Work Instruction
for
providing
Elderly Care Services
in
Health and Wellness centre Sub Health Centre

Prepared by: Signature & Date	Name of the Health Facility:	Doc No: Version No: Effective Date:

Elderly and Palliative Care Services

Purpose: Overall purpose of this work instruction is to ensure elderly patients are mapped, screened, managed and timely referred.

Scope: It applies to all the staffs who are involved to provide services in the HWC. It broadly covers 4 (four) areas

a. General Awareness about Healthy life style, Social Security scheme for elderly and promote active & healthy aging, Identification of age-related ailments and increase supportive environment in families.
b. Mapping of elderly Population.
c. Comprehensive Geriatric assessment by Primary health Care team and
d. Domiciliary visits to bed ridden patients

Procedure:

Sl.	Activity/Description
1.	**General awareness and counseling**
1.1	All staff should be an avid listener to the problems mentioned by the senior. Should counsel the patient on dietary uptake, importance of regular exercise or brisk walk etc. to maintain good health. Mention and involve elderly in wellness activities such as Yoga etc. and document it. Should be able to understand signs and symptoms relating to health issues in elderly In the facility or home visit extensive counseling to be provided to the family members regarding risks of fall, memory loss, disturbed sleeping pattern, regular monitoring of cleanliness and hygiene is done etc. Risk of fall can be assessed by the health team (ASHA) by using simple tool

Sl.	Item	Yes	No
1.	Have you ever had a fall in last one year		
2.	Are you taking more than 4 types of medicines? (sedatives, antidepressants, anti-Parkinson's,		

	antihypertensives, diuretics, etc)		
3.	Are you suffering from any of the following? (anxiety, depression, loss of judgement /cooperation / insight)		
4.	Did you have dizziness or light headedness on getting up from the bed in last one year?		

For positive response to >2 questions, refer to CHO

Staff should be able to create elderly supportive groups "Sanjeevani" and ensure involvement of active and mobile elderly in various awareness generation activities.

2.	**Mapping of the population**
2.1	Undertake household visits and through general OPD record list out exact number of elderly populations using a defined checklist
2.2	The staff should be able to categorize and analyze the population into 3 categories a. Mobile Elderly b. Restricted mobility elderly (mobility only with personal assistance/device) c. Bed bound (assistance required in some form)/Home bound elderly for any reason and those requiring palliative care or end of life care
2.3	Based on the mapping of the elderly population in the catchment area prioritizing high risk elderly in terms of services, frequency of home visits to them and drugs availability
3.	**Screening using Geriatic Assessment Tool**
3.1	Activity of daily living checklist to be used by CHO at the HWC or during the home visit. Using the checklist, categorize the patient into independence or dependence category and based on that treatment and counseling will follow

Activity Points (0 to 1)	**Independence (1 point) NO supervision, direction or personal assistance**	**Dependence (0 point) WITH supervision, direction, personal assistance or total care**
Bathing	(1 POINT) Bathes self completely or needs help in bathing only a	(0 POINT)

	single part of the body such as the back, genital area or disabled extremity.	Needs help with bathing more than one part of the body, getting in or out
Dressing	(1 POINT) Gets clothes from closets & drawers & puts on clothes & outer garments complete with fasteners. May have help tying shoes.	(0 POINT) Needs help with dressing self or needs to be completely dressed.
Toileting	(1 POINT) Goes to toilet, gets on & off, arranges clothes, cleans genital area without help	(0 POINT) Needs help transferring to the toilet, cleaning self or uses bedpan or commode
Transferring	(1 POINT) Moves in & out of bed or chair unassisted. Mechanical transferring aides are acceptable	(0 POINT) Needs help in moving from bed to chair or requires a complete transfer.
Continence	(1 POINT) Exercises complete self-control over urination and defecation	(0 POINT) Is partially or totally incontinent of bowel or bladder.
Feeding	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINT) Needs partial or total help with feeding or requires parenteral feeding
TOTAL POINTS = _____ 6 = High (patient independent) 0 = Low (patient very dependent)		

3.2 **Geriatric Depression Scale (GDS)**

CHO must have a knowledge to use geriatric depression scale for self-report measure of depression in older adults.

Users respond in a "Yes/No" format. The GDS was originally developed as a 30-item instrument.

There is preliminary evidence that it has good internal reliability down to **age 40** in a general adult population

Item	**Answer**	**Score**
Are you basically satisfied with your life?	Yes/No	
Have you dropped many of your activities & interests?	Yes/ No	
Do you feel that your life is empty?	Yes/ No	
Do you often get bored?	Yes/ No	
Are you in good spirits most of the time?	Yes/ No	
Are you afraid that something bad is going to happen to you?	Yes/ No	
Do you feel happy most of the time?	Yes/ No	
Do you often feel helpless?	Yes/ No	
Do you prefer to stay at home, rather than going out & doing new things?	Yes/ No	
Do you feel you have more problems with memory than most?	Yes/ No	
Do you think it is wonderful to be alive now?	Yes/ No	
Do you feel pretty worthless the way you are now?	Yes/ No	
Do you feel full of energy?	Yes/ No	
Do you feel that your situation is hopeless?	Yes/ No	
Do you think that most people are better off than you are?	Yes/No	
Answers in bold indicate depression. Score 1 point for each bolded answer. A score > 5 points is suggestive of depression. A score ≥ 10 points is		

almost always indicative of depression. A score > 5 points should warrant a referral to the PHC

3.3 Mini Mental State Examination (MMSE)

The MMSE test can be used by CHOs **to help diagnose dementia and to help assess its progression and severity.**

The MMSE provides measures of **orientation, registration (immediate memory), short-term memory** (but not long-term memory) as well as language functioning.

The MMSE is composed of 11 major items; **temporal orientation (5 points), spatial orientation (5 points), immediate memory (3 points), attention/concentration (5 points)**, delayed recall (3 points), naming (2 points), verbal repetition (1 points), verbal comprehension (3 points), writing (1 points), reading a sentence (1)

CHO must use the below MMSE checklist for evaluation:

Patient's Name _____ Date _____

Instructions: Ask the questions in the order listed. Score one point for each correct response within each question or activity.

Maximum score	Patient's Score	Questions
5		What is the year? Season? Date? Day of the week? Month?
5		Where are we now State? Country? Town/city? Hospital? Floor?
3		The examiner names three unrelated objects clearly & slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible Number of trials _____

5		I would like you to count backward from 100 by sevens. (93, 86, 79, 72, 65,.....) Stop after five answers. Alternative "Spell WORLD backwards" (D-L-R-O-W)
3		"Earlier I told you the names of three thins. Can you tell me that those were?"
2		Show the patient two simple objects such as a wristwatch and a pencil and ask the patient to name them
1		1 Repeat the phrase 'No ifs ands or buts
3		"Take the paper in your right hand, fold it in half, and put it on the floor" (The examiner gives the patient a piece of blank paper)
1		1 "Please read this and do what it says." (Written instruction is "Close your eyes.")
1		Make up & write a sentence about anything." (This sentence must contain a noun & a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper & asks him/her to draw the symbol below. All 10 angles must be present & two must intersect.) 
30	Total	

If value < 24, refer the individual to PHC, if the individual has studied above 8th class.

If value < 21 refer the individual to PHC, if the individual has studied below 8 class

HWC undertake preliminary assessment for the need of assistive devices

a. CHO should map out the elderly population requiring aid for daily assistance

		b. The requirement or need should be documented & to be presented to the MOIC c. CHO must ensure for supportive aids viz Walking sticks, callipers, infrared lamp, shoulder wheel, pully & walker (as per requirement) through PHCs d. The whole process must be documented at HWC
		Dispense drugs and consumables a. MPW/CHO shall accord special attention for restricted mobile elderly, home bound /bedridden elderly persons and single elderly and ensure timely drug prescription, drug dispensing as well as assistive devices. b. HWC could supply prescribed drugs for bed-ridden patients through family members and care givers. However strict check for compliance to treatment shall be ensured. c. Recording and reporting at HWC