A GUIDE TO

SUPPORTING INDEPENDENCE IN OLDER ADULTS

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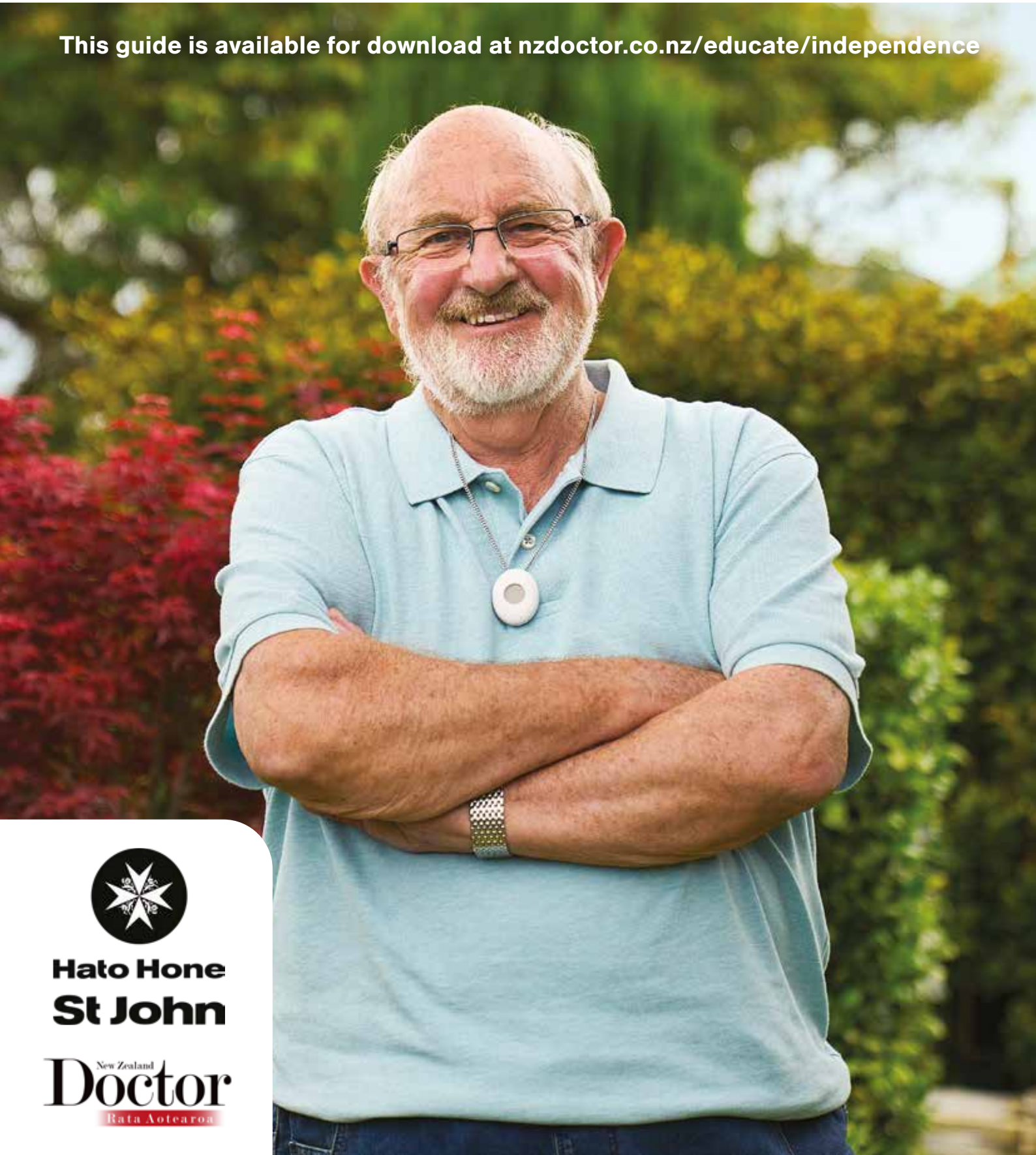

Hato Hone St John

New Zealand Doctor Rata Aotearoa

The positive influence of independence on older adults

Most healthcare professionals will be well aware of the benefits associated with the preservation of independence for their older patients.

Remaining at home can give older adults a sense of independence, freedom and identity, and allows them to retain their privacy and stay in control of their lives.

Maintaining this sense of control can help promote feelings of purpose, achievement, and self-worth. And of course, living at home allows seniors to stay connected with family, friends, and the community, which is critical for social support.

As Dr Ngaire Kerse notes in her article titled "Independence in older age requires a lifetime of independence" (see the first story in this publication), functional independence for older adults depends on a number of factors, including regular physical activity, pleasant home environments, interacting with supportive and positive people, feeling a sense of purpose, having autonomy in decision-making, keeping the brain stimulated and having optimal management of health conditions.

Even with all these elements in place, seniors can still face threats to their independence, such as falls and other accidents, respiratory disorders, and heart conditions. While some of these threats are unavoidable, appropriate measures can be put in place to minimise their impact on senior independence.

Over the last few years, *New Zealand Doctor Rata Aotearoa* has published a number of articles concerning the issues facing older patients. Now, with the support of Hato Hone St John, we have compiled many of those articles into this handy guide.

We intend for it to serve as a useful resource to help you when considering how to support the independence of your older patients.

Many of these articles are also available online at: nzdoctor.co.nz

If you would also like a digital version of this publication, you can find it here: nzdoctor.co.nz/educate/independence

For more information about St John Medical Alarms, visit: stjohnalarms.org.nz/hcp

Cover photo: Hato Hone St John

Hato Hone St John

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New Zealand Doctor Rata Aotearoa

Independence in older age requires a lifetime of independence

OLDER PEOPLE

Specialist GP Ngaire Kerse reflects on what helps keep older people independent, including the factors throughout life that primary care can have an impact on

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Cognitive challenge is helpful for older people, especially when in a social context

The importance of independence for older people is pretty well known, and GPs and nurse practitioners will have dealt with transitions, decline and recovery in their older patients. As New Zealand emerges from the restrictions of the pandemic, it is useful to reflect on what it is that keeps older people independent.

I have observed the independence of loved ones and patients reducing over the three years of the pandemic, and they will require significant encouragement for this to reverse.

Life and Living in Advanced Age, a Cohort Study in New Zealand (LiLACS NZ) shows us that naturally there is a flux in functional status for those in the 80 and over age group, with as many staying the same or improving as declining.[1] Of course, this assumed usual family, whānau and social activities were available.

Physical activity is essential for functional independence. The more steps per day the better,[2] and increasing levels of activity preserves and improves functional status, prevents falls and is a national imperative for all. Older people don't do as much activity as when they were younger, and those with physical impairment and social deprivation do even less. Start now with easy, accessible activity that *can't* be avoided; make it habitual and ongoing to preserve functional independence in ageing.

Think of innovative ways to enable activity in daily life for older people, and help them make it happen. A really good idea is to constantly and repeatedly refer them to the community exercise programme facilitated by ACC through your local health service. For the Auckland region, this is through CareConnect eReferrals, and there are many providers of appropriate exercise. In-home exercise is also available for those who can't make it out.

Optimal management of health conditions and reduction of medication-related harms are needed for maintenance of independence. This is your job, and attention to updated management trends, new medications and appropriate use of old ones all helps.

LiLACS NZ found that *omissions* of appropriate medication were more predictive of hospitalisations and mortality than inappropriate use.[3] The omitted medications included bisphosphonates and those for cardiovascular disease risk management, among others.

However, the factors that promote independence are more than just good health.

The environment and context of the older person makes a big difference. For some, the natural requirement of maintaining a house means walking to the mailbox, attending to the garden and thinking about the maintenance. For those in smaller dwellings, the requirements are smaller and, therefore, the amount of habitual activity is smaller.

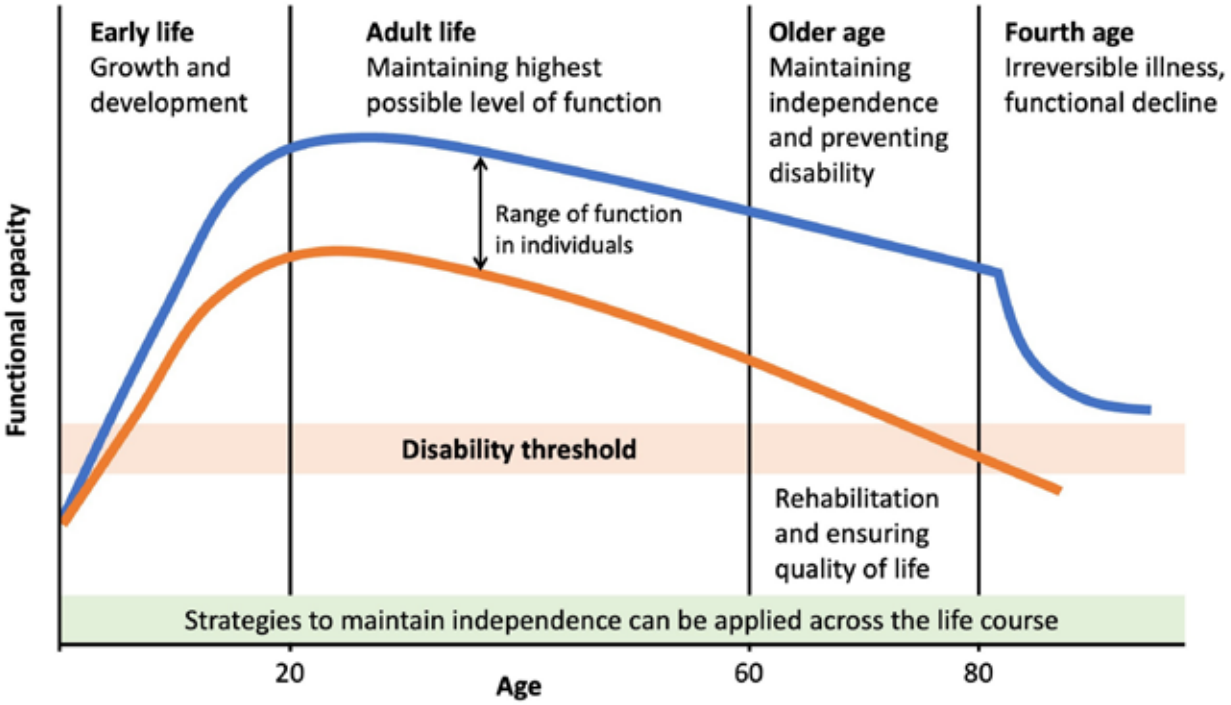
Having supportive and positive people around the older person contributes to wellbeing and the ability to undertake activities. Attention to family and social relationships, including their quality and quantity, may lead to action towards enabling positive interactions.

A sense of purpose, the economic and social resources to pursue that purpose, and the autonomy to make it happen on the older person's terms, also promotes independence. It's a cycle – achieving purposeful actions promotes independence, and, in turn, independence enables pursuit of meaningful activities. Thinking broadly about the implications of this in all our roles will enable older people to flourish and recover from forced constraints related to the pandemic, incidental disease and health events.

Autonomy for all older people to make decisions, and the resources to follow through on them, cannot be overemphasised. This applies to Māori and all cultural groups. For those with a collective societal view, the ability to

Key points

- Physical activity, brain stimulation, optimal management of medications and health conditions, having supportive and positive people available, and having a sense of purpose and autonomy all help to maintain independence in older age.
- Independence in older age is affected by growth and development in infancy and childhood, and by modifiable risk factors and socioeconomic status throughout life.
- Taking a preventive and strengths-based approach to healthcare delivery throughout life can have a substantial impact on your patients' independence in ageing.



Adapted from Eldemire-Shearer et al (*West Indian Med J* 2014;63[1];3–8)

Possible trajectories of functional capacity by age

participate in whānau and societal decisions, decide to fulfil leadership roles and fully participate in the life they choose will sustain independence.

Autonomy means choosing where to live and who with, when to go to bed, when to turn out the light, what to eat and when, etc. This autonomy stimulates brain activity, as does physical activity and social and environmental interaction, and contributes to the cycle of sustainable independence. Even when older people have some cognitive impairment, they require as much autonomy as can safely be achieved, to maintain their independence, feel respected and know they are contributing to society.

Brain stimulation can be accomplished in many ways. Talking, thinking, reading with immediate recall and use of the information read, social interactions, making connections with things and people (eg, visiting museums, understanding whakapapa and your place in the world), and past and future events have all been shown to be beneficial.

Physical exercise, especially dual-task exercise where the exercise is cognitively challenging (kapa haka is a great example), is especially important. Cognitive challenge with puzzles and crosswords is helpful, especially if taken in a social context. Wordle may be altering the cognitive trajectory of the world!

> “To be independent in older age, one must be independent when *reaching* older age”

Independence across the life course

To be independent in older age, one must be independent when *reaching* older age. The figure shows different trajectories for independent ageing and for ageing less independently.

Birth weight predicts strength in late life, and if growth and development in infancy and childhood does not proceed optimally, maximal functional levels will be lower. This also applies to mental health trajectories, and we can all think of patients who have been destroyed psychologically and physically from trauma of various sorts in childhood. Nutrition and brain stimulation early on are really important for realising potential.

In adult life, there are many things that can impact independence in older age. The 2020 *Lancet* Commission report on dementia prevention, intervention and care is a great example and easy reading.[4] If the risk factors found to be associated with development of dementia were addressed through health and social services (low education in early life; hearing loss, obesity, hypertension in midlife; depression, smoking, physical inactivity, diabetes, and social isolation in late life), 35 per cent of cases of dementia could be prevented.

This is primary care’s job!

Of factors less easy to impact, low socioeconomic position makes independence in older age less likely, whether low socioeconomic status was in childhood, adult years or older age. This is government policy’s job.

There is good evidence that frailty can be detected in people aged 40 to 50. The lower end of the range of muscle strength and cognitive function is detectable, but trials to impact on-going “low-trajectory status” have not been able to show impact, probably because we need sustainable change in lifestyle and ongoing preventive opportunities.

Being frail is a strong predictor of losing independent function, and taking a preventive and strengths-based approach to our healthcare delivery throughout life can have a substantial impact on independence in ageing.

Over the next months of the health reforms, we all hope there will be room for more social cohesion, attention to independence for older people and consideration of prevention approaches throughout the life course. Let’s all be on the lookout for opportunities to promote independence in any way possible. ■

Ngaire Kerse is president of the New Zealand Association of Gerontology and the Joyce Cook Chair in Ageing Well, University of Auckland

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Awareness of falls risk helps older adults retain their independence

The ability to live independently is highly valued by seniors.[1] Much of that independence, which is critical to the mental health and wellbeing of older adults, comes from living in their own home. Seniors report moving out of home into an age related residential care facility as one of their greatest fears.[1]

In addition to cardiac events and respiratory disorders, falls are a common reason for older adults losing their independence. One-third of those aged 65 years or older living in the community experience a fall at least once a year and up to one-half of seniors requiring hospital admission with a fall-related injury are discharged to an age related residential care facility.[2]

With falls being a major threat to the wellbeing and independence of older adults, identifying your senior patients who are at risk of falling allows steps to be taken to reduce harm and support their desire to maintain their independence.

Assessing the risk of falling in your older patients

Routinely asking your older patients about falls is critical as they may never proactively raise the topic during a consultation for fear that doing so may lead to the loss of their independence, i.e. having to leave home and enter aged residential care.

The Health Quality and Safety Commission has developed a 3-step process for screening those at risk of falling and addressing their risk factors: **Ask, Assess, Act.**[3]

The next time you see one of your senior patients you can start the process by screening your senior patients' risk of falling with three key questions **(Ask)**:

1. Have you slipped, tripped, or fallen in the last year?
2. Can you get out of a chair without using your hands?
3. Have you avoided some activities because you might lose your balance?

Being aware of medical factors that indicate susceptibility to falling will also help in the screening of your patients who are at risk of falling. Studies indicate that the following are major medical risk factors for falls:[4-6]

- Impaired balance and unsteady gait.
- Medication use, especially polypharmacy.
- Previous falls and fear of falling.
- Use of an assistive device.
- Postural hypotension.

Identifying your older patients who are at risk of falling allows steps to be taken to reduce harm and support their desire to maintain their independence.

Other falls risk factors include female gender, visual impairment, cognitive decline, incontinence, and certain comorbid conditions (depression, diabetes, osteoporosis).[4-6] Susceptibility to falls results from the interaction of multiple medical factors, with the risk of falling increasing with the number of risk factors.[7]

If a patient's replies to the three key questions indicate that they are at risk of falling **(Ask)**, you can arrange for an in-depth evaluation of their risk factors **(Assess)** and development of a personalised care plan **(Act)**.

An immediate action you can take for all your patients at risk of falling is to refer them for a St John Medical Alarm.

Supporting the independence of older patients at risk of falling

Medical alarms offer the potential for maintaining the wellbeing and independence of seniors living at home by enabling timely intervention in case of a fall, or other health-related events such as a cardiac event or respiratory issue. The use of a medical alarm can reduce mortality rates as well as hospital admissions and inpatient days in community-residing older adults,[8,9] potentially reducing the requirement for long-term aged care.

It is not possible to be there to protect your patients all of the time, but with a St John Medical Alarm seniors in your care are able to go home and be and feel safe knowing they can access help 24/7 if they need it, giving them the peace of mind and reassurance to live a full, independent life, and to stay at home for longer.

A St John Medical Alarm offers 24/7 response and is the only medical alarm that connects directly to Hato Hone St John. All patients are eligible for a **FREE trial,** and referral is a straightforward process through your Practice Management System via Healthlink or ERMS.

For more information go to: stjohnalarms.org.nz/hcp

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Reframing ageing: Ageism is an insidious problem and it's linked to bad health

OLDER PEOPLE

Specialist GP Ngaire Kerse writes about how we think and talk about older people, and how it makes a difference to their wellbeing

Ageism is deeply embedded in our society and institutions, and we are products of that society and operate in its institutions. As "the doctor", your words, attitudes and ways of working have an impact on the health and wellbeing of your older patients.

You may not think or see this, but qualitative and intervention research shows benefit to older people when they are given respect and feel listened to, and their behaviour changes because of GPs' words and advice.

Similarly, negative words and attitudes can have a huge impact.

Our aim should be full inclusion and participation in society of our older patients, so let's be part of the solution, not part of the problem.

FrameWorks Institute is an organisation that develops and disseminates useful toolkits to inform, raise awareness and provide resources to help people change. They give some simple suggestions about reframing our language about ageing (see table).

For GPs, nurses and nurse practitioners, it is easy to change words, but changing our thinking is harder. Here are a few areas to consider:

- Demographic change is an opportunity, rather than a burden. Emphasise the contributions that older people make to our lives, to each other's lives and to the translation of wisdom through the generations.
- A comprehensive approach to ageing is needed, not just for health but for housing, transport, income support and local government – recognising that the non-medical determinants of wellbeing are as important as health, is critical to giving advice and pointing out opportunities.
- Allow older women and men to be self-advocates and let them speak on their own behalf. This pertains to difficult choices that they may wish to make themselves, and applies to strong family members (eg, spouses, daughters), other clinicians and neighbours.

Key points

- Ageism is associated with worse physical and mental health outcomes and high healthcare costs.
- Mechanisms by which ageism impacts on health include psychological, behavioural and physiological pathways.
- Interventions that combine education with intergenerational contact can change attitudes towards older people, knowledge about ageing and comfort with older people.
- The ageing population should be seen as an opportunity, rather than a burden.

> "During the COVID-19 pandemic, older people were labelled as vulnerable and dispensable overnight"

Why should you care?

Because ageism is bad for health.

During the COVID-19 pandemic, older people were labelled as vulnerable and dispensable overnight – a direct effect on mortality related to age was obviously associated with access to treatment.

The Australian Royal Commission into Aged Care Quality and Safety also outlines numerous issues and areas for improvement (tinyurl.com/AgedCareReport).

Further, the ABC has nicely summarised issues of ageism that are broader than residential care (tinyurl.com/ABCageism).

Those people who feel discriminated against (high age discrimination on questionnaires) have worse diseases and incur more costs. Using population prevalence estimates, and adjusting for confounders, one study found that one year of ageism costs US$63 billion, or one of every seven dollars spent on eight common chronic diseases.[1]

Potentially, those subjected to discrimination don't value themselves, don't look after their health and are denied opportunities (sounds familiar!). Impacts on loneliness, social isolation and even cognition have been associated with ageism against older people.

A systematic review published in 2020 found the simultaneous impact of *structural ageism*, where institutions reinforce systematic bias against older people, and *individual ageism*, where older people assimilate negative views of ageing from their culture, results in worse health outcomes all around the world and across age groups, and has greater negative impact on people otherwise economically and educationally disadvantaged.[2]

This review reported on 50 studies about physical illness and 42 studies about mental illness where ageism was associated with worse outcomes. On a brighter note, when older people resisted negative age stereotypes, they were less likely to experience suicidal ideation, post-traumatic stress disorder and anxiety.[2]

Mechanisms by which ageism impacts on health include psychological (low self-efficacy, less perceived control, lack of purpose in life, greater intention to leave work), behavioural (less physical activity, less career-advancing activities) and physiological (C-reactive protein partially mediates the relationship between positive self-perceptions of ageing and longevity) pathways.[2]

There are examples of successful interventions that changed attitudes towards older people, knowledge about ageing and comfort with older people.

Combined interventions with education and intergenerational contact worked the best, and the most impacted were women, and adolescent and young adult groups. However, no significant effects on anxiety about one's own ageing or interest in working with older adults were found.[3]

Whether health outcomes for older people were improved was not studied – this would be hard to study as the impacts of ageism are likely to be accrued over a lifetime.[3]

So, I invite you to the bandwagon of anti-ageism, to think about older people positively, to act positively and encourage full participation in society for your older patients. Their health will benefit, and your job will be easier as a result. ■

Ngaire Kerse is president of the New Zealand Association of Gerontology and the Joyce Cook Chair in Ageing Well, University of Auckland

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Ageism is ingrained in our society – almost everyone has negative feelings about ageing

Reframing conversations about ageing

Instead of using...	Try to...
Catastrophic terms about the growing population of older people (time bomb, silver tsunami)	Talk affirmatively about longer and healthier lives, and about ageing as an opportunity
Terms that are homogenising and stoke stereotypes (seniors, elderly)	Use more neutral terms (older people, older New Zealanders)
Pronouns (they, them) or "othering" terms that frame older people as a group to set aside, assuming they are different	Use inclusive terms (we, us) in reference to the universal experience of ageing and to give a voice to self-advocates
References to "youth" to describe older age (accumulated youth, 60 is the new 50) or positive achievements or behaviours (young at heart)	Use direct affirmation of being old (it's okay to be old) or alternative adjectives to describe positive achievements or behaviours
Possessive pronouns that assume older people are someone's property (our older people)	Remove the possessive pronouns
Adjectives around frailty to describe a whole age group (vulnerable, at-risk population)	Specify the risk factors that are putting people in situations of vulnerability
Conflict-oriented words to describe ageing experiences (struggle, battle, fight ageing)	Use the building momentum metaphor: ageing is a dynamic process that leads to new abilities and knowledge we can share with our communities

Inspired by Quick Start Guide (Aging). *Washington, DC; FrameWorks Institute: 2017. tinyurl.com/ReframeAgeing*

The importance of timely treatment for CVD events

It is already well-understood that timely intervention is essential to mitigate the effects of cardiovascular events. That is particularly relevant when it comes to adults aged over 65 years, for whom the prevalence of heart attack, stroke and heart failure is highest.[1]

Assessment of your older patients regarding their vulnerability to cardiovascular disease (CVD) should ideally include consideration of their home environment. If they live independently or are likely to be on their own for extended periods, then it might be appropriate to consider recommending a personal emergency response device such as a medical alarm when tailoring their care plan.

Prompt therapy leads to improved outcomes

The key to acute management of heart attacks is the amount of time it takes to restore the coronary artery blood flow.[2,3] The sooner that percutaneous coronary intervention (PCI) can be performed (typically within 12 hours of coronary occlusion), the better the chance of a good outcome. Total time to performance of PCI is the sum of onset-to-door time (OTD: time between symptom onset and hospital arrival) and door-to-balloon time (DTB: time between hospital arrival and performance of PCI).

Compared with longer DTB (≥90 mins) and OTD (≥4 hrs) times, patients with acute heart attack requiring PCI who had shorter DTB (<90 mins) and OTD (<4 hrs) times had lower longer-term mortality (3.51% vs 7.25%).[4] Demonstrating the strong effect of travel time on clinical outcome, a longer OTD time (≥4 vs <4 hrs) was associated with significantly ($p<0.03$) higher longer-term mortality despite a shorter DTB time (<90 vs >90 mins).[4]

The need for early treatment is even more critical for stroke patients, with thrombolytic therapy having a therapeutic window of only several hours.[5,6] Initiating therapy within this narrow window is essential for improved outcomes. Stroke patients who used an ambulance were more likely to reach the hospital and be treated with thrombolytic therapy within the therapeutic window than non-ambulance users (64.6% vs 29.6%; $p<0.001$).[5] The OTD time was significantly shorter for ambulance users than for non-ambulance users (32 vs 44.5 min; $p<0.001$).

The longer-term implications if treatment is delayed

Delayed treatment, for whatever reason, in patients experiencing exacerbation of their heart failure symptoms has been demonstrated to be significantly associated with an increased risk of rehospitalisation and mortality after discharge.[7]

Patients whose health status is diminished following either a heart attack, stroke, or the onset of heart failure risk loss of functionality,[8] and their ability to continue to live independently may be threatened. Acute and chronic post stroke health status are especially undesirable, with the functional impact likely to involve cognitive and mobility impairments. The acute health state after a heart attack is also associated with reduced function. At least four in every ten survivors of a heart attack requiring hospitalisation experience clinically relevant declines in physical functioning in the year following the event.[9]

Getting help when it's needed

Intervention strategies are recommended to reduce the pre-hospital delay so that medical care for CVD events is received within the therapeutic window, thereby likely improving clinical outcomes and the ability to live independently. A personal emergency response such as a medical alarm can be an appropriate solution to this need.

Patients whose health status is diminished following either a heart attack, stroke, or the onset of heart failure risk loss of functionality,[8] and their ability to continue to live independently may be threatened.

Referring a St John Medical Alarm can offer your older patients 24/7 response and is the only alarm that links directly to Hato Hone St John. As part of the treatment plan for your older patients, access to help through a medical alarm can instil the confidence to live a more independent life.

Referral is straightforward through your Practice Management System via Healthlink or ERMS and your patients have access to a **FREE trial**.

For additional information visit: stjohnalarms.org.nz/hcp

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Optimising ageing: Think about frailty, exercise, habitual activity

OLDER PEOPLE

Specialist GP Ngaire Kerse discusses the interplay of frailty, physical activity and social connections in older people

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Making up almost half of older women's activity, housework is life-saving!

I have been reviewing some conversations I had with the physiotherapists at one of their conferences. They were surprised I wasn't a physio, and I was very happy with the honorary physio-for-a-day title they gave me. Anyway, here are some thoughts on optimising ageing.

Of course, your older patients are sometimes your favourites, sometimes your nemeses. Living at home is great, but as one ages, sometimes that gets difficult. There seems to be a trend for everyone to downsize, go into retirement villages or move hundreds of miles away to a new place that is cheaper, near children, with more sunshine, or just for the hell of it.

So, here are some things to think about the next time you see one of your older patients.

Key points

- Frail older people are vulnerable to worsening health status from minor illnesses.
- There is a dose–response relationship between increasing physical activity and decreasing frailty.
- When older people move into retirement villages or aged-residential care, they must replace their daily habitual activity with some other activity.
- Social connection is associated with higher activity levels and better outcomes.

Frailty

Frailty is a clinical syndrome that might not be very obvious to the untrained and non-inquiring eye.

Figure 1 (over page) shows the imagined line in the sand for functional abilities – that of having enough function to look after yourself in your own home (with or without support) – and two hypothetical people trucking along (shown by the green line higher up and the red line lower down). Then there is a "perturbation", such as a urinary tract infection, and you can see the red line (person) dipping down below the line of independence before recovering to a slightly lower base level. The green line above has a relatively small dip and recovers to the same level as before the perturbation. The green line represents an older person who is not frail, and the red line is frail – vulnerable to worsening health status from minor illnesses.

Obviously, how you recognise frailty is another story. You may look at physical ability – slowness, weakness, low physical activity, exhaustion and unintentional weight loss are the five criteria of the Fried frailty phenotype.

An accumulation of many deficits is the Rockwood model that was developed from the interRAI comprehensive assessment. The Rockwood Index can be constructed from usual data considering as many items as you have available (it has to be more than 30 items across functional assessments, blood tests, conditions, etc). If you have 30 items, those with deficits in more than 20 per cent of them are said to be frail.

GPs tend to recognise frailty with a "gut feeling". For example, you might think that your patient will do badly after their knee replacement or if they were to fall. What is needed, of course, is some prehabilitative action – some encouragement and a check over, looking for underlying anaemia, inactivity and misery.

Treatments for frailty can be reactive or preventive, and nutrition and exercise tend to be the most common. You might say, "Eat more protein, especially in the morning, and exercise please." Or, if you are more into motivational interviewing, you can ask, "How could you manage to do a little more activity?"

Exercise and habitual activity

Exercise, particularly progressive resistance training in the formally supervised, thrice-weekly, vigorous form is effective in delaying and reversing frailty. However, it is not consistent and also very hard to "enforce" in those aged 70 and over.

General habitual activity is good too and is associated with less frailty (it's a chicken or egg scenario, but exercise can be influenced more easily than frailty). Those who live in houses with stairs live five years longer. The biggest differential is between the very sedentary and those with any activity, and it is a dose response where more is better.

Figure 2 (over page) is from my PhD in Australia in the 1990s. I think it still

applies, especially when I talk with older patients living in the family home. The figure shows the activity patterns of 276 people over age 65 living in Melbourne suburbs. Activity (minutes per two weeks) was self-reported and categorised into walking, gardening, sports (mostly bowls, golf and swimming), housework and home maintenance, and other. I never published these data, so you are the first official audience.

It is not rocket science to see that, overall, men outstrip women in activity levels in everything except housework. The main point is that housework makes up almost half of older women's activity, and I postulate that in this setting, housework is life-saving! I was giving this talk one day and my husband in the audience piped up and said, "So, when are you going to start?" Hmmm.

Now, let's imagine what happens when that little old lady moves into a unit – what happens to her access to housework activity? It *must* be replaced by other activity on a regular daily basis. How to do that in the new environment is a very important question you can ask.

Where are your favourite people?

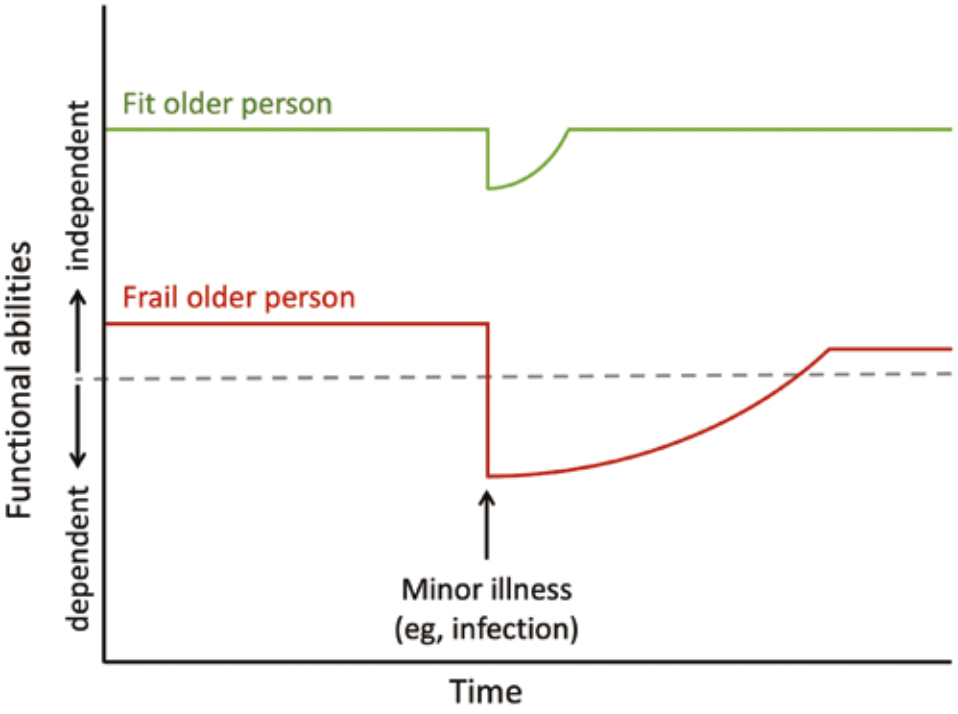
Social connections, activities and interactions are also life-saving. Vibrant social networks are associated with better activity levels, longer life, fewer adverse events and pretty much most positive outcomes.

I met a woman walking in a South Island city, and she told me her tale of moving across town because a unit was available there (not locally) after her husband died.

The trouble was, her bridge partner and reading buddies were now across town, and she had trouble getting back for the weekly activities. The folk in the new place weren't friendly, and she had never been so lonely.

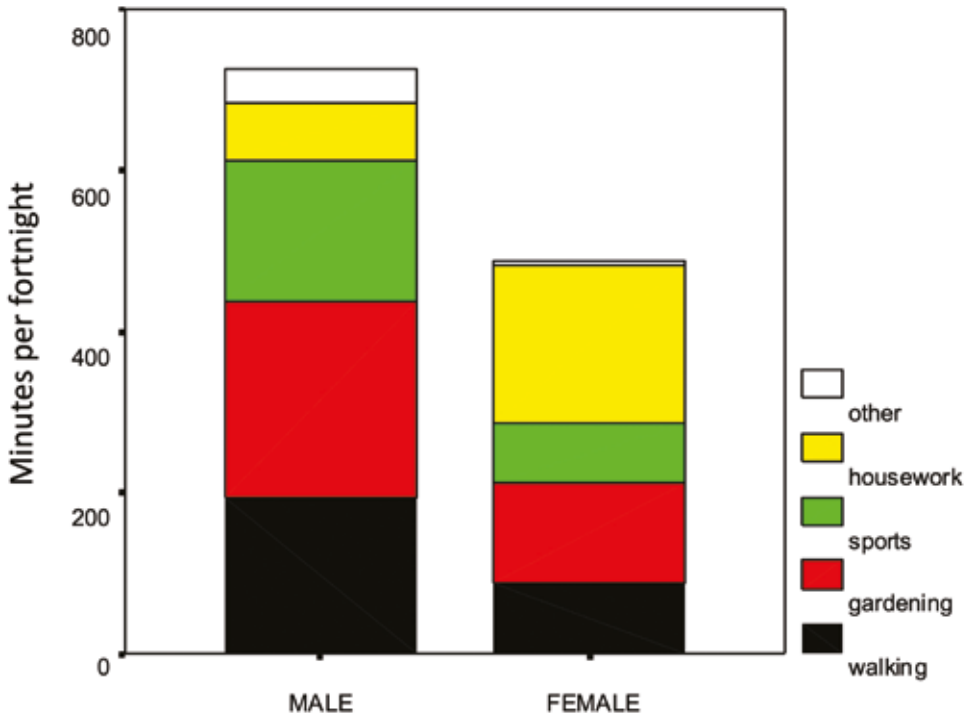
So, what happens when a patient's move is further and the oomph needed to create new social connections has faded? Talking with older people about these things can edge into your regular conversations, as well as talking through other complex family matters. Perhaps, it is part of the life coach role that the GP has – after all, the longer you stay in the one place, the more events go by to talk about, such is the flavour of continuity.

So, to optimise ageing, think about frailty, take habitual activity like a daily therapy, and hang out with your favourite people. ■



Adapted from Clegg A, et al. (*Lancet* 2013;381:752–62)

Figure 1. Vulnerability of older people to a sudden change in health status following a minor illness



Supplied

Figure 2. Patterns of activity in older people

Ngaire Kerse is president of the New Zealand Association of Gerontology and the Joyce Cook Chair in Ageing Well, University of Auckland

Reference: Clegg A, Young J, Iliffe S, et al. Frailty in elderly people. *Lancet* 2013;381(9868):752–62.

Mitigating the risks of breathing difficulty in older adults

Breathing problems represent a major health challenge for as many as one-in-three older adults,[1] and rank among the most frequent reasons for an ambulance call out in New Zealand.[2] Breathing difficulty in seniors is associated with compromised wellbeing, increased clinic and emergency department visits, high rates of hospital admission, and an increased risk of death.[3,4]

Hospitalisation due to exacerbation of chronic obstructive pulmonary disorder (COPD) can lead to physical and functional impairment in older adults,[5] and risk their ability to live independently. A higher frequency of falls, which can also result in a loss of independence,[6] has been observed after hospitalisation in older patients with exacerbation of COPD compared with stable COPD, attributable to balance deficits due to increased breathlessness and reduced muscle strength.[7]

With breathing difficulties having the potential to threaten the independence of older adults, measures can be taken to mitigate this risk.

Enabling older adults to live independently

Research indicates that seniors have a strong desire to live independently,[8,9] and that two-thirds are open to using assistive technologies to support them to do this.[9] Specifically, they want assistive technology that is connected to a network, easy to find, and simple to use.[10]

A medical alarm, or personal emergency response system, is an assistive technology that can play an important role in preserving the quality of life and independence of older adults. Studies confirm that older adults find medical alarms simple to use, and that they instil enhanced feelings of safety and security, which likely contributes to seniors being able to live independently.[11-13] Studies also show that the use of a medical alarm can reduce hospital admissions, shorten hospital stays and improve quality of life in community-living seniors,[14,15] potentially delaying the need for long-term age-related care.

Peace of mind for you and your older patients

With a St John Medical Alarm, help is just the push of a button away. This makes it easy for your senior patients to get the support they need when you cannot be there, such as if they are unable to phone someone because they are struggling to breathe. Breathlessness is one of the most common reasons for the activation of a medical alarm.[16]

The use of a medical alarm can reduce hospital admissions, shorten hospital stays and improve quality of life in community-living older adults.[14,15]

A St John Medical Alarm offers 24/7 response and is the only medical alarm that connects directly to Hato Hone St John, offering your older patients around-the-clock access to expert care and the reassurance to be able to live an independent life and stay at home longer.

Your patients have access to a **FREE trial** of a St John Medical Alarm. Simply refer them through your Practice Management System via Healthlink or ERMS.

For additional information visit: stjohnalarms.org.nz/hcp

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Planning for the future: Be positive about ageing and you will live longer

OLDER PEOPLE

Specialist GP Ngaire Kerse reflects on attitudes about ageing and how these can affect both your patients' wellbeing and your own future

One of the best reads I have had recently is summarised in this short YouTube clip (youtu.be/A74CKWkp6B4), which may be more palatable than the full report for most busy people. *The Perennials: The Future of Ageing* is the product of ongoing surveys with older people in over 20 countries around the world, and surveillance of leading ageing research and demography.[1]

As our ageing population flourishes into being half of consultations over the working life of those GPs just starting out, let's reflect on what difference attitudes make.

How old is 'old'?

If you ask the 16 to 24-year-olds, they will say age 61 is old; if you ask a 50-year-old, they will say around 75; and if you ask a 75-year-old, they will say 80s. It's always older than you are.

Around the world, how old is old differs as well. In Spain, you are old at age 74, and in Saudi Arabia, you are just 55. I asked the emeritus professor of geriatric medicine David Richmond when he was 92, and he said, "I think I have made it to the target group that we want to study."

For clinicians, being old is realised with the complexity of medical conditions and balancing of pills, creams and investigations, working out the combination of support needed to maintain independent living, filling in the insurance claims for travel (now that it has started up again) and negotiating the complex family issues. Societies and older people themselves have different views than the GP.

The negative

The negativity about older people comes from societal and media portrayal of older people being frail, ill, dependent, having low social status, contributing little to the economy and being a drain on health services.

Key points

- People with negative views of ageing have greater difficulty planning for the future, can struggle with relationships and are more likely to have depression and loneliness; those with positive attitudes about ageing live longer.
- Socioeconomic status affects ageing and longevity, adding to ethnic disparity.
- Older people who contribute to their families and society are more content, and intergenerational contact helps dissipate ageism.
- Be alert to sexually transmitted infections in older people in new relationships.

Older people get 1.5 per cent of parts in TV shows and movies, and when you look at dialogue, older men get 5 per cent of speaking parts and women 3 per cent – no wonder they are invisible. Most advertising has people aged under 40 in it, but most money is spent by those aged over 40.

People with a negative view of ageing have greater difficulty planning for the future, can struggle with relationships and are more likely to have depression and loneliness. At least 20 per cent of older populations are affected by loneliness or isolation.

COVID-19 has made this worse for some and better for others. With children worrying about older parents, contacts may have been more frequent during lockdowns, and when the lockdowns lifted and people went back to work, older relatives went down the priority list again.

We are in for a difficult time, and all of us will need to think about our older members of society, include them and listen out for them.

> "We are in for a difficult time, and all of us will need to think about our older members of society"

Poverty

Socioeconomic status makes a difference to ageing, and longevity is affected by the postcode lottery like a lot of things.

As you travel south in Auckland from the North Shore, life expectancy decreases (Stats NZ data 2017–2019; stats.govt.nz). For men, life expectancy at birth on the North Shore is 83+, and in south Auckland, it is as low as 75. Women living on the North Shore have a life expectancy of 87+, compared with 79 for some areas of south Auckland. This is shocking in our safe, first-world, developed society!

Age discrimination adds to racial discrimination, and regional differences add to the ethnic disparity of at least seven years lower life expectancy for Māori.

The positive

There is, of course, another view. Interviews with older people who were "ill", by our standard (complex multimorbidity), showed they were not focused on their health, manage daily activities despite health issues, and focus on family, wellbeing and plans for society.

The reality is that older people are happier – the least happy section of the population is those aged 40–64 (the busy years). Older people are more connected, and those who are contributing to their families and society are more content. Older people are considered wise, and many younger people now value older people's contributions, especially as older people stay in the workforce for longer.

Older people also make active relationship choices, with the divorce rate in the 60s climbing over the last decades – perhaps people see the next 30 years as needing to be different from the last 30.

With this comes an increase in sexually transmitted infections for those aged 50–70 and beyond. An 85-year-old acquaintance contracted hepatitis B from a new partner a few years ago, so be alert to this. At least 40 per cent of those between age 65 and 85 are sexually active (higher if they have a partner), and approximately half of those aged over 65 say they are not getting enough sex.

What can you do?

Don't forget there is a person under there, even when they have dementia with delusions, live in a nursing home, have COVID-19, take their time to get up on the examination table, or don't recognise you in your personal protective equipment.

Enjoy the wisdom of older patients, and encourage them to continue contributing to their families, whānau and communities. Intergenerational contact, engagement and activities help dissipate ageism. Any ways you can encourage that in your practice, and in the way you live, will be good for older people.

Those who have positive attitudes about ageing, during mid and late life, live an average of seven years longer. So, my last word, for your own good, is to be positive about ageing and you will live longer. ■

Reference: Hall S, Rennick K, Williams R. *The Perennials: The Future of Ageing*. London, UK: Ipsos MORI, Centre for Ageing Better; 2021. thinks.ipsos-mori.com

Janosch Lino on Unsplash

Ngaire Kerse is president of the New Zealand Association of Gerontology and the Joyce Cook Chair in Ageing Well, University of Auckland

Encourage older people to continue contributing to their families and whānau

Using technology to support the independence of older adults

The social policies of many countries, including New Zealand, advocate for older adults to remain in their own homes and communities, as this can be fundamental to sustaining personal independence and social connection.[1] These social policies are consistent with older adults expressing a strong desire to remain living at home and avoid entering an age related residential care facility.

However, acute medical events due to cardiovascular disease (CVD) can threaten the independence of seniors, who are more likely to be living with CVD than their younger counterparts.[2] A non-fatal heart attack or stroke can result in physical and/or cognitive disability that contributes to loss of independence.[3,4]

Reducing the risk of delayed treatment

Disabilities as a result of stroke and heart failure following an acute heart attack are related to infarct size, and delayed treatment is a determinant of increased infarct size.[5] Also, delay in seeking medical care in patients experiencing worsening heart failure symptoms has been linked with a greater likelihood of rehospitalisation following discharge.[6]

Causes of delayed treatment and not using emergency medical services after an acute CVD event are targets for improvement interventions to shorten the time to medical treatment.[7] This can be addressed by the use of a technological intervention such as a personal medical alarm, the potential value of which is highlighted by the finding that 63% of heart attacks in the home occur when no one else is present.[8]

Maintaining independence with a personal medical alarm

Older adults do not appear averse to using technology to support their wellbeing and independence if they consider it safe, user-friendly and relevant to their personal needs.[9] Personal medical alarms promote safety and security to age at home, and generally consist of simple-to-use push-button devices connected to an emergency response monitoring centre.[10,11]

Additionally, older adults provided with a personal medical alarm on discharge from an emergency department required fewer inpatient days if readmitted and demonstrated improved measures of quality of life compared with those who received telephone-only follow-up.[13]

The use of a personal medical alarm by community-living older adults has been associated with reduced requirements for hospital admission and fewer inpatient days compared with living without an alarm.[12]

Personal medical alarms help to empower seniors so they can remain active and maintain their independence. Older adults report that having a personal medical alarm enhances their feelings of safety and security, which should also help to support independence and ageing at home.[10,14]

Referring a medical alarm for your older patients

A St John Medical Alarm offers 24/7 response and links directly to Hato Hone St John. Referring a St John Medical Alarm for your older patients will give them reassurance to live independently knowing that timely intervention in case of a CVD event or other acute health-related event is just the press of a button away.

Referral is straightforward through your Practice Management System via Healthlink or ERMS. **A FREE trial** is available to all patients.

For additional information visit: stjohnalarms.org.nz/hcp

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The importance of supporting older adults to keep their independence

The majority of older adults want to reside in their own homes for as long as possible, emphasising how highly they value their ability to live independently.[1] Independence should not be undervalued as a significant contributor to seniors' mental health and wellbeing. In fact, older adults rate loss of independence and moving out of home into an aged care facility as their greatest fears.[1]

Remaining in their own home allows older adults to preserve their independence and freedom, and hence sense of identity. Older adults living at home are able to retain their privacy and keep control over their lives. Maintaining a sense of control promotes feelings of purpose, achievement, and self-worth. And of course, living at home facilitates connection to family, friends, and the community, which is critical for social support.

The children of older adults also feel it is important that their ageing parents are able to live at home.[1] They fear for their parents' quality of life if they have to move out of their home, being particularly concerned about how the loss of independence will affect their mental wellbeing.

Falls and other medical events risk loss of independence

Falls, cardiac events, and respiratory disorders are among the most common risk factors for those older adults who live independently, with falls and fall-related injuries being especially common among seniors. Around one in three aged 65 years or older living in the community experience a fall at least once a year.[2] The risk increases to one in two for those aged 80 years or over. In 2018, more than 190,000 seniors aged 65 years or greater sustained injuries from falling, and two-thirds of all ACC claims for those aged 85 years or older were due to falls.[3]

A fall is a major health-related risk event that can lead to partial or complete loss of independence. As many as one-half of seniors admitted to the hospital for a fall-related injury are discharged to an aged care facility.[2] Additionally, a prolonged period lying on the floor after a fall (i.e. long lie-time) has been linked to serious health outcomes in seniors and subsequent admissions to hospital and long-term care.[4]

Falls can also have a psychological consequence – fear of falling, which can lead to avoidance of activities, loss of strength, agility, and balance, further increasing the risk of future falls.

Supporting older patients' independence

Research suggests that two-thirds of seniors are open to using assistive technologies that will enable them to live independently.[1]

As a healthcare professional you can support your senior patients to live independently at home and when in the community by referring them for a St John Medical Alarm.

Medical alarms (personal emergency response systems) offer the potential for maintaining the wellbeing and independence of seniors living at home by enabling timely intervention in case of a health-related event such as a fall, cardiac event, or respiratory issue. Timely intervention is important for averting hospital admission and minimising the need for long-term care in an aged care facility.

Studies have demonstrated that medical alarm use can reduce mortality rates as well as hospital admissions and inpatient days in community-residing seniors,[5,6] potentially reducing the likelihood of loss of independence.

While you cannot be there to protect your patients all of the time, older adults in your care are able to go home, and be and feel safe knowing they can access help 24/7 if they need it, with a St John Medical Alarm, giving them the peace of mind and confidence to live a full, independent life, and to stay at home for longer.

> Older adults rate loss of independence and moving out of home into an aged care facility as their greatest fears.[1]

A St John Medical Alarm offers 24/7 response and is the only medical alarm that connects directly to Hato Hone St John. Your patients have access to a **FREE trial**, and can be referred simply through your Practice Management System via Healthlink or ERMS.

For more information go to: stjohnalarms.org.nz/hcp

References: 1. Ageing in place in America. Research Study. PositiveAgeing Sourcebook. 2018. https://www.retirementlivingsourcebook.com/articles/research-study-%E2%80%9Cageing-in-place-in-america-%E2%80%9D%C2%9D **2.** Soriano TA, et al. Clin Interv Ageing. 2007;2(4):545-554. **3.** ACC 2018. What's tripping us up? How Kiwis are falling over. https://www.acc.co.nz/newsroom/stories/whats-tripping-us-up-how-kiwis-are-falling-over/ **4.** Fleming J. BMJ 2008;337:a2227. **5.** Roush RE, et al. South Med J. 1995;88(9):917-22. **6.** Bernstein M. Manag Care Q. 2000;8(1):38-43.

Offer your patients the freedom of living on their terms

Hato Hone St John

Older adults rate loss of independence and moving out of home into an aged care facility as their greatest fears.[1] Maintaining a sense of control can promote feelings of purpose, achievement and self-worth. By referring your patients for a St John Medical Alarm, they will have the peace of mind knowing their medical alarm connects directly to the 24/7 care of Hato Hone St John.

Refer your patients for a FREE TRIAL through your Practice Management System via Healthlink or ERMS, and we'll take care of the rest.

For more information visit stjohnalarms.org.nz/hcp

References: **1.**Aging in place in America. Research Study. PositiveAging Sourcebook. 2018.