and challenging to diagnose, its effects can greatly diminish a senior's health and well-being, complicate the treatment of other chronic diseases, and even lead to death.

Risk Factors and Causes of Health Issues in the Elderly Population

Here are some possible triggers for mental illness in senior citizens

- Chronic pain
- Chronic disease
- Physical impairments like thyroid or adrenal disease that affect emotion, thought, or memory
- Physical disabilities
- Loneliness
- Major life changes
- Grief
- Widowhood
- Certain medications
- Heavy alcohol consumption or drug abuse
- Malnutrition/poor diet
- Dementia-causing illness

Symptoms of Mental Illness in the Elderly

As we grow older, it isn't uncommon to see changes. General forgetfulness is normal, but persistent depression, anxiety, memory loss, or other cognitive issues can be signs of something more serious.

If you are a caregiver or have an elderly loved one in your life, you can help spot indicators of a mental health issue. Here are some common warning signs to look for

- A marked change in appetite, energy level, and/or mood
- Feeling emotionally “flat” or finding it difficult to experience positive emotions
- Trouble sleeping too much, or difficulty falling and staying asleep
- Persistent thoughts of hopelessness, sadness, or suicidal thoughts
- A desire or need for drugs or alcohol
- Feeling on edge, restless, or having trouble concentrating
- Increased feelings of stress or worry
- Short-term/recent memory loss
- Anger, agitation, or increased aggressiveness
- Obsessive-compulsive behavioral tendencies or thoughts
- Unusual behaviors or thoughts directed towards others
- Behaviors or thoughts that affect social opportunities, work, or family
- Persistent digestive issues, pain, or headaches not explained by other health problems
- Difficulty managing finances or tasks involving numbers
- Problems with grooming or household maintenance

Common Elderly Mental Health Disorders

While there is a lot of focus on the mental health of younger people, it is equally important for elderly individuals to get treatment, especially for depression, which can complicate the treatment of a number of medical conditions including stroke, diabetes, heart disease, and more.

Here are some of the most common mental health illnesses experienced by older adults:

1. Depression

Depression is a type of mood disorder that ranks as the most pervasive mental health concern among older adults. If untreated, it can lead to physical and mental impairments and impede social functioning. Additionally, depression can interfere with the symptoms and treatment of other chronic health problems.

Common symptoms of depression include ongoing sadness, problems sleeping, physical pain or discomfort, distancing from activities previously enjoyed, and a general "slowing down."

Seniors suffering from depression generally visit ERs and doctors more frequently, take more medications, and experience longer hospital stays than their same-age peers. Women are more likely to be affected than men.

2. Anxiety Disorders

Like depression, anxiety is a very common mood disorder among the elderly. In fact, these two problems often appear in tandem. Statistics from the CDC show that nearly half of older adults with anxiety also experience depression.

Anxiety in seniors is thought to be underdiagnosed because older adults tend to emphasize physical problems and downplay psychiatric symptoms. Women in this age group are more likely to be diagnosed with an anxiety disorder than men.

Risk Factors for Anxiety Disorders in Old Age

Anxiety in the elderly is linked to a number of risk factors, including but not limited to

- General feelings of poor health
- Sleeping problems
- COPD, certain cardiovascular diseases, diabetes, thyroid disease, and related chronic conditions
- Side effects caused by certain medications
- The abuse/misuse of alcohol, street drugs, or prescription drugs
- Physical impairments limiting daily functioning
- Stressful events like the death of a spouse, serious medical condition, or other life-altering event
- Traumatic or difficult childhood
- Perseveration on physical symptoms

There are several different types of anxiety disorders, with the most common being generalized anxiety disorder and phobias. Here is a list of anxiety disorders you may observe:

❖ Generalized Anxiety Disorder:

The effects of generalized anxiety include persistent worry or fear, which can get progressively worse with time.

These symptoms eventually interfere with socialization, job performance, and day-to-day activities. Seniors with anxiety tend to become more withdrawn and reclusive.

Symptoms and Signs of Generalized Anxiety Disorders in Seniors

Elderly individuals with generalized anxiety may experience the following symptoms:

- Excessive, uncontrollable worry/anxiety
- Edginess, nervousness, or restlessness
- Chronic fatigue or tiring out easily
- Become irritable or agitated
- Poor quality of sleep or difficulty falling/staying asleep
- Tense muscles

In addition to generalized anxiety disorder, seniors can be diagnosed with the following related disorders including:

❖ Phobia:

An extreme, paralyzing fear of something that usually poses no threat, phobias can cause individuals to avoid certain things or situations due to irrational fears. Examples can include fear of social situations, flying, germs, driving, etc.

❖ Panic disorder:

This disorder is characterized by periods of sudden, intense fear that can be accompanied by heart palpitations or pounding, rapid heartbeat, shaking, sweating, difficulty breathing, or experiencing feelings of doom.

Symptoms of Panic Disorder

- Sudden, repeated bouts of intense fear
- Feeling powerless or out of control
- Persistent worry about the “next” attack
- Avoiding situations where past panic attacks have occurred

❖ Social Anxiety Disorder:

This social phobia causes individuals to fear being in certain social situations where they feel they might be judged, embarrassed, offensive to others, or rejected.

Social Phobia Symptoms

- Extreme anxiousness about being with others
- Difficulty talking to others in social situations
- Self-consciousness in social settings
- Fear of being judged, humiliated, or rejected
- Fear of offending others
- Worrying about attending social events long before they take place
- Avoiding social situations
- Difficulty with friendships
- Feeling queasy around other people
- Sweating, blushing or shaking around others

❖ Post-Traumatic Stress Disorder:

PTSD is a disorder that usually manifests following a traumatic event that threatens a person's safety or survival, greatly impacting his or her quality of life.

Symptoms of PTSD

- Emotional numbness
- Flashbacks to the event
- Nightmares
- Depression
- Irritability
- Easily distracted or startled
- Anger

❖ **Obsessive-Compulsive Disorder:**

Those who suffer from OCD experience uncontrollable recurring thoughts (obsessions) or rituals (compulsions). Examples of rituals include washing hands, checking if appliances are on or off, counting, or other behaviors typically done to quell obsessive thoughts (e.g. washing hands repeatedly to remove germs and avoid getting sick).

Treatments for Anxiety Disorders

A variety of techniques, supports, and treatments, including medication, psychotherapy, or a combination of both, are available to address various anxiety disorders in seniors. If you suspect someone you care for has symptoms of an anxiety disorder, get in touch with their care team as soon as possible.

3. Bipolar Disorders

Bipolar disorders, or manic-depressive illnesses, are often marked by unusual mood shifts and are frequently misdiagnosed in senior citizens because the symptoms presented are typical with

the aging process, especially related to dementia and Alzheimer's. Bipolar disorder occurs equally among women and men in this age group.

While younger people in the manic phase of bipolar disorder will show classic signs like elation and risky behaviour, seniors are likely to become more agitated or irritable.

Late-Onset Bipolar Disorder Symptoms

- Confusion
- Agitation
- Irritability
- Hyperactivity
- Psychosis
- Cognitive issues including memory problems, trouble problem solving, loss of judgment, and loss of perception

It is worth noting that the effects of certain medications and some types of illnesses show similar symptoms. The individual should be seen and diagnosed by a medical professional to determine the root cause of any symptoms as well as the best options for treatment.

Treatments for Mental Illness in the Elderly

There are a variety of treatment options for those suffering from mental health disorders, including medications, therapies, or a combination of both.

If you suspect that your loved one is struggling with a mental health issue, don't hesitate to get in touch with the individual's health care provider. They can direct you to a geriatric psychiatrist, psychologist, or counsellor who can help.

Treatment for seniors is a team effort, especially when they are unable to care for themselves. Ensure that the elderly individuals in your care are well supported by seeking help when symptoms are spotted and providing love and emotional support to help ensure the highest quality of life possible

SOCIAL PROBLEMS AMONG ELDERLY

ELDER ABUSE

Abuse can happen to anyone—no matter the person's age, sex, race, religion, or ethnic or cultural background. Each year, hundreds of thousands of adults over the age of 60 are abused, neglected, or financially exploited. This is called elder abuse.

Abuse can happen in many places, including the older person's home, a family member's house, an assisted living facility, or a nursing home.

DEFINITION

Elder abuse can be defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" -WHO

TYPES OF ABUSE

There are many types of abuse:

- **Physical abuse** happens when someone causes bodily harm by hitting, pushing, or slapping.
- **Emotional abuse,** sometimes called psychological abuse, can include a caregiver saying hurtful words, yelling, threatening, or repeatedly ignoring the older person. Keeping that person from seeing close friends and relatives is another form of emotional abuse.
- **Neglect** occurs when the caregiver does not try to respond to the older person's needs. **It can be Self-neglect when there is a failure to provide for the self because of lack of ability or lack of awareness**
- **Abandonment** is leaving a senior alone without planning for his or her care.
- **Sexual abuse** involves a caregiver forcing an older adult to watch or be part of sexual acts.
- **Financial abuse** happens when money or belongings are stolen. It can include forging checks, taking someone else's retirement and Social Security benefits, or using another person's credit cards and bank accounts. It also includes changing names on a will, bank account, life insurance policy, or title to a house without permission from the older person. Financial abuse is becoming a widespread and hard-to-detect issue. Even someone you've

never met can steal your financial information using the telephone or email. Be careful about sharing any financial information over the phone or online—you don't know who will use it.

- **Healthcare fraud** can be committed by doctors, hospital staff, and other healthcare workers. It includes overcharging, billing twice for the same service, falsifying Medicaid or Medicare claims, or charging for care that wasn't provided. Older adults and caregivers should keep an eye out for this type of fraud.

RISK GROUPS

Most victims of abuse are women, but some are men. Likely targets are older people who have no family or friends nearby and people with disabilities, memory problems, or dementia.

Abuse can happen to any older person, but often affects those who depend on others for help with activities of everyday life—including bathing, dressing, and taking medicine. People who are frail may appear to be easy victims.

SIGNS OF ABUSE

- Has trouble sleeping Share this info graphic and help spread the word about recognizing the signs of elder abuse.
- Seems depressed or confused
- Loses weight for no reason
- Displays signs of trauma, like rocking back and forth
- Acts agitated or violent
- Becomes withdrawn
- Stops taking part in activities
- Has unexplained bruises, burns, or scars
- Looks messy, with unwashed hair or dirty clothes
- Develops bed sores or other preventable conditions

PREVENTION OF ELDER ABUSE

There are various potential causes that lead to elder abuse, such as understaffing of facilities or personal problems among caretakers. However, by understanding the ways to reduce rates of elder abuse overall, this will help prevent elder abuse from happening.

Steps you can take to prevent abuse of the elderly includes the following:

- **Avoid isolating elders.** This can cause depression, sadness and loneliness that will increase the chances of neglect or abuse.
- **Stay in touch with your elders.** Family members can help care for the elderly person and be on the lookout for changes that may suggest abuse.
- **Keep elders active**. By staying active in old age, this can prolong an elder's life and decrease the chances that they will be vulnerable to elder abuse.
- **Encourage elders to attend religious services and community activities.** This can help them stay in touch with things that have been important to them throughout their life.
- **Don't allow elders to live with someone who is known to be abusive or violent.** Once a person has a history of violence, they are likely to repeat that behavior again, especially when someone is vulnerable.
- **Be wary of caregivers or friends needing financial help, or those who have issues with illicit drugs.** These are people who may manipulate an elder and steal or mismanage finances.
- **Elders should be aware of their own financial affairs.** Elders may require the help of a trusted relative or friend to manage their money, but ultimately they should be the sole one in control of finances.

- **Don’t allow a caretaker or family member to impulsively alter an elder’s will, or add their names to financial accounts or land titles.** These are people who put an elder at risk for financial exploitation.

- **Inform elders to be wary of solicitations from the telephone, internet or mail.** These are likely to be scams designed to steal an elderly person’s money.

MANAGEMENT OF ELDER ABUSE

Medical visits are often the only times victims leave their homes or are allowed out by the abuser. Because older adults do not usually self-report instances of elder abuse, the responsibility for identification, reporting, and intervention rests largely with healthcare professionals, social service agencies, and police departments.

Many factors are involved in the management of older persons who have been abused, including immediate care, long-term assessment and care, education, and prevention.

- Elder abuse and neglect are not problems that can be assessed quickly. Intervention can be a lengthy process, especially in a busy ED. Due to the wide variations of types of abuse, interventions vary from simple social service referral to the extreme of removing the patient from the home.
- The clinician's highest priority in suspected abuse cases is in balancing the safety versus the autonomy of the patient.
- The ultimate goal is to provide the aging adult with a more fulfilling and enjoyable life.
- Once it is suspected, elder mistreatment should be reported to adult protective services. However, most healthcare professionals feel unprepared to fulfill this role, lacking guidance on how to proceed. Most hospitals have no protocols for identifying or addressing elder abuse;
- The multidisciplinary team should include physicians, nurses, office-based social workers, community-based social workers, visiting nurses, and Adult Protective Services case workers.
- Immediate care in the emergency department focuses on treating the physical manifestations of abuse and assuring the safety of the patient. This may include the following:

    - Admitting the patient to the hospital
    - Obtaining a court protective order
    - Placing the patient in a safe home
    - Permitting return home if the patient has the capacity to make an informed decision and refuses intervention
- Referral to social services and Adult Protective Services are also vital to decrease morbidity and mortality and to further guide patient care after the ED encounter.
- No federal statute is specifically dedicated to preventing the mistreatment of elderly persons similar to those targeted at child abuse and domestic violence.
- Currently, elder abuse is defined by state laws, but state definitions vary considerably from one jurisdiction to another. They contain multiple sections regarding who is protected, who must report, definitions of reportable behavior, requirements for investigation of reports, penalties, and guardianship.
- Barriers to recognizing and reporting elder abuse also must be addressed. The lack of uniform definitions has been a major obstacle. Conceptual problems in defining elder abuse have hampered clinical, educational, and research efforts.

  Various factors serve as barriers to reporting elder abuse. These include lack of knowledge, denial, ageism, fear of making the situation worse, desire to maintain family relationships, fear of ending up in court, or lack of belief that the situation will improve. The key to eradicating these barriers is education that increases both public and professional awareness.
- Increasing awareness is considered instrumental in the prevention of elder abuse. Services for seniors, such as meals on wheels, home health care, homemaker, and chore services, are thought to aid in abuse prevention, although preventing elder abuse needs further study.

Consultations

Person can be reffered to following departments as per needs

- Psychiatry consultation - For patients who are demented, depressed, suicidal, disoriented, or to determine issues of capacity
- Geriatrics or internal medicine consultation - For specialized care of the geriatric patient, or admission to hospital as necessary

- Neurology or neurosurgical consultation - For patients with focal neurological findings, or intracranial injuries
- Orthopedics consultation - For patients with fractures

EXERCISES

Answer briefly

1. What are the types of elder abuse?
2. What are the measures to prevent elder abuse?
3. What are the risk factors for elder abuse?
4. What are the signs and symptoms of elder abuse?
5. How the dementia can be managed?
6. Enlist the mental issues among elderly
7. Enlist the medical problems among elderly

Short notes

1. Explain the medical problems among elderly
2. Explain the mental problems among elderly
3. Explain the social problems among elderly

Long essay

1. Define elder abuse. Enlist the risk factors of elder abuse. Explain the prevention and management of elder abuse in detail.

MODULE – 4

This module introduces you to understand the Nurses role in geriatric care and provides an overview of responsibility of nurses.

Content

- General care consideration
- Special consideration of care of elderly
- Nursing process

MODULE: 4

ROLE OF NURSE IN GERIATRICS

LEARNING OBJECTIVES

By the end of this module, you will:

- understand the role of nurse in general care of elderly
- identify the Special consideration of care of elderly
- explain Nursing process in care of elderly

NURSING MANAGEMENT OF PROBLEMS OF ELDERLY

GENERAL CARE CONSIDERATION

➢ Environmental consideration

As people age, the environment in which they live can be adapted to increases safety and comfort. Uncluttered floor space, railings, increased lighting and non lights and clearly marked stair edges are some of the easiest and most practical adaptations

- The older adult in an inpatient or long term care setting needs a through orientation to the environment.
- The nurses should repeatedly reassure the patient that he is safe and attempt to answer all questions
- Unit should foster patient orientation by displaying large print clothes, avoiding complex or visually confusing wall designs, clearly designating and using simple bed and nurse call controls.
- Lighting should be adequate while avoiding glare
- Beds should be close to the floor with four side rails that can be modified to individuals needs

➢ Assistive devices

Many older adults use or could benefit from the use of assistive devices such as dentures, glasses, hearing aids, walkers, wheelchairs, protectors, adaptive utensils, elevated toilet seats and skin protective devices. These tools and devices should be involved in the patients care plan when appropriate. The nurse is in apposition to assure the correct and consistent use of these devices.

➢ Pain management

- When pain is a known complication of a particular condition the nurse should offer pain medication at regular intervals.
- The use of verbal and visual pain scales can assist in correct assessment
- For the patient with ongoing pain a pain diary may be helpful in identifying activities that relieve or increases pain
- Nurse should ask the patient to describe different techniques used to reduce pain. Mental imaging, positive thinking, prayer and other spiritual interventions are used.

➢ Medication use

Medication usage in the older adult requires through assessment and care planning. Common medication errors made by the older adult includes

(1) Forgetting to take drugs

(2) Failing, to understand instruction or the importance of drugs, treatments

(3) Taking over –the –counter drug

(4) Taking out-of-date drugs

(5) Taking drugs prescribed for someone else

(6) Refusing to take medication because of undesirable side effects such as nausea and impotence.

Nursing interventions Related to the Uses of Medications by Older Adults

- Emphasize medications that are essential.
- Attempt to reduce medications usage that is not essential for minor symptoms.
- Screen medication usage using a standard assessment tool-including over the counter drugs, eye and ear drops, antihistamines, and cough syrups.
- Assess alcohol usage
- Encourage the use of written or medication –remainder system
- Monitor medication dosage strength normally the strength should be 30-50% less than of the younger person
- Encourage the use of one pharmacy.
- Work with physicians and pharmacists to established routing drug profiles on all older adult patients.
- Advocate (with drug companies) for low- income prescription support service and dosage routines that are simple once-a-day time-release forms.

➢ Nutritional Management

Maintaining adequate nutrition can be a problem for the older adult for physical and social reasons. Physiologically, food may be less appealing with the decline in taste and smell, and chewing is more difficult with dentures or loss of teeth. Swallowing and digestive problems may also result because of a decrease in saliva, gastric motility, and enzyme production.

- The nurse can have the patient keep a 3-day dietary history. Analysis of this record is helpful in determining dietary adequacy.
- When appropriate the nurse can arrange for transportation to a senior meal site delivery of home meals.
- Attention to and correction of the many reasons for poor nutrition in the elderly person and important nursing responsibility.

Recommended daily intakes for micro nutrients as recommended by the Department of Health DRVs (Dietary Reference Values)

Nutrient	**Recommended daily intake for 50+ years**
Calcium (mg)	700
Phosphorus (mg)	550
Magnesium (mg)	270
Sodium (mg)	1600
Potassium (mg)	3500
Chloride (mg)	2500
Iron (mg)	14.8
Zinc (mg)	9
Copper (mg)	1.2
Selenium (µg)	60
Iodine (µg)	140
Vitamin A (µg)	600
Thiamin (mg)	0.8
Riboflavin (mg)	1.1
Niacin (mg)	12
Vitamin B_6 (mg)	1.2
Vitamin B_{12} (µg)	1.5

Nutrient	Recommended daily intake for 50+ years
Folate (µg)	200
Vitamin C (mg)	40
Vitamin D* (µg)	10

Estimated energy requirements as recommended by the Department of Health DRVs (Dietary Reference Values)

Age (years)	Estimated energy Requirement for males (kcals per day)	Estimated energy Requirement for females (kcals per day)
51-59	2550	1900
60-64	2380	1900
65-74	2330	1900
75+	2100	1810

- **Sleep**

Older adults may be disturbed by insomnia and complain that they spent more time in bed but still feel tired. Frequently, the older person prefers to spread sleep throughout 24 hours with short naps that provide adequate rest. Often, assurance from the nurse that this type of sleep pattern is adequate and normal for the patient's age will relive anxiety concerning sleep. Many times a later bedtime will promote a better night's sleep and a feeling of being refreshed upon awakening.

- **Safety**

Environmental safety is crucial in the health maintenance of the older person. With normal sensory changes, slowed reaction time, decreased thermal and pain sensitivity, changes in gait and balance, and medication effects, the older adult is prone to accidents. Most accidents occur in or around the home. Falls, motor vehicle accidents, and fires are the common causes of accidental

death in older adults. Another environmental problem arises from and impaired thermo regulating system that cannot adapt to extremes in environmental temperatures.

The nurse can provide valuable counsel regarding environmental changes, which may safety for the older adult. Measures such as stronger lighting, colored step strips, tub and toilet grab bars, and stairway handrails can be effective in "safety-proofing" the living quarters of the older adult. The nurse can also advocate for home fire alarms.

- **Behavioral Management**

When patient behaviors such as agitation, anxiety, resisting care, and wandering become problematic the nurse needs to plan nursing interventions carefully.

- Initially the patient's physical status needs to be assessed.
- The patient should be checked for changes in vital signs urinary pattern, or constipation, which could be responsible.
- Disruptive behaviors can be interrupted and redirected by staking papers singing playing music, exercising, or walking with the nurse.
- When the patient is agitated by the environment either the patient is or the stimulus should be moved. The patient can be assisted to call family members if it is reassuring.
- When a patient resists or pulls tubes or dressings, these items can be covered with stretch tube gauze or removed from the visual field.
- Relating orientation can be used to orient to time, place, and person.
- The patient's emotional state should be closely observed. The patient's statement can be rephrased to validate its meaning.
- The nurse should not threaten to restrain the patient or call the physician.
- Patient should be monitored frequently, and all interventions should be documented.

- **Use of Restrains**

Chemical and physical restrains should be a last report in the care of the older patient. The nurse should clearly document restraint use and the behaviors that require this intervention. The use of restrains makes care more time consuming and complex. Restrains do not refuse falls but do increase potential patient confusion and the severity of injury when falls occur. Restraint alternatives require vigilant, creative nursing care. Restraint alternatives include wedge cushions, low beds, body props, and bed alarm signaling devices.

SPECIAL CONSIDERATION IN CARE OF ELDERLY

Life in an institution setting or group living usually involves some restriction to personal choice and library. Disability and dependency further limit the control individuals have over their own lives and their daily pattern of living.

- Encourage the older patient in the maximum of personal choice, decision making and participation in their own care on the part of the patients.
- Respect for the elderly patient's feeling and emotion.
- Depression is common amongst elderly people and this can be aggravated to illness or social deterioration decussating admission to hospitals. So a sympathetic considerate approach is more likely to succeed than authoritarian one.
- The nurse should attempt to understand the underlying reason for the patient anger and frustration.

Approach to the patient

Elderly may have difficulty in understanding what is said to them because of loss of sensory function and reduce comprehension.

- Nurse should sit with the patient while feeding elder patient.
- The nurse who cares for elder patient should have inspiration instead of ignorance, should have understanding instead of prejudice, should have strength instead of weariness, should dress neatly and show beauty instead of ugliness, and should show companionship instead of loneliness.
- Nurse should convert their sandiness into joy and should give them courage to face these challenges of old age.
- Nurse should give them faith in the treatment they are getting.
- Nurse should show them love in place of their dear and near ones and give them joy.
- Should give selfless service instead of forget fullness and negligence.
- Should consider them as her mission and fulfill it as her hearts direction.

Daily living activities of the patient

- The patient is encouraged to be out of bed as much as possible so as to promote mobility to reduce the risk of complications. Such as pressure sores, contractures dehydration thrombosis and dependency independence encourage self-respect.
- Cleanliness and personal tidiness are important to health and safety.
- Lifelong habits of elderly patients should be accepted whatever it may be and not made reasons for unnecessary clashes between staff and patients.

Promotion of comfort

Physical and mental comfort and relaxation has to be achieved. There are many factors that contribute to the comfort of the elderly patient which apply the patients in any age group and the nurse will apply skills and knowledge obtained in general training when dealing with the elderly also.

Additional points to consider are:

- Care of the skin.
- Care of the bony structures.
- Maintain nutrition status
- Maintain fluid balance.
- Maintain body temperature.

Safety

- Unpolished floor, good lighting, the absence of impediments to easy movement and mobility
- Correct height of bed and chairs, extra comforts with cushions, the provision of walking aids like, walker or walking sticks or wheel chairs, grab-rails to hold and walk and also hand rails, which are environmental features which contribute the safety of the patients.
- Constant personal observation and support has to be provided for frail, ambulant patients, for those with degree of confusion and for restless bed ridden patients.

Promotion of independence

- Patient is encouraged to the maximum possible level of self-care and decision making

- Planning their daily activities or their future living pattern are an activities in which patients should be involved themselves as much as possible, rather than having done for them with little or no participation
- Staff should give guidance encouragement and support rather than try to control the whole life of the patient.
- The provision of the personal lockers or cupboards that lock, can give patient more control over their own needs.

Promotion of movement and mobility

The patient is encouraged to be out of bed as much as possible according to the capabilities and needs.

Promotion of mental activity and interests

Consideration must be given to meeting intellectual and recreational needs of all patients as well as providing means for ensuring that the mental stimulus, essential to the improvement of maintenance of mental functioning are included as part of the therapeutic programme.

Use of medications in elderly

Drug interactions increases with age and the number of drugs taken. Many elderly report adverse reaction to the medication. Therefore, nurses needs to have knowledge of various drugs, their actions, side effects and must use drugs cautiously for the elderly.

Rehabilitation

Rehabilitation for the elderly includes all those activities which aim at restoring the patient to the highest possible degree of independent living of which he is capable which should also include physiotherapy and speech therapy.

NURSING PROCESS

Since aging is a normal and fundamental part of life. Providing nursing care for elderly clients should not only be isolated to one field but is best given through a collaborative effort which includes their family, community, and other health care team. Through this, nurses may be able to use the expertise and resources of each team to improve and maintain the quality of life of the elderly.

Major possible problems of elderly are

1. Risk for Falls
2. Impaired Gas Exchange
3. Hypothermia
4. Disturbed Sleep Pattern
5. Constipation
6. Adult Failure to Thrive
7. Risk for Aspiration
8. Risk for Deficient Fluid Volume
9. Risk for Injury
10. Risk for Infection
11. Risk for Impaired Skin Integrity
12. Disturbed thought process
13. Impaired verbal communication
14. Impaired memory
15. Disturbed role performance
16. Ineffective family coping

1. ***Risk for fall related to Impaired physical mobility/Loss of muscle strength/Altered sensory perception/Presence of illness (Alzheimer's disease, dementia, osteoporosis/Improper use of aids (e.g., canes, walkers, wheelchair, crutches)***
    - ❖ Identify factors that increase the level of fall risk
    - ❖ Assess the patient's environment for factors associated with an increased risk for fall.

- ❖ Secure a wristband identification to warn healthcare providers to implement fall precaution on the patient
- ❖ Place assistive devices and commonly use items within reach
- ❖ Review hospital protocols regarding transferring a patient.
- ❖ Keep the patient's bed in the lowest position at all times.
- ❖ Answer call light as soon as possible.
- ❖ Use side rails on bed as needed
- ❖ Orient the patient to the surroundings. Avoid re-arranging the furniture in the room.
- ❖ Instruct the patient how to ambulate at home, including using safety measures such as handrails in the bathroom.
- ❖ Encourage the patient to engage in a program of regular exercise and gait training
- ❖ Collaborate with other health care team to assess and review patient's medications that can contribute to the risk for falls. Identify the peak effects of the medications that can alter the consciousness of the patient.

2. Impaired Gas Exchange related to reduced oxygenation with decreased functional lung tissue as evidenced by dyspnea, irritability, lethargy, abnormal ABG

- ❖ Monitor and record the following during admission and routinely thereafter respiratory rate, depth, and pattern; breath sounds, cough, sputum, and mental status. Provides baseline data for subsequent assessments of the patient's respiratory system.
- ❖ Encourage breathing and coughing exercises. Instruct patient in use of incentive spirometry if applicable.
- ❖ Encourage increased fluid intake (greater than 2.5 liters daily) unless contraindicated by a renal or cardiac condition.
- ❖ Treat hyperthermia immediately, reduce pain, lessen pacing activity, and decrease anxiety.
- ❖ Teach the patient in the use of support devices such as nasal cannulas or oxygen masks

3. Hypothermia relate to age related changes in thermoregulation and environmental exposure as evidenced by shivering, cool skin, pallor, tachycardia

- ❖ Monitor temperature through the use of a low-range thermometer if available. This assessment will indicate the presence of hypothermia.

- ❖ Watch out with the use of sedatives, muscle relaxants, and hypnotics (including anesthetics).

- ❖ Make sure to give blankets to patients undergoing testing or x-ray examination.
- ❖ Initiate slow rewarming if the patient is mildly hypothermic.
- ❖ Warm the patient internally by providing warm oral or IV fluids if the patient's temperature drops below 35°C (95°F).
- ❖ Watch out for signs of excessive rapid rewarming.
- ❖ Administer antibiotics as prescribed for sepsis, glucose for hypoglycemia, or thyroid therapy.

4. Disturbed Sleep Pattern related to unfamiliar surroundings and hospital routines/interruptions as evidenced by verbal complains of difficulty falling asleep/Decreased ability to function/ Dissatisfaction with sleep/ Desired Outcomes

- ❖ Assess and record the patient's sleeping pattern, gathering information from the patient's significant others or caregiver.
- ❖ Gather inquiries regarding activity level and nap.
- ❖ Try to arrange activities together such as doing vital signs, taking medication, and toileting.
- ❖ Refrain the patient from drinking caffeinated coffee, cola, and tea after 6 pm.
- ❖ Provide a calm and quiet environment and lessen interruptions during sleep hours
- ❖ Administer pain medications as ordered, provide back rub, and pleasant conversation at sleep time.

5. ***Constipation related to change in diet, decreased activity and psychosocial factors as evidenced by Changes in bowel pattern; unable to pass stool***

- ❖ During admission, assess and record the patient's normal bowel elimination pattern (frequency, time of day, associated habits, and previous measures to manage constipation).
- ❖ Quantify the amount of roughage to the severity of constipation. Excessive roughage taken too rapidly can cause gas, bloating and diarrhoea.
- ❖ Assess hydration status for signs of dehydration. Maintain diet, fluid, activity, and continuation of routines.

- Inform the patient that changes happening during hospitalization may increase the risk of constipation.
- Educate the patient about the connection between fluid intake and constipation. Encourage fluid intake (2500 ml/day) unless contraindicated.
- Instruct the patient to include roughage in every meal when possible. For patients with low tolerance to raw foods, encourage intake of bran via cereals, bread, and muffin.
- Educate the patient about the connection between activity level and constipation. Support optimal activity for all patients.
- Institute and build an activity program to foster participation; include devices necessary to enable independence.
- Regular exercise stimulates peristaltic movement thus it can reduce or prevent constipation.
- Administer laxatives as ordered after diagnostic imaging of the gastrointestinal tract with the aid of barium.

6. Risk for Aspiration related to impaired cough and gag reflexes or ineffective esophageal sphincter

- Evaluate the patient's swallowing reflex by putting your thumb and index finger on both sides of the laryngeal prominence and instruct the patient to swallow.
- Monitor food intake. Record patient's food consumption (including amount and consistency), where the patient puts food in the mouth, how the patient manipulates or chews prior swallowing, and the duration of time before the patient swallows the food bolus.
- Anticipate a video fluoroscopic swallowing exam (VFSE) or modified barium swallow exam (MBS) to evaluate the patient's gag and swallow reflexes
- .Anticipate the need for a speech therapist as indicated. .
- Tilt the head forward 45° during swallowing for patients with impaired swallowing reflex.
- Encourage adequate rest periods prior meals.Low energy or exhaustion raises the risk of aspiration.
- Put the patient in an upright position with the chin tilting down slightly during eating or drinking, and place pillows on the side to maintain the upright position.

- ❖ Instruct patients with dementia to chew and swallow with every bite. Watch out for retained food between sides of the mouth. A patient with dementia tends to forget to chew and swallow.
- ❖ Allow sufficient time for the patient to finish eating and drinking. Usually, patients with swallowing problems need twice as much time for eating and drinking as those whose swallowing is intact.
- ❖ Allow someone to stay with the patient during meals or fluid intake. Promotes safety in case of choking or aspiration.

7. Risk for Infection related to age-related changes in immune and integumentary systems and/or suppressed inflammatory response occurring with long-term medication use (e.g., steroids, analgesics, anti-inflammatory agents), slowed ciliary response, or poor nutrition

- ❖ Monitor baseline vital signs, including the level of consciousness and orientation.
- ❖ Assess the patient's skin for tears, breaks, redness, or ulcers. Record condition of the patient's skin on admission and as an ongoing assessment.
- ❖ Assess the patient's temperature, using a low-range thermometer if possible.
- ❖ Obtain temperature readings rectally if the oral reading does not match the clinical picture (i.e., skin is very warm, the patient is restless, mentation is depressed) or if the temperature reads 36.11°C (97°F) or higher.
- ❖ Assess the quality and color of the patient's urine.
- ❖ Limit urinary catheters insertion when possible.

8. Risk for Impaired Skin Integrity related to reduced subcutaneous fat and decreased peripherally capillary network in the integumentary system

- ❖ Assess the patient's skin upon admission and regularly thereafter. This assessment provides a baseline for succeeding assessments of skin integrity.
- ❖ Monitor skin over bony prominences for erythema.
- ❖ Observe skin for any areas of redness, changes in the texture or any breaks in the skin surface.

- ❖ Use a lift sheet or roll the patient during repositioning.
- ❖ Provide a turning schedule at least every two (2) hours.

- Utilize waterbed, airbed, air-fluidized mattress, alternating pressure mattress, or other pressure-sensitive mattresses for older individuals who are unable to get out of bed or on bed rest. These mattresses promote comfort and protect skin from injury produced by prolonged pressure.
- Pad bony prominences with pillows or pads, even when the patient is up in a wheelchair or sits for long periods.
- Use lotions generously on dry skin. Lotions provide moisture and can make skin smooth and supple. Lanolin-containing lotions are particularly helpful.
- Assist the patient out of bed as frequently as possible. Amply utilize mechanical lifting devices to assist during patient's transfers.
- Establish and provide a turning schedule on the patient care plan and at the bedside.
- Discourage placing tubes under the patient's head or limbs. Place a pad or pillow between the patient and the tube for cushion support. Too much pressure from tubes can result in decubitus ulcer.
- Use tepid water (32.2°-40.5°C [90°-105°F]) and super-fatted, no perfumed soaps. Hot water can burn older adults, who have diminished pain sensitivity and reduced sensation to temperature. Super-fatted soaps prevent skin dryness.

Exercises

Short notes

1. Explain the role of nurse in care of elderly
2. Explain the nursing management of old age based on nursing process.

MODULE – 5

This module introduces you to the field of Geriatric rehabilitation and involvement of government in geriatric rehabilitation in India

Content

- Social support for elderly
- Government support for elderly in India

MODULE: 1

CONCEPTS OF GERIATRIC CARE

LEARNING OBJECTIVES

By the end of this module, you will:

1. Understand the social support for elderly
2. Identify the government support for elderly

GERIATRIC REHABILITATION

Rehabilitation interventions are focused toward adapting to or recovering from disability. When proper training, assistive equipment and attendant personal care the patient with disabilities can often live an independent life.

- The nurse needs to understand physical disability in the older adult
- The older adult often loses functioning because inactivity and immobility. This reconditioning can occur as a result of unstable acute medical conditions, environmental barriers that limit mobility, and a lack of motivation to stay in condition. The nurse must use passive and active range-of-motion exercises with all older adults to prevent reconditioning and subsequent functional decline.
- The goal of geriatric rehabilitation is to strive for maximal function and physical capabilities considering the individual's current health status. When a patient demonstrates sub-optional health, the nurse screens and evaluates for risk behaviour.

Rehabilitation is directed at preventing permanent disability. Therefore rehabilitation interventions emphasis four areas:

1. Functional activity to increase capacity and mobility
2. Balance improvement
3. Good nutrition
4. Social and emotional support

SOCIAL SUPPORT FOR ELDERLY

Social support for the older adult occurs at three levels.

- Family and kinship relations are the first and preferred providers of social support.
- A semiformal level of support is found in clubs, churches, neighborhoods, and senior citizen centers.
- The older adult may be linked to a formal system of social welfare agencies, health facilities, and government support.

1. Caregivers

Generally more than 80% of care is proved by a family caregiver who lives with the patient. A caregiver is usually a married woman who is often old herself, has chronic diseases and disabilities, and is often poor.

A caregiver provides supervision, direct care, and coordinates services. The tasks of care giving include assisting, providing emotional and social support, and managing health care.

Caregiver problems

Common problem facing the caregiver include the following:

- Lack of understanding of the time and energy needed for care-giving
- A lack of information about specific tasks of care-giving, such as bathing or medication administration
- A lack of respite or relief from care-giving
- An inability to meet personal self-care needs, such as socialization and rest
- Conflict in the family unit related to decisions about care-giving
- Financial depletion of resources as a result of a caregiver's inability to work and the increased cost of health care

The nurse should asses the caregiver and the patient for the possibility of caregiver strain and elder abuse.

Emotional problems of caregivers

- The nurse should consider the caregiver as a patient and plan behaviors to reduce caregiver strain
- The nurse should communicate a sense of empathy to the caregiver while allowing discussions about the burdens and joys of care-giving.
- The caregiver can be taught about age related changes and diseases and specific care-giving techniques.
- The nurse can also assist the caregiver in seeking help from the formal social support system regarding matters such as respite care, housing, health coverage and financers.
- The nurse should monitor the caregiver for indication of declining health, emotional distress and caregiver strain.

2. Older adult network

A network of services supports the older adult both in the community and in health care facilities. To understand the older adult situation the nurse should know the government structures that fund and regulate the older adult programs. Now the role of the government has changed from that of regulator to provider.

3. Medicare

Medicare also covers persons who receive social security, disability benefits and persons with end stage renal disease. Medicare is designed for acute illness care. It is composed of two parts A and B. Part A covers inpatient hospital care, Medicare A pays reasonable charges on the basis of the diagnosis and not on the length of stay. It also pays for home care if it requires skilled nursing or rehabilitation intervention. Hospice care is covered under Medicare A. part B covers outpatient treatment and physician services. Medicare B is voluntary and has a monthly premium and an annual deductible before payment begins. It does not cover long term nursing care.

4. General support services

Services for the older adult include hospital and medical benefits, community based services, long term institutional care, house and shelter assistance, transportation, employment programs and income maintenance and support. The nurse can assist the elderly patient and the caregiver by acknowledging the complexity of the health care system. The nurse can assisted the older adult to access the appropriate service or refer the patient to a case manager or other healthcare expert when appropriate.

GOVERNMENT SUPPORT FOR ELDERLY IN INDIA

Help age India

. Help Age India was formed in 1978 with the active help from Mr. Cecil Jackson Cole, Founder member of help the Aged, United Kingdom. Objectives are

- To create an awareness and understanding of the changing situation and the needs of the elderly in India and to promote the cause of the elderly.
- To raise the funds for creation of infrastructure through the medium of voluntary social service organizations for providing a range of facilities especially designed to benefit the elderly and thus to improve the quality of their lives
- ” Help Age India is basically a funding organization which looks for partner agencies in the field that are able to implement the various projects and programmes of the organization.
- The head office of Help Age India is located in New Delhi and it has around twenty-four regional and area offices located all over the country.
- It has been closely associated with the formulation of the National Policy of Older Persons,

Ophthalmic Care:-

- Old age is associated with a number of health problems, one of them being decrease in vision.
- This results in the aged being dependent on his family for help as he faces the disability to carry out the normal activities of daily living.
- Since many older persons in India suffer from cataract related blindness which is treatable, cataract surgery is the most important of eye care services provided by Help Age India.
- Through such services the organization tries to reduce the dependency which is very common among the older age groups as well as through the 7 restoration of vision try to help the aged in being independent and strong and not being weighed down by the society and the family.

- The organization focuses on the elderly not only in the urban areas but mainly in the rural areas as they are unable to access treatment due to their physical location and financial constraints.

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➢ Care for the Leprosy Patients:-

- It is estimated that 2% of the elderly are affected by leprosy. Leprosy is a chronic disease which is transmitted by direct contact and it can be controlled but not cured, by prolonged treatment with sulphur drugs.
- Help Age India addresses the problems of the aged in a different perspective that of long term care through rehabilitation.
- By introducing various projects to designate social spaces for the leprosy affected elderly through the construction of a colony for leprosy victims, along with schemes which provide to each of the residents a monthly income to subsidies his basic needs

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➢ Mobile Medical Care:-

- The medicalization of aging by Help Age India is represented by the mobile medical units (MMU) which practice what is called social and preventive medicine and provide primary health care for the senior citizens.
- The MMU's were started because a majority of the rural aged as well as the urban slum dwellers were unable to receive medical aid and advice because of their inability to go to the hospitals coupled with the scarcity of hospitals in rural areas.
- As a result a lot of the aged suffered from medical problems which went undetected and undiagnosed.
- Thus Help Age India started MMU's which would go to the remote rural areas as well as to the urban slums to cater to the health needs of the weak aged.

➢ Community Development Programmes:-

- As has been stated earlier the aged persons have special health care and nutritional requirements.
- It is even more so in rural areas where the aged suffer from poor living conditions, insufficient and imbalanced diet coupled with hard work and low income..
- Help Age thus provides "overall care" for the elderly which it does through the community development programmes.
- Help Age .India thus brought about certain developments which not only improved the lives of the elderly in particular but the whole village in general. This was done through:-
    1. Provision of health care facilities.
    2. Provision of clean drinking water by installing hand pumps.
    3. Improving agricultural yield through high quality seeds has resulted in increase of vegetables.
    4. Providing livestock to the elderly has helped in generating a regular income from the sale of milk and also in improving their dietary status.
    5. Encouraging poultry farming has led to a decent income from the sale of eggs and also they have eggs for their own consumption.

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• Old Age Homes and Day Care Centres:-

- Help Age India has sponsored the construction and maintenance of old age homes in India.
- These homes cater to the needs of those elderly who are unable to live by themselves and for those who have been abandoned by the family or are neglected and uncapped for by their children.
- These old age homes provide and cater to the various needs of the elderly so that they can spend the "evenings of their lives" with dignity and respect and not feel a burden to the society.

- There are over 800 old age homes all over India and nearly half of them are being sponsored and funded by Help Age India.
- Besides old age homes, Help Age India also supports day care centers where the elderly come for a few hours every day or on certain days of the week and spend some time together.

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. Free Entitlements for Older people

The Department of Social and Family Affairs administers a group of allowances to which many people over 66 years are entitled. These are known as the *Household Benefits Package* or the free schemes.

Household Benefits Package **and the other main entitlements for older people**:

- **Free Electricity** - you qualify if you are over 70, or over 66 and receiving most social welfare pensions and meeting a means test
- **Free Natural Gas** - offered as an alternative to free electricity. You must be a registered consumer of natural gas on the Board Gas domestic supply
- **Free Bottled Gas** - offered if you are not connected to natural gas or electricity
- **Free Television License** - offered if you qualify for free electricity, natural gas, or bottled gas
- **Free Telephone Rental** - offered to all over 70, regardless of means; those over 66 receiving most social welfare pensions or allowances such as disability allowance; those over 66 not receiving benefit but satisfying a means test.
- **National Fuel Scheme** - offered to those dependent on social welfare payments
- **Medical Card** - offered to all over 70, regardless of means. Others considered on the basis of income but those receiving most social welfare pensions generally qualify, also those receiving some other allowances such as disability allowance.
- **Free Travel**
- **Carers Allowance and Carers Benefit** - if a person is receiving full-time care, their carer may qualify for a Carer's Allowance or Carer's Benefit. Carer's Allowance is a means-tested payment, whereas Carer's Benefit is based on PRSI contributions

- **Treatment Benefit** - entitlement is based on PRSI contributions.
- **Living Alone Allowance** - offered to social welfare pensioners living alone and 66 years or over. It is also available to people under age 66 who are receiving allowances such as disability allowance and who live alone
- **Supplementary Welfare Allowance** – those receiving a social welfare or similar type payment may qualify in an emergency situation or in special circumstances

- Grants and subsidies

The Government provides a means tested Old Age Grant for women at 60 and men at 63 of just R940 per month .In addition to this, they provide subsidies to organizations housing certain categories of older people:

1Category	Fit Elderly	No subsidy. Expected to cope on a state pension of R940,
2Category	Assisted Living	R 705 per month paid to the institution in addition to the grant the pensioner receives.
3Category	Frail Care	R 1215 per month paid to the institution in addition to the grant the pensioner receives.

Health care

Older citizens' health needs are meant to be addressed with 6-monthly check ups at State-run Day Hospitals where chronic medications are dispensed in 3 month cycles. At present, specialist geriatric services at State hospitals are severely limited.

Legislation

- The Older Persons Bill will shortly become the Older Persons Act, replacing the Aged Persons Act of 1967 and the Aged Persons Amendment Act of 1998.

- The intentions of the Bill are to deal with the plight of older people by establishing a framework aimed at the empowerment and protection of the elderly and at the promotion and maintenance of their status, rights, well-being, safety and security.
- Following lively public hearings held in August 2005, the Bill is unlikely to be passed into law before more changes are made.

Policies/Schemes

- These schemes and policies are meant to promote the health, well-being and independence of senior citizens around the country.
- Some of these programmes have been enumerated below .The central government came out with the National Policy for Older Persons in 1999 to promote the health and welfare of senior citizens in India.
- This policy aims to encourage individuals to make provision for their own as well as their spouse's old age.
- It also strives to encourage families to take care of their older family members.
- The policy enables and supports voluntary and non-governmental organizations to supplement the care provided by the family and provide care and protection to vulnerable elderly people.

This policy has resulted in the launch of new schemes such as-

1. Strengthening of primary health care system to enable it to meet the health care needs of older persons
2. Training and orientation to medical and paramedical personnel in health care of the elderly.
3. Promotion of the concept of healthy ageing.
4. Assistance to societies for production and distribution of material on geriatric care.
5. Provision of separate queues and reservation of beds for elderly patients in hospitals.
6. Extended coverage under the Antyodaya Scheme with emphasis on provision of food at subsidized rates for the benefit of older persons especially the destitute and marginalized sections.

New Schemes

For the benefit of senior citizens it has been proposed that-

- The National Housing Bank will introduce a 'reverse mortgage' scheme under which a senior citizen who owns a house can avail of a monthly stream of income against mortgage of the house. The senior citizen remains the owner and occupies the house throughout his or her lifetime, without repayment or servicing of the loan. Regulations are to be put in place to allow creation of mortgage guarantee companies.
- An exclusive health insurance scheme for senior citizens is to be offered by the National Insurance Company. Three other public sector insurance companies as mentioned in the Medical Insurance section, are to offer a similar product to senior citizens.
- The Maintenance of Parents and Senior Citizens Bill : - This bill has been recently introduced in Parliament. It provides for the maintenance of parents, establishment of old homes, provision of medical care and protection of life and property of senior citizens.

Vocational Rehabilitation Centre

The Government of India has set up the Vocational Rehabilitation Centre for disabled at Bangalore and the same has been functioning from 1991. The Centre is providing vocational training in Computers, Carpentry, Welding, Fitter, Electrical, Embroidery, Book Binding and Tailoring etc. The Vocational Rehabilitation Centre has provided 100% placement for all the trainees who have undergone training. The Vocational Training Centre also provides counseling services for children / persons with intellectual disabilities.

National policy on older persons

- The Government of India announced a National Policy on Older Persons in January, 1999. This policy provides a broad framework for inter-sect oral collaboration and cooperation both within the government as well as between government and non-governmental agencies. In particular, the policy has identified a number of areas of

intervention -- financial security, healthcare and nutrition, shelter, education, welfare, protection of life and property etc. for the well- being of older persons in the country.

- To facilitate implementation of the policy, the participation of Panchayat Raj Institutions, State Governments and different Departments of the Government of India is envisaged with coordinating responsibility resting with the Ministry of Social Justice & Empowerment.

National Council for Older Persons

A National Council for Older Persons (NCOP) has been constituted by the Ministry of Social Justice and Empowerment to operationalize the National Policy on Older Persons. The basic objectives of the NCOP are to

- Advice the Government on policies and programmes for older persons
- Provide feedback to the Government on the implementation of the National Policy on Older Persons as well as on specific programme initiatives for older persons
- Advocate the best interests of older persons
- Provide a nodal point at the national level for redressing the grievances of older persons which are of an individual nature
- Provide lobby for concessions, rebates and discounts for older persons both with the Government as well as with the corporate sector
- Represent the collective opinion of older persons to the Government
- Suggest steps to make old age productive and interesting
- Suggest measures to enhance the quality of inter-generational relationships.
- Undertake any other work or activity in the best interest of older persons.

Old age and income security

- The Ministry has also launched a project called "Old Age Social and Income Security (OASIS)".
- An Expert Committee is constituted under the project.
- The first reports of the Committee and the existing income security instruments available to older persons have been comprehensively examined.

- The report also contains detailed recommendations for enhancing the coverage, improving the rate of returns and for bringing about a qualitative improvement in the customer service of Public Provident Fund, the Employees Provident Fund, the Annuity Plans of LIC, and UTI etc.

An integrated programme for older persons

It has been formulated by revising the earlier scheme of Assistance to Voluntary Organizations for programmes relating to the welfare of the aged. With the aim to empower and improve the quality of older persons, the programmes hope to:

- Reinforce and strengthen the ability and commitment of the family to provide care to older persons.
- Foster amiable multi-generational relationships.
- Generate greater awareness on issues pertaining to older persons and enhanced measures to address these issues.
- Popularize the concept of Life Long Preparation for Old Age at the individual level as well as at the societal level.
- Facilitate productive ageing.
- Promote healthcare, Housing and Income Security needs of older persons.
- Provide care to the destitute elderly.
- Strengthen capabilities on issues pertaining to older persons of local bodies/state governments, NGOs and academic/research and other institutions.

National old age pension (noap) scheme

Under National Old Age Pension Scheme, Central Assistance is available on fulfillment of the following criteria

- The age of the applicant (male or female) should be 65 years or more.

- The applicant must be a destitute in the sense that he/she has no regular means of subsistence from his/her own source of income or through financial support from family members or other sources.
- The amount of old age pension is Rs 75 per month. This scheme is implemented in the State and Union Territories through Panchayat and Municipalities. Both Panchayat and Municipalities are encouraged to involve voluntary agencies as much as possible in benefiting the destitute elderly for whom this scheme is intended.

Annapurna

A new scheme called Annapurna has been recently initiated by the Government of India under which free food grains up to 10 kg per month will be provided to such destitute older persons who are otherwise eligible for old age pension under the National Old Age Pension Scheme but are not receiving it and whose sons are not residing with them.

Travel

- *By Road*

Delhi: Fifty per cent discount on fare for travel on Delhi Transport Corporation buses to senior citizens who have attained the age of 65 years. Discount is applicable on Monthly Pass only.

Kerala: Free passes are provided to old people who are freedom fighters to travel in fast and express buses.

- *By Train*

Indian Railways provide **30 per cent concession** in all classes and trains including Rajdhani /Shatabdi trains for citizens who have attained a minimum age of 65 years in case of men and 60 years in case of women. No certificate is required for booking but senior citizens must carry a documentary proof of their age during travel

By Air

Indian Airlines: Fifty per cent discount on the basic fare for travel on Indian Airlines domestic flights to senior citizens who have attained the age of 65 years, in case of men and 63 years in case of women. Discount is applicable in economy class only.

Jet Airways: Fifty per cent discount on basic fare for travel on Jet Airways domestic flight to senior citizens who have attained the age of 65 years. Discount is applicable in economy class only. The airline also offers fifty per cent discount on the basic fare to cancer patients and blind people.

Air Sahara: Fifty per cent discount on basic fare for travel on Air Sahara flight to senior citizens who have attained the age of 65 years. Discount is applicable in economy class only. The airline also offers fifty per cent discount on the basic fare to cancer patients and blind people.

Special Counters

Railway Ticket Booking

Separate reservation counters are earmarked for Senior Citizens at various PRS (Passenger Reservation System) Centres if the average demand per shift is more than 120 tickets. The position is reviewed from time to time for continuity of this facility.

Old Age Homes

There are 728 Old Age Homes in India today. Detailed information of 547 homes is available. Out of these, 325 homes are free of cost while 95 old age homes are on pay & stay basis, 116 homes have both free as well as pay & stay facilities and 11 homes have no information. A total of 278 old age homes all over the country are available for the sick and 101 homes are exclusively for women. Kerala has 124 old age homes which is maximum in any state.

Health Care

Sunday Clinics in Delhi

Sunday Clinics at various Hospitals of Delhi exist to enable senior citizens to get medical Care easily. The aim is to provide OPD services/facilities on Sundays in the hospitals under Delhi Government so that the older patients' caregivers can also accompany them without having to take leave from their workplace.

These Hospitals have also the separate counter for Senior Citizens for Medicines and OPD.

Miscellaneous

Telephone

Telephone connection would be given on priority to senior citizens of age 65 years and above. They shall be entitled to registrer their demand for one telephone connection in their names. The telephones thus provided shall be transferable only in the name of spouse, if alive after death of the subscriber as a general category telephone and subsequent transfers shall be governed by prevailing telephone transfer rules.

Helpline

On the initiative and with the financial assistance of Ministry of Social Justice & Empowerment, Age well Foundation, an NGO of Delhi, has started a Helpline for older persons. A centre named AADHAR is also being set up with the financial assistance of Ministry of Social Justice & Empowerment to receive and process the representations/petitions of older persons pertaining to their various problems and to take follow up action thereon.

Mobile Medicare unit programme

The Mobile Medicare Unit (MMU) Programme is the only programme directly implemented by Help Age India to provide basic essential Medicare at the door steps of needy and underprivileged elderly in India.

Three more MMUs at Jaipur and Bhopal and Delhi-III/Gurgaon are to be launched within next two months or so and another at Coimbatore a little later. In addition, Help Age India has provided about 80 MMUs to grass root NGOs for the similar service

Magazines for the Elderly

There are two magazines specifically for elderly Dignity Dialogue brought out by Dignity Foundation and Senior Heritage Selections by Heritage Medical Centre. The publications deal with a wide spectrum of issues, starting from the indignity of elder abuse to alternative medicine, to some philosophy and some inspirational material. Moreover, they provide a forum for the elderly to express their opinions and creativity.

Health Care in Kerala

In Government Hospital, Trivandrum there is a geriatric ward having 12 beds (male -8, female - 4) and free treatment is provided to old people whose income is below Rs. 300/- per month. Medical College Hospital, Trivandrum has an Out Patient Wing on every Monday from 10.30 am to 12.00 noon for senior citizens. District Blindness Society under the chairmanship of Collector and with the support of Health Services Department have a detection of cataract and further action for older persons.

Widow Pension in Kerala

Widow pension is Rs 110 per month. The person must be a destitute and her income per year must be below Rs 12,000. Age is no bar.

The government has launched various schemes and policies for older persons. These schemes and policies are meant to promote the health, well-being and independence of senior citizens. The main objective of this policy is to make older people fully independent citizens.

This policy has resulted in the launch of new schemes such as-

1. Strengthening of primary health care system to enable it to meet the health care needs of older persons
2. Training and orientation to medical and paramedical personnel in health care of the elderly.

3. Promotion of the concept of healthy ageing
4. Assistance to societies for production and distribution of material on geriatric care.
5. Provision of separate queues and reservation of beds for elderly patients in hospitals.

- The Integrated Programme for Older Persons is a scheme that provides financial assistance up to 90 per cent of the project cost to non-governmental organizations or NGOs as on March 31, 2007. This money is used to establish and maintain old age homes, day care centers, and mobile Medicare units and to provide non-institutional services to older persons.
- Another programme of the government is the Scheme of Assistance to Panchayat Raj Institutions voluntary organizations and self-help groups for the construction of old age homes and multi service centers for older persons
- The Maintenance of Parents and Senior Citizens Bill (Enclosed) of 2007 - This bill has been recently introduced in Parliament. It provides for the maintenance of parents, establishment of old homes, provision of medical care and protection of life and property of senior citizens.

Tax benefit

Those who attain the age of 60 years and above are eligible for the following exemptions extended by the government:

1. Section 88 of Finance Act, 1992, provides income tax rebate of up to Rs. 15,000 or actual tax whichever is less to senior citizens who have attained the age of 65 years at any time during the relevant previous year.
2. Senior citizens are excluded from the "One by Six" scheme for filing the Income Tax Return under provision Section 139
3. For senior citizens, the deduction in respect of medical insurance premium is up to Rs. 15,000/underSection80D.

Loan

Senior citizens are usually denied regular loans because of their inability to show proof of a regular level of income. However, recently, banks have started offering loans to pensioners and older people who can provide collateral in the form of an asset such as a home or land. This loan can be used to meet various expenses such as medical costs, marriage of grand children or paying old age home fees.

EXERCISES

MUTIPLE CHOICE QUESTIONS

Each question in this section is a multiple-choice question with four answer choices. Read each question and answer choice carefully and choose the ONE best answer.

1. What is the expansion of NOAP?
    a) National Organization of aged people
    b) National Old Age policy
    c) National Old Age population
    d) National Old Age Pension Scheme
2. What was the emphasis of Annapurna programme of India government?
    a) Special counters
    b) Discount on travel fare
    c) Food for destitute older person
    d) Sunday clinics
3. Maintenance of Parents and Senior Citizens Bill was passed in..
    a) 2007
    b) 2009
    c) 1998
    d) 1992

Answer key

1. d 2.c 3. A

SHORT NOTE

1. Explain the geriatric rehabilitation

CONCLUSION

In conclusion, current trends in demographics coupled with rapid urbanization and lifestyle changes have led to an emergence of a host of problems faced by the elderly in India. Although this paper has mainly focused on the medical problems of the elderly and strategies for improving health care services, it must be remembered that improving the quality-of-life of the elderly calls for a holistic approach and concerted efforts by the health and health-related sectors.

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