Psychosocial care for elderly in old age homes in Kerala

SOCIAL JUSTICE DEPARTMENT
care, protection & empowerment

NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES

Social Justice Department, Govt. of Kerala

IN COLLABORATION WITH

DEPT. OF PSYCHIATRIC SOCIAL WORK

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES

BANGLORE

PSYCHO-SOCIAL CARE FOR ELDERLY IN OLD AGE HOMES IN KERALA

FACILITATOR MANUAL

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FOREWORD

The National policy statement of 1999 and 2011 for the aged assures dignified life in their last phase; assures physical & financial security, health care, shelter; and acknowledges the need for affirmative action by the government, especially for the elder women, and rural poor. The improved health care facilities and health indicators have increased the life span (75.5 years against the national average 65.5 years) in Kerala. Though growing elderly population is a global phenomenon, the elderly makes up 10.5 percent of Kerala's population of roughly 3.33 crore. Among the states in India, Kerala has more elderly. Though periodical inspections and modernisation of government run homes could help to some extent, greater framework is essential to deal with the growing needs of the elderly by developing a holistic approach to the aged. These old age homes provide different kinds of care such as food, shelter, cloths, medicine and so on. But the fact is that those cares are not enough as per the needs of elderly. That means, majority of the institutions of elderly (Old age homes) do not provide adequate bio-psycho-social care to their residents. Scientific interventions to the needy is not a unidimensional approach, it is multi-dimensional. Considering the cases in an old age home, the residents must have different needs and problems to face. And those problems need different types of interventions. Therefore, it is necessary to give training to every service provider to deal with the elders scientifically and manage them psycho-socially. Training should be conducted in such a way that they are equipped to provide bio- psycho-social intervention, as envisioned in this project.

The first phase of the training is "Knowing Ageing" includes theories on ageing, challenges and needs of elderly. The second phase named as "Working with Elderly" explains the

principles, skills, method and techniques of care providing. " Caring of Carers " is the third and last phase of this training manual. This session mainly handling the problems faced by the caregivers and its management. I greatly appreciate the efforts taken by the authors of this book to bring out this facilitator manual through their master training programme and the work in the field.

Director

NIMHANS

Bengaluru

March 2021

PREFACE

Psychosocial Care for Elderly in Old Age Homes in Kerala is a project of NIMHANS funded by the Department of Social Justice, Kerala. It is structured for providing better care to institutionalized elderly people across Kerala. This project mainly focussed on making the atmosphere elder friendly, preparing individual care plan and training of care providers.

This facilitator manual on psychosocial care for elderly in old age homes is a capacity building tool for the master trainers to train the staff in the old age homes. This manual is developed according to sessions. Each session consists of an introduction, activity, discussion, case scenario and take-home message. This gives information to the master trainers about the process of conducting sessions as well as the probable questions that may arise. This manual needs to be used as a capacity building tool by the master trainers.

We would like to thank all the Master trainers from Thiruvananthapuram, Ernakulam and Kozhikode for their active participation in the training programme. Their experience-sharing, contributions and constructive suggestions took this document to another level to deal with the practical difficulties of elderly in old age homes.

First of all, we would like to thank Dr. G. Gururj, The Director of NIMHANS for his valuable support from the beginning and in every aspect of the programme. We are using this

opportunity to express our deepest gratitude to Mr. Biju Prabhakar IAS, Special Secretary, Ms. Sheeba George IAS (Director, Social Justice Department, Kerala) Ms. Jalaja, Joint Director, Ms. Preethi Wilson, Assistant Director and all the officials at Social Justice Department of Kerala who facilitated and helped to implement all the activities in the state of Kerala.

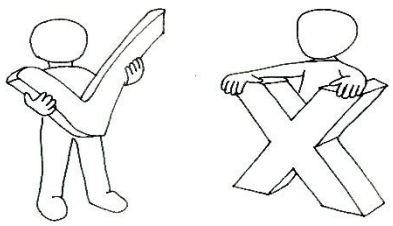
We also express our sincere thanks to the Department of Psychiatric Social Work, NIMHANS, the Head of the Department Dr. Dhanasekara Pandian and all the faculty members in the department who involved and/or supported in implementation of this project. We extend our sincere thanks to Mr. Amaljith Jose, social worker of the project , Officials in project section, Back office staff, Futura and the NIMHANS publication for their help and support.

The Authors

1. AGEING AND IT'S COMPONENTS

In India, among all states, Kerala has more elderly. Kerala's 60 plus population is set to rise to 6.6 million by 2021 and to 11.17 million by 2051

Growth in the number of the elderly population is a global phenomenon. Census data of 2011 showed there were 98 million older persons in India, i.e., 8.1 percent of total population were elderly. The number of older persons in India is expected to increase three-fold to 298 million in 2051, accounting for a little over 17 percent of the total population.



In India, among all states, Kerala has more elderly. Kerala's 60 plus population is set to rise to 6.6 million by 2021 and to 11.17 million by 2051. The elderly makes up 10.5 percent of Kerala's population of roughly 3.33 crore. There are 577-registered old age homes in the State. The State has an effective guideline for old age homes and policy interventions but lacks the effective mechanism to apply it. Elderly people have some specific needs. When a person moves towards old age, he/she suffers brain ageing, this in turn results in noticeable physical, psychological, cognitive and social changes. But the

condition of those people differs who move towards care homes because most people seek shelter in old age home, because the circumstances which forced them to seek admission in a care home have been social insecurity caused by the absence of people whom they can depend, being abandoned by the family, being lonely due to the death of the near and dear ones, being abused and being estranged by society. So, they have high level of exposure to severe psychosocial stressors.

WHO defines Healthy Ageing "as the process of developing and maintaining the functional ability that enables wellbeing in older age". At the biological level, ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. This leads to a gradual decrease in physical and mental capacity, a growing risk of disease, and ultimately, death. But these changes are neither linear nor consistent, and they are only loosely associated with a person's age in years. While some 70-year-olds enjoy extremely good health and functioning, other 70-year-olds are frail and require significant help from others.

In old age the physical decline depends upon hereditary, lifestyle and environmental factors.

Beyond biological changes, ageing is also associated with other life transitions such as retirement, relocation to more appropriate housing, and the death of friends and spouses. In developing a public-health response to ageing, it is important not just to consider approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth ("What is Healthy Ageing?", 2020).

The physiological, psychological, social, emotional and financial needs are unavoidable in old age. These problems of ageing usually appear after the age of 60 years. Physiological problems are a part of old age (Han & Lee, 2015). The person becomes more vulnerable for physical illnesses like cardio-vascular diseases, diabetes, blood pressure and other chronic illnesses. The physical decline depends upon hereditary, lifestyle and environmental factors.

With advancing age, the sexual potency decreases along with a waning of secondary sex characters. Women go through menopause generally at the age of 45-50 years accompanied by nervousness, headaches, giddiness, emotional instability, irritability and insomnia. Mental disorders are very much associated with old age. Older people are susceptible to suffer depression. The two major psychotic disorders of older people are senile dementia (associated with cerebral atrophy and degeneration) and psychosis with cerebral arteriosclerosis (associated with either blocking or ruptures in the cerebral arteries). Decline in mental ability makes them dependent. They no longer have trust in their own ability or

judgements, still they want to tighten their grip over the younger ones. They want to get involved in all family matters and business issues (López & Parra, 2017).

Older people suffer social losses greatly with age. Their social life is narrowed down by loss of work associated, death of relatives, friends and spouse and weak health which restricts their participation in social activities. The home becomes the centre of their social life which gets confined to the interpersonal relationship with the family members. Retirement from service usually results in loss of income and the pensions that the elderly receive are usually inadequate to meet the cost of living which is always on the rise. Even though they spent all their money on marriages of children, acquiring new property, education of children and family maintenance however, at the end they may face the trouble of inadequate resource for fulfilling their personal needs (Chong, 2017).

1.1 Case Scenario: Knowing ageing

Rohan rarely had seen his dad shouting at the family or the employees in the company where he had been a manager. He was a very good leader and problem solver. So, Rohan was always proud of his dad. By the time of his dad's retirement, Rohan and his wife started working in an IT firm. After the retirement his dad seemed to be lost in thinking and preferred to sit alone. Due to the busy working schedule of Rohan and his wife, they couldn't give much attention to those changes in their dad's behaviour. Gradually, he started shouting at Rohan for no reason and resisted to have food on time. Sometimes he used to visit nearby houses and inform them that Rohan and wife did not provide food and other things. Eventually Rohan was in a situation where he was not able to manage his dad and his behaviour.

1.1.1 Brain Storming Questions

1. Does the behavior of a person change due to ageing?
2. Does the ageing affect the relationship of a person?
3. Does ageing alter the thinking pattern of a person?
4. What are the other changes occur due to ageing?

1.2	**Walk back**

A C T I V I T Y	 The aim of the activity is to make the trainees understand about the challenges they experience during the old age. This activity can be done in an activity area or in any room/hall where trainees can gather. As the first step, select two trainees from the group randomly. Then place some harmless obstacles in the activity space. After that instruct one trainee to walk forward amidst through it. And tell the other one to walk backward through it. It will be clearly visible that the one who tries to walk backward will feel it very difficult because of the obstacles placed. The trainee who walks forward can easily do that. Repeat the same activity as instructed above with 2 or 3 pairs of trainees. After that the entire group including the participant pairs should discuss about the activity, list out the pros of walking forward and the cons of walking backward. No materials are needed in this activity other than few harmless objects placed during the activity.

1.2.1: Instructions

- This activity must be done in an activity area/ hall where it is visible to all participants.
- Materials used for creating obstacles for this activity should not harm or cause injury to participants.
- Only few participants are required to perform this activity.

Aging is a normal process in life

There will be decline in fitness as we age.

Ageing is not only a physical process this has psychological and social dimensions.

2. NEEDS OF ELDERLY

The older adult population can be divided into three life-stage subgroups: the young-old (approximately 65–74 years), the middle-old (ages 75–84 years), and the old-old (over age 85 years). The needs of elderly can vary as age increases.

All individuals have various needs or requirements for their health and well-being. In brief these can be classified as the basic or physical needs, psychological and social needs (See figure 2.1 for hierarchy of needs) Some of these needs are common to all individuals, but as they pass through each life stages, the intensity of these needs may differ and also may develop more specific needs. Most adults are able to meet most of their basic needs, but in the old age the dependency may increase to achieve the same. When a person moves towards old age, brain undergoes some changes, and result in changes in the behaviour. This in turn results in significant physical, psychological, cognitive and social changes and these changes may give rise to loneliness and diminished quality of life in elderly people (Aldwin & Gilmer, 2013) thus as mentioned earlier, older adults have more specific needs and may require support from health and social care services.

When a person moves towards old age, brain undergoes some changes these result in changes in the behaviour.

Bio-psycho-social needs of elderly can be further categorised to health, family, social, economic, legal and institutional needs for better understanding. In brief, the health needs include nutrition, mobility, medical care, hygiene, exercise, mental health, stimulation, knowledge and opportunity to learn. Family needs include communication with family members, sense of belonging, being loved and being cared. Social needs indicate about social contact, interaction with other people and relationship with colleagues or friends and

community. Economic needs include sense of autonomy in expenditure, meeting medical/ health expenses, financial stability. Legal needs can be better interpreted as the concerns regarding safety and security of elderly in terms of protecting their rights and preventing exploitations. The institutional needs include accessibility, elder friendly environment and access to all basic services.

Fig 2.1: Maslow's hierarchy of needs:

Maslow's hierarchy of needs is a human motivation based psychological theory on the pursuit of different levels of needs. The theory describes that humans are motivated to fulfil their needs in a hierarchical order. This order begins with the most basic needs before moving on to more advanced needs. The ultimate goal, according to this theory, is to reach the fifth level of the hierarchy: self-actualization which means achieving one's full potentiality.

2.1 Case Scenario: Needs of elderly

A 65-year-old widow spent her entire life for bringing up and educating her 4 sons. At present all her sons are married and well settled, but none of them are ready to take care of their mother for a longer period. So, they decided to take care of their mother in turn. Due to this monthly shifting to different homes neither she received enough care from any of her children nor her needs were fulfilled. At last, she decided join an old age home to avoid frequent change of residence and there would be some people, who can help her to fulfil basic needs.

2.1.1 Brainstorming Questions

1. What are the needs of elderly?
2. How can we address the needs of an elderly?
3. What are the reasons for children to show less interest in caring elderly?
4. How do you address the needs of elderly in your home?

2.2	**Case discussion**
ACTIVITY	Aim of this activity is to make the trainee to understand the different needs of elderly. All the trainees will read the case details given above. Then list out the needs of elderly from the case illustration under the classifications given in the work book which is health, family, social, economic, legal and institutional needs. Through this activity trainees can understand that elderly people have different types of needs like people in other life stages and also, they lack support to fulfill those.

Health	Family	Social	Economic	Legal	Institutional

2.2.1 Instructions

- The language and description of case details should be simple.
- Give opportunities equally to participants for sharing their observations from the case details.

- A holistic bio-psycho-social care is needed in the institution.
- Needs of elderly varies in each age group.
- Through satisfying their needs, quality of life can be ensured.

3. BIO-PSYCHO-SOCIAL ISSUES AMONG ELDERLY

Older people have many issues which can be briefly classified as physical/biological health or neurological issues, mental health issues and social issues. As age increases these issues also may increase. These issues are inter-related and can also have an impact on healthy ageing or one issue can lead to another issue or group of issues. Psychosocial factors such as stress, anxiety, depression, social isolation, and poor relationships have been associated with the risk of hypertension, stroke, and cardiovascular disease. Likewise, chronic or debilitating somatic or physical conditions such as cancer, diabetes, arthritis, cardiovascular and/or respiratory diseases, and hearing loss are associated with increased rates of loneliness and depression (Linda & Paul, 2017). The complex and multifactorial nature of biopsychosocial issues demands a comprehensive care system in the institutions.

The complex and multifactorial nature of biopsychosocial issues demands a comprehensive care system in the institutions.

3.1 Physical health/ Neurological issues among elderly:

Stroke

This is a life-threatening condition in which the blood supply in the brain is suddenly interrupted or when a blood vessel in the brain bursts. The symptoms include: sudden numbness or weakness in the face, arm weakness, loss of balance and trouble in speech.

Neuropathy:

This is a disorder that occurs in the nerve which causes numbness and weakness in the hands and feet. It can occur due to diabetics or the side effects of medication and other causes**.**

Alzheimer's:

Alzheimer's is a progressive disease that destroys the brain cells, memory and other important mental and physical function. It is a form of dementia and still the exact cause is unknown.

Parkinson's:

Parkinson's disease is a chronic and progressive movement disorder which involves the malfunction and death of vital nerve cells in the brain. Symptoms include tremor, slow movement, stiffness and loss of balance ("Neurological Disorders – a Common Problem of Aging", 2020).

Other physical health declines are sensory impairments, lungs issues, heart issues, loss of body balance and loss of strength and flexibility of Muscles, tendons, and joints.

3.2 Mental health issues

	Description	Symptoms
Depression	Depression is a common and serious mental illness that negatively affects the mood of a person. Experiencing persistent feelings of sadness and hopelessness and lose of interest in activities for at least 2 weeks are the major signs. Risk factors include family history of mood disorders, brain structure, trauma, medical conditions and drug use.	Feeling sad or depressed mood, loss of interest in activities, changes in appetite, change in sleep pattern, increased fatigue, feeling worthless or guilty, difficulty in cognition and thoughts of death or suicide.
Anxiety	Feeling of excessive or persistent worry and fear for the stressors or things which may be perceived as normal or less fearful by other individuals. It may be caused by certain health conditions, trauma and personality traits.	Restlessness, feeling unease or fatigue, difficulty in concentrating, cold, sweaty, numbness, dry mouth, heart palpitations muscle tension or problems sleeping.
Mild cognitive impairment	MCI is the phase between the expected cognitive decline of normal aging and the more serious decline of dementia. There is no single cause of MCI. Symptoms of MCI may remain stable for years, progress to Alzheimer's disease or another type of dementia, or improve over time.	Forgetfulness, forgetting of familiar things, places and events, difficulty in completing task, impulsivity, poor judgement, depression, anxiety and apathy
Dementia	Dementia is a progressive and severe loss of cognitive function, marked by memory problems which is caused by damage of brain cells.	Difficulty in communication and identifying the words, severe memory loss, disorientation, wandering, confusing, difficulty in tasks, coordination and motor activity, depression, anxiety, paranoia, agitation, and inappropriate behaviour
Delirium	Delirium is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment. The start of delirium is usually rapid (within hours or a few days) the risk factors include: illness, low sodium, medication, infection, surgery and alcohol or drug intoxication or withdrawal.	Reduced awareness of the environment, extreme confusion, poor thinking skills, behavioural changes and emotional disturbances

("Highlights of Changes from DSM-IV to DSM-5", 2013)

3.3 Social issues

As age increases in old age, the ability to do daily activities (functional ability) declines to some degree in every person. Also, older people, on average, tend to have more diseases and disabilities than younger people. But the changes that accompany aging are more than just changes in health. Social issues also influence an older person's risk and experience of illness

(Daniel B & Barbara J, 2020). Few social issues are Trouble in interpersonal relationships, Loss of independence, Limitation in social contact or involvement and Social isolation.

3.4 Case Scenarios:

1. A resident always asks for medicines more than 20 times in a day after having her regular medication. She is not able to recognize the staff and she tries to run away from old age home whenever the gate is open.
2. A resident always complains that he wants to die and has no interest in continuing life. He also complaints that he is not able to sleep, has body pain, indigestion, and constipation, and food is not good.
3. A resident started talking irrelevant things and not able to identify people around him, the place and time etc. all of a sudden in a fine morning.
4. A resident is always adamant to follow the rules of the old age home, filing RTI against the authorities, frequent hunger strikes for meeting his needs and demanding special food and facilities for him, disrespecting the staffs etc.
5. A resident always wants to gain leadership or power among other residents. For that he takes the help of a political party and attempts to poke into the privacy of other residents. Also, he considers himself as a right person and not ready to listen to staff, due to the fact that he came to the old age home through political influence.

3.4.1 Brainstorming Questions

1. Have you noticed such behaviour in residents?
2. What are the reasons for such behaviours?
3. How do you handle such behaviour?
4. Is it possible to forget the things, place and people around him all of a sudden?
5. Can we change the personality of a person through counselling?

3.5	**Group Discussion**
ACTIVITY	Aim of the activity is to make trainees understand the bio-psycho-social issues and its risk factors among elderly. The participants are divided into three groups under the classifications - physical health issues, mental health issues and social issues among elderly. Based on the case scenario the group members discuss each issue, risk factors associated with it and write it down in a chart paper, later one representative from each group need to present their case and their findings on the topic. This activity thus discusses the social, physical and mental health issues among the elderly. The materials needed for the activity are chart paper, marker and white board.

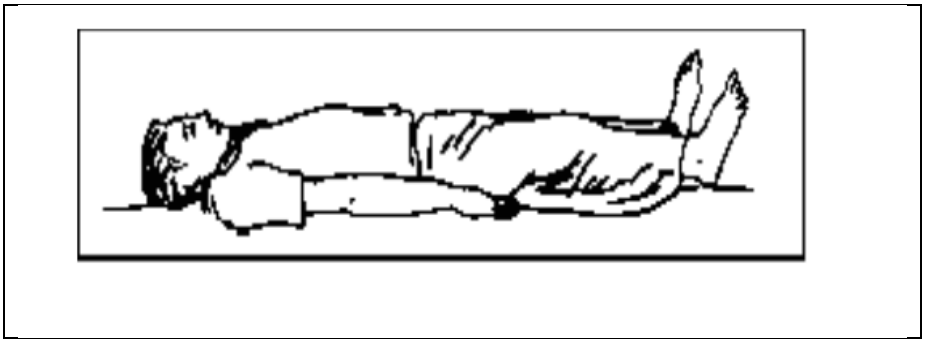
3.5.1 Instructions

- The duration of the group discussion is for 10 minutes.
- Every member in the group should be given opportunity to contribute in the discussion.

- All of the issues among elderly are interconnected.
- Neurological disorders are diseases of the central nervous system, but can affect the mental health and behavior of a patient.

4. END OF LIFE ISSUES & PALLIATIVE CARE

There is often a tendency to treat older persons as if they were dying regardless of how serious or irreversible their condition actually is. The challenges faced by the dying person are substantial and potentially overwhelming. These challenges include physical pain, depression, a variety of intense emotions, the loss of dignity, hopelessness, and the seemingly uninteresting tasks that need to be addressed at the end of life. An understanding of the dying person's experience will help care takers to improve their care of the terminally ill residents (Jennifer, Guy & Theodore, 2020).



The end-of-life issues can be classified in to three which are physical, psychological and social issues.

Under **Physical issues**, Pain, and the fear of pain, is the most common and often drives the behaviour of patients at the end of life. Most of the people with advanced or chronic disease may experience pain in the end of their life. There is no evidence that the perception of potential pain is altered by advancing age, the older people are often unwilling to report their pain because they believe it is a normal symptom of aging and that their pain is directly associated with the worsening of their illness. But in most cases, the pain can be successfully treated. Pain is a notable risk factor for depression and suicide, particularly in those at the end of life, and it must be carefully assessed and monitored. Other physical issues include: shortness in breath, sleep trouble and loss of appetite (Woo, Stern & Maytal, 2006).

The organic mental disorders (Delirium, dementia, Alzheimer's disease) can also mimic the features of disorders like depression and anxiety

Under **Psychological issues** at the end of the life, Depression can be considered as the common one. Studies have shown that the presence and severity of depression are intensifying with the severity of physical illness and pain. Anxiety commonly co-exists with depression, and it may be driven by fears of helplessness, loss of control, abandonment, or pain. The organic mental disorders (Delirium, dementia, Alzheimer's disease) can also mimic the features of disorders like depression and anxiety. Behavioural changes, aggression can also be noticed in the person at his/her end-of-life stage. Another factor is, a dying person's, a primary illness-related concern is the preservation of dignity, broadly defined in terms of being worthy of honour, respect, and esteem. For many patients, dignity is directly related to the level of independence and autonomy retained through the course of illness (Jennifer, Guy & Theodore, 2020).

Loss of independence, limitation in social contact or involvement and social isolations are the few **social issues** which may be present during one's end of life stage.

4.1 Management

Dying is a normal part of life, but more often death is treated as an illness. As a consequence, many people die in hospitals, alone and in pain. Palliative care focuses primarily on anticipating, preventing, diagnosing, and treating (including Medicine, Nutritional guidance, Physical therapy, Occupational therapy, Integrative therapies) symptoms experienced by patients with a serious or life-threatening illness and helping patients and their families make medically important decisions. The ultimate goal of palliative care is to improve quality of life for both the patient and the family, regardless of diagnosis. The role of palliative care intensifies and focuses on aggressive symptom management and psychosocial support. The psychosocial support mainly includes; emotional support, social support, coping problems and spiritual intervention.

4.2 Case Scenario:

A 75-year-old resident in the old age home has been bedridden for years, and she is not able to attend any programmes happening in the old age home. Other than the weekly visit of a few residents, nobody visits her from outside. Due to her ill health, she is immobile, sad, and she has lost all the hope in life. She always wants people around her due to the fear of death.

4.2.1 Brainstorming Questions

1. How do you care such individual?

2. What would you do for her to live with dignity?

4.3	**Case presentation and discussion**
ACTIVITY	Aim of the activity is to make trainees understand the end-of-life issues and palliative care needs among elderly. The participants are divided into three groups under the classifications – physical, mental and social. Then three groups are given similar cases and they have to present the case study. Along with which they have to discuss the risk factors for those issues occurring among the elderly. Materials needed of the activity are printed case studies.

4.3.1 Instructions

- All the participants should take participate in the case discussion
- Each group will have a case study

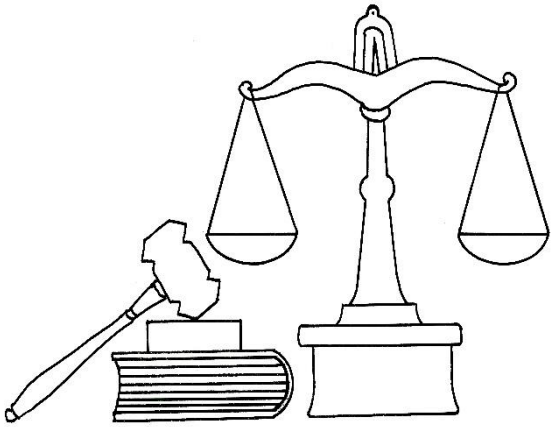
The elderly in their last phase of life needs to be treated with dignity.

The aim of the palliative care is to improve the quality of life of a person regardless of his/ her diagnosis.

5. RIGHTS AND LEGAL PROVISIONS OF ELDERLY

Regardless of age, human rights and basic constitutional provisions are for all. In India the constitutional rights and legal provisions are there to protect the rights of elderly. This can be classified in to three; Basic rights, relevant constitutional provisions and acts.

The **Basic rights** include the fundamental rights of India (Article 14 to 32) which are:



1. Right to Equality.
2. Right to Freedom.
3. Right against Exploitation.
4. Right to Freedom or Religion.
5. Right to Cultural and Educational Rights.
6. Right to Constitutional Remedies.

As per rights guaranteed in the National Policy for Older Persons 1999, all Indian citizens aged above 60 years are entitled to 30 per cent concession in ticket prices, while travelling in the Indian Railways. The concession is 50 per cent for women aged above 60 years along with the provision for separate counters and other services including berth requests. Air India is also bound to provide a concession of 45 per cent to senior citizens at the time of taking a booking for economy class, as per the National Policy for Older Persons, 1999.

According to The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 every district must have at least one old age home for senior citizens who are indigent.

5.1 Relevant constitutional provisions

Provisions are mentioned in the Constitution of India for the senior citizens. Directive principles of state policy contain these provisions. Article 41 and article 46 are the constitutional provisions for them. Although directive principles are not enforceable but the state should consider it while making the law.

Article 41 of the Constitution secures the right of senior citizens to employment, education and public assistance. It also ensures that the state must uphold these rights in cases of disability, old age or sickness. Meanwhile, Article 46 asserts that the educational and economic rights of the elderly must be protected by the state.

Article 47 (Directive principles of state policy) also indicates the duty of the State to raise the level of nutrition and the standard of living and to improve public health. The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.

Section 125(1) (d) of the Code of Criminal Procedure 1973 Section 20 (1 & 3) in regarding order for maintenance of wives, children and parents, states that if someone's father or mother, unable to maintain himself or herself then Magistrate of the first class upon the proof of such neglect or refusal, can order to such person to make a monthly allowance for the maintenance of his wife or such child, father or mother.

5.2 Acts for the protection of elderly:

In India, different religions have varying laws in place to protect the interests of senior citizens. Some are very particular such as the statutory provision for maintenance of parents under Hindu personal law contained in Section 20 of the Hindu Adoption and Maintenance Act, 1956. Similar laws are found in Muslim laws, Christian laws, and even in Parsi laws.

Section 88-B, 88-D, and 88-DDB of the Income Tax Act of India allow senior citizens to claim a discount in tax. The elderly people are also entitled to get higher interest on tax saving plans apart from having a wide variety of LIC policies and post office saving schemes to choose from.

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007, makes it a legal obligation for an heir/offspring of the elderly to provide a monthly allowance for them as maintenance upon the complaint of parents and it also gives provisions for old age homes. According to this act every district must have at least one old age home for senior citizens who are poor and needy. ("Laws protecting rights and interests of senior citizens in India; All you need to know", 2020).

5.3 Case Scenario:

A 75-year-old female who has been admitted to an old age home for last 5 years, was more

depressed during her initial days of admission. She never spoke to anybody. Later on, with the influence of her fellow residents, she started to talk with others, but not as expected. The counsellor in the old age home could build trust with her and she finally opened up about her past that one of her relatives borrowed her gold and a good amount of money 8 years ago for his house construction. But he never returned her money and gold. Later when she repeatedly asked him, he said that he would never return the money and gold. She became so depressed and started to feel helpless and hopeless.

5.3.1 Brainstorming Questions

1. What are the rights of the elderly?
2. As a primary care giver, what can be done when you have a resident with such issues?

5.4	**Group discussion and presentation**
ACTIVITY	Aim of the activity is to make the trainees understand the rights and legal provisions of elderly in our nation. The participants are divided into small groups and given a printed copy of different legal cases (the possible cases seen in the old age home scenario) to them. They need to identify the legal issues in the case and later present in front of other groups. Other group members could give the comment on the cases presented. The materials needed for the activity are plain paper, pen, and printed copies of the cases.

5.4.1 Instructions

- The time given for discussion is 5 minutes.
- Encourage group members to give the reason for their respective comments.

- Rights and legal provisions are to ensure the minimum standard of life of elderly as other age groups.
- It is not just the duty but the legal liability of the children/ grandchildren to care their elderly

6. SUPPORT SYSTEM FOR ELDERLY

The humans are social animals and also have the tendency or craving for social interactions, the support system is very essential for the elderly. At various times, individuals either seek or provide support. Social support contains interpersonal communication and interaction, love and understanding, caring and concern, affection and companionship, financial assistance, and respect and acceptance. Social support has an impact on mental and physical health throughout the life span and especially important later in life (Bettina, 2008).

As a study finding indicates, influence of social support on the cognitive functioning of elderly is highly present and it was associated with marital status and functional value of networks (Schwarzer & Gutiérrez Doña, 2005). Hence it is highly relevant to study one's social network and its components. **Network analysing** is a best way to analyse a person's social environment or social support and the size of social network and perceived quality of relationships with others.

Social support has an impact on mental and physical health throughout the life span and especially important in later life.

6.1 Social support

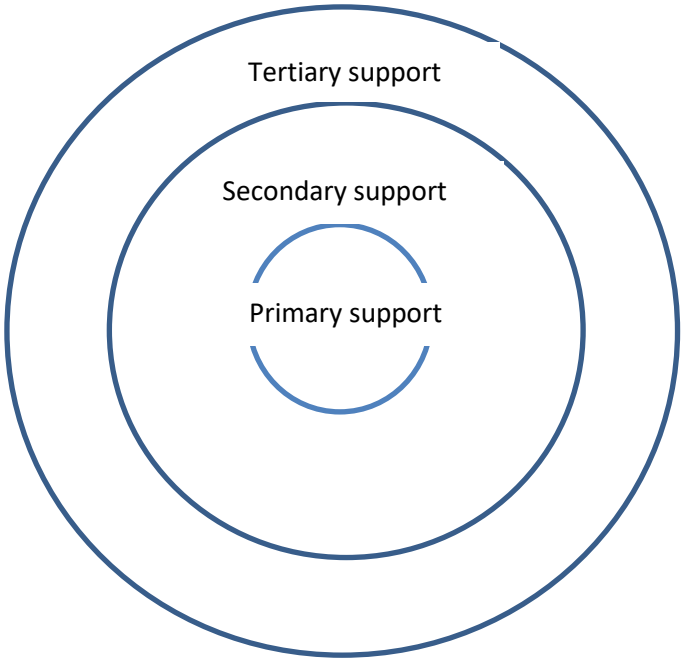
Social support means the various ways in which individuals assist each other. Social support has been considered as an important and positive part in the health and well-being of individuals. To receive support from another, a person must participate in at least one important relationship. In short, social support can be better understood as a network of individuals on whom one can rely for psychological or material support and to cope effectively with stressors in daily life ("Social Support - IResearchNet", n.d.).

It is often differentiated in terms of three types of resources: instrumental, informational and emotional. *Instrumental support* involves the provision of material aid, for example, financial assistance or help with daily tasks. *Informational support* refers to the provision of relevant information intended to help the individual cope with current difficulties and typically takes the form of advice or guidance in dealing with one's problems. *Emotional support* involves the expression of empathy, caring, reassurance,

and trust and provides opportunities for emotional expression and venting (Sheldon, 2020). For the better understanding of social support, it is divided into three levels: Primary, Secondary and Tertiary. In which primary level is the support from family and close relatives, secondary level is the support from friends and neighbours and tertiary level is the support from the institutions and organization.

6.2 Perceived support

Perceived social support is the support that individual believes to be available for them regardless of whether such support is actually available. Perception of support may be a function of the degree of intimacy and affection within one's relationships. Compared with actual support, perceived support may be just as important (and perhaps more so) in improved health and well-being. Actually, perceived support seems to appear closely with improving health status than one's actual social support. Similar to actual support, perceived support may heighten the belief that one is able to cope with current situations, may decrease emotional and physiological responses to events and may positively alter one's behaviour ("Social Support - IResearchNet", n.d.).



Elderly in the institutional settings may have less primary and secondary support as compared to the elderly living with the family or in the community. They have high level of exposure to

psychosocial stressors in the institutions but lack of support system in the institutions. Most active support system for the elderly in the institution is tertiary level support system.

6.3 Case Scenario:

A 71-year-old man had a broken relationship with his family members and was living alone in a home for years. He was able to manage everything well, but gradually he became sick. None of the family members came to help him. So, neighbours and distant relatives were taking care him for an extent. Later they too showed less interest, realizing the fact that he would be a burden for them. With the help of a Panchayath member he was admitted to an old age home.

6.3.1 Brainstorming Questions

1. How do you support him, if you were his neighbours?
2. What are the support systems available for him in our society?

6.4	**Network analysis**
ACTIVITY	Aim of the activity is to make the trainees understand the support systems that needed for elderly people in an institution. The facilitator divides the participants into 3 groups and asks each group to do a network analysis of any one of the individual residents in their institution. After the presentation of each group's network analysis the facilitator explains categorization of support systems such as primary support which includes family, close circle then secondary support includes friends and neighbours and territory supports like institutions. The materials needed of the activity are marker, chart paper and white board.

6.4.1 Instructions

- Participants from same old age homes need to be in one group.
- The cases chosen by each group should be from their own old age homes.
- Time given for the discussion and presentation is 10 minutes.

- All the levels of support systems are equally important.
- A person in the old age home will have less primary and secondary level support and strong tertiary support system..

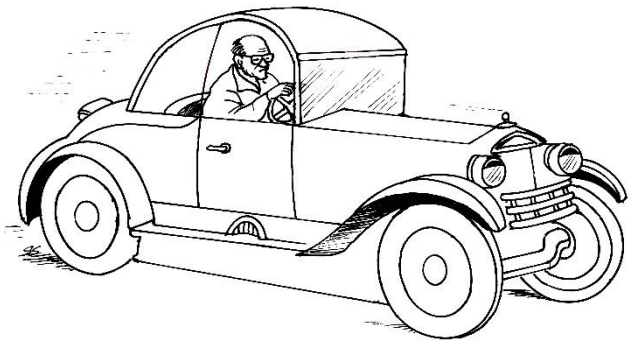
7. PATHWAYS TO OLD AGE HOME

Pathways to old age home refers to the factors that lead an individual to rely on any care home institutions in his/her final stage of life. Those factors cannot be considered as an immediate one, the process of institutionalization does not happen in a day. It's a long-term process. Advancing age, marital status, domicile, lack of home ownership, presence of organic mental disorders like Alzheimer's disease or dementia, increases the chances of entry to care home institutions (Tomiak, Berthelot, Guimond & Mustard, 2000). Medical conditions such as musculoskeletal disorders, other mental disorders, functional disability are also important factors leading to institutionalization.

The process of institutionalization does not happen in a day it's a long-term process.

The main individual factors leading to institutionalization is looked on the basis of variables like dementia, cognitive functioning, age, history of past illness and physical functioning. A study conducted in 1810 persons above the age of 75 to find the determinants of institutionalization found that dementia and cognitive impairment are the main predictors of institutionalization among elderly (Agüero-Torres, 2001). The increased demographic shift in elderly population, the changes in the family system, the lifestyle of the younger generation have led to the changes in the living arrangements of elderly living in both in developed countries and developing countries like India (Maralusiddaiah, 1966). Being aged, being single, not having a formal education, and being dependent for daily activities were identified as predisposing factors for institutionalization (Woo, Ho & Yu, 2000).

The main environmental factors leading to institutionalization is looked on the basis of variables like marital status, type of family, having children, gender of the children, and gender of the individual. The structural change in a family will lead to the admission in care home. Similarly, 55 percentage of persons with no living spouse enter into a nursing home at the age of 85. It also



says having a daughter or sibling reduces the chance of institutionalization (Freedman, 1996). As per another study conducted in India, the lack of family support, death of spouse, and migration of the children were the reasons for being institutionalized (Pinto, 1996).

A study conducted in Kerala reported that most of the residents in old age home ended up in the home because of there were no one to take care at home. Migration of children also plays an important role in pushing their old parents to old age homes (Rajan, 2000).

7.1 Case Scenario:

A 74-year-old female belonged to a middle-class family, after her 10th standard, she was sent for a job to Chennai. Where she was cheated and sent to brothel. She escaped from there and started working in the quarry and other odd jobs for her existence. She got married and had a happy life. At the age of 60 years as she lost her husband she shifted to Kerala and was staying in a rented house. She is not in good terms with her family. She felt loneliness and decided to go back to Tamilnadu, where she lived with her husband. She tried to shift to Tamilnadu but couldn't find any known person and came back to Kerala. She didn't know where to go and was subconscious state when she was brought to the old age home.

7.1.1 Brainstorming Questions

1. What was the incident in her life which was a turning point for institutionalization?
2. What are the reasons of her institutionalization in this case?

7.2	**Reframing of pathway**
ACTIVITY	Aim of the activity is to make the participants aware about how a person reaches into an old age home and its leading factors. The facilitator asks the participants to fill up with the leading reasons of institutionalisation in the picture of a ladder printed and given to each participant. Time period/ year of the incident should be written in the bottom left side of the ladder, person involved should be written in the bottom middle and incidents at the bottom right of the ladder. The leading factors should be written in an ascending order. It also should be from the very initial factors of institutionalization and till the admission of the individual in the institution. The materials needed for the activity is printed picture of ladder and pen.

7.2.1 Instructions

- Each participant should write different stories from their known people in the old age homes.
- On each step of the ladder, participants may write different reasons and how a person reached in the old age home over a time frame.
- The time given for the activity is 15 minutes.

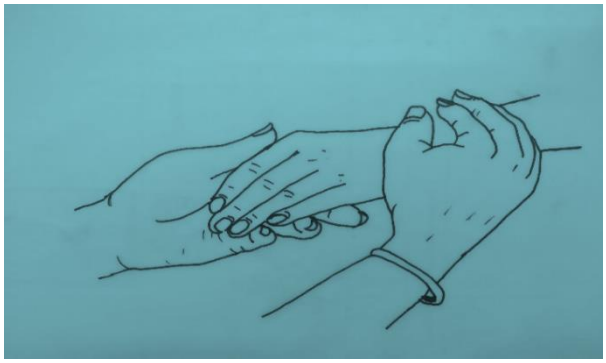
- Institutionalization is a long-term process.
- For every individual, reason for the institutionalization may be different.

8. PRINCIPLES OF CARE

There are 18 principles given by the United Nations for older persons. It can be grouped under five themes which are: independence, self-fulfillment, participation, care and dignity. However, considering the cultural differences and care giving practices that are prevalent in Indian scenario, we discuss few important principles related to care giving.

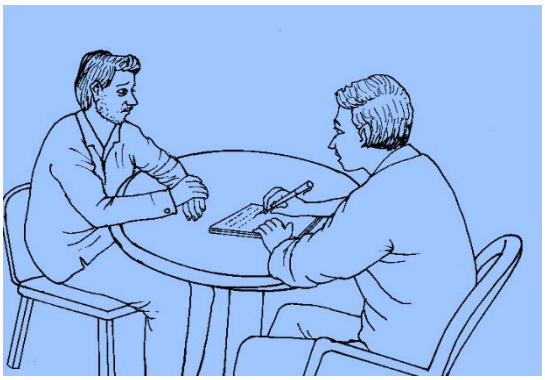
8.1 Acceptance

The principle of acceptance implies that a care giver must perceive, acknowledge, receive and establish a relationship with the resident in the institution as he/she actually is, not as we wish them to be.



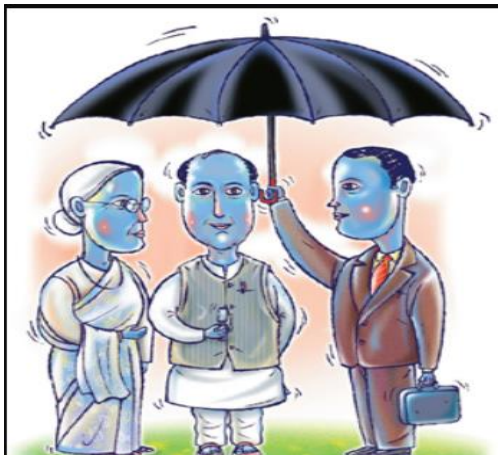
8.2 Patience

It is important to have patience to help the residents with complex behaviour and those who need longer periods of time to cope with their situations. This empowers care givers to understand the resident's situation and avoid hasty decision-making and frustration that can lead to costly errors and poor outcomes. for the client.



8.3 Respect

Respect is the recognition of a person as an autonomous, unique, and free individual. It also means that we recognize that each person has the right and capacity to make their own decisions. Respecting a person ensures that dignity is valued.



8.4 Unconditional support

Unconditional support means, caring the resident as a separate person, with permission to have his own feelings and his own experiences but not in a way to satisfy the care giver's own need.

8.5 Dignity and worth of an individual

Care givers should treat people in a caring and respectful manner, mindful of individual differences, cultural and ethnic diversity. It promotes social responsibility and self-determination and also to enhance resident's capacity and opportunity to change and address their own needs.

8.6 Case Scenario:

A man with an unpleasant past was admitted to the old age home. Due to his past mistakes, he was abandoned by his family members. He was bedridden when he was admitted in the old age home. His guilt turned out to be anger, and he was not ready to cooperate with the staff. He always scolded them if he doesn't find them around. He began to make big issues out of small matters.

8.6.1 Brainstorming Questions

1. How do you understand his behaviour, such as scolding you for small matters?

2. How would you help him to adjust with system?

8.7	**Games and Role-play**
ACTIVITY	**Aim of the activity is t**o make the participants understand about the basic principles of care in an institution**.** The trainer explains principle of acceptance, patience, respect dignity and worth of an individual and unconditional support before starting the activities. Then the trainer starts the session with an activity of "unwrapping gift" to explain what patience is and how it performs in elderly settings. Write down the word "PATIENCE" in a small piece of paper. Then, cover it with several layers of papers and sheets like a gift voucher. Then give it to trainees. Ask them to remove each layer one by one, one trainee should uncover one layer and then pass the box to next trainee to do the same. After removing the last layer, trainees reach to the paper piece named "PATIENCE". This activity show what is patience and the importance of it when handling with people especially elderly. Then choose four members from trainees for two role plays to introduce the other principles such as; acceptance, respect, dignity and worth of individual and unconditional support in elderly institutions. In the first pair one person should act as a careless care provider and other one act as an elderly resident in the institution. Then facilitator ask other trainees' observation on the act and ask them to give opinion on how could it be improved. Then facilitator asks other pair to act avoiding all the mistakes happened in the last role play and act using the above-mentioned principles. Then asked the participants to observe the act and give a comparison on previous act and current act. Materials used for the activity are papers for making the gift, papers and pen for writing their ideas regarding the role plays if needed.

8.7.1 Instructions

- Each participant should participate in the gift unwrapping activity
- The gift should be manageable for all trainees by its weight and size
- The sitting arrangement should be in a "U" shape manner for better participation
- Each participant should observe the role paly and give their opinion
- Time given for role pay is 20 minutes

- Following the principles will help the care takers to provide better care.
- These principles will guide the care takers to deal with the elderly in an efficient manner.

9. SKILLS AND TECHNIQUES

9.1 Empathy:

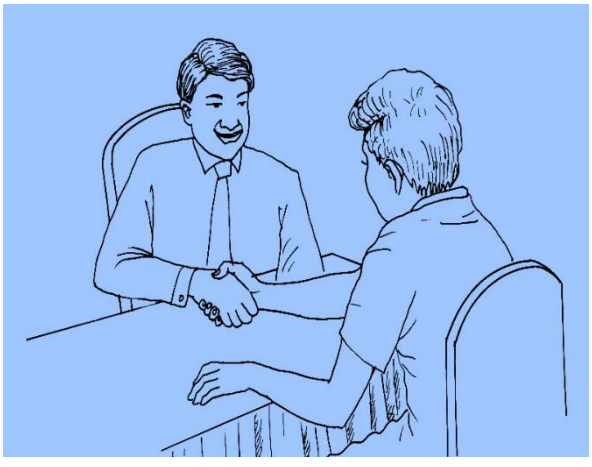
Empathy is the ability to accurately put yourself "in someone else's shoes" to understand the other's situation, perceptions and feelings from their point of view. While using this technique care giver should try to view the perspective of the elderly and tries to look at the problem from their world. Of course, in order to do this care giver must know the world and views of the elderly. In other words, care giver must know and recognize the environmental factors in which the elderly lives. Care giver must also be able to return to his/her role after being in the role of elderly. Care giver must not resemble the care recipient, must not be identified with them, must not sympathize and justify them.

9.2 Observation skill

By meaning, observation skills refer to the ability to use all five of our senses to recognize, analyse and recall the surroundings. When dealing with elderly, it's not just enough to talk with or even listen them. Sometimes, they may not be able to articulate what's going on with their health due to the lack of knowledge and awareness, or they may even try to actively hide something like any deterioration in their conditions such as health out of fear.

9.3 Communication skill

The ability to communicate information accurately, clearly and as intended, is a vital life skill. Communication skill can be considered as the corner stone in elderly care giving because elderly are the people with many physiological and psychological deteriorations and issues which is often



results in limited communication or feedback ability and behavioural issues. Hence, dealing with them is not an easy task. Building trust, maintaining a professional relationship depends on the pattern or mode of communication between care giver and elderly.

9.4 Listening skill

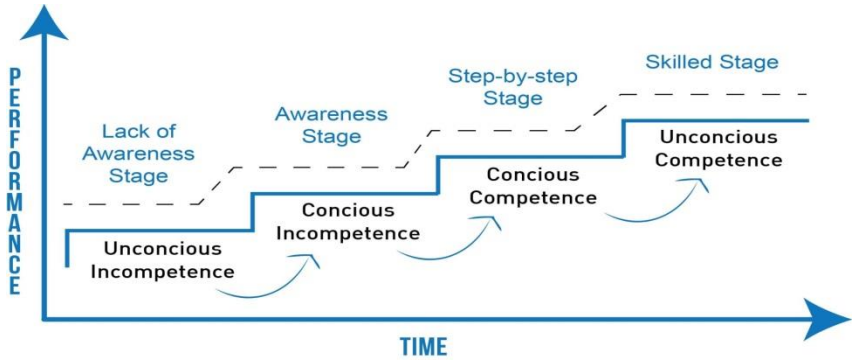
Listening is a key to all effective communication. Without the ability to listen effectively, messages are easily misunderstood. In elderly care giving, listening skill is not meant by just hearing them, it involves active listening. As mentioned previously, elderly needs more attention and care due to their deteriorating conditions. In such situations, they need or they will expect someone to respect them, understand their emotions and someone who they can trust. The skill of active listening will help the care giver in there. Active listening mainly includes many techniques such as rephrasing, reflecting, summarizing and redirecting which will help the care giver to make elderly feel like, the care giver is listening, understanding and processing the information they have passed.

9.5 Non-judgmental attitude

The non-judgemental attitude is the ability to interpret the things on the basis of the situation and not on the basis of the individuals involved. The role of a care giver is to inquire and understand ‘what or why’ the elderly as they are, but it is very important to not be the critic of their actions. There is simply no room for judgment where the elderly is concerned. The positive attitude from the elderly requires the maintenance of non-judgemental attitude.

Sometimes in work life, caregivers often face many difficulties. The nature of their work requires developed skills as mentioned earlier. Many of these skills might found very difficult, impossible and inappropriate for the care givers but what we need to understand is as per a model called, conscious competence model, the care giver can only achieve skill through skill development stages as given below (see fig 9.1).

Fig 9.1 Conscious competence model- developed by Noel Burch (Linda, n.d.)



Any professionals or let's take care givers itself, build their skills care giving by passing or progressing through these stages. Care givers who have no idea about the skill requirement are unconsciously incompetence. The people, who find the use of these skills difficult or inappropriate are likely to be in the consciously incompetent stage. Care givers who are using the skills effectively but still feel or putting their maximum effort are likely to be consciously competent. And the care givers who learned the skills who are no longer aware that they are using the skills and don't feel difficult are unconsciously competent. It can be reassuring to know that you will progress through the skill-development matrix.

9.6 Case Scenario:

A 72-year-old, unmarried, female was born and brought up in a well to do family. When she was 12 years old, her both father and mother committed suicide in a 6 months gap. Both of them had some kind of mental illness but were not on medication. After this incident she was left alone and thrown out by the other family members. So, she started working in nearby houses as a house maid for years. There she had to face so many physical and mental abuses. The history of parent's mental illness and her personal bad experiences later lead her to mental illness. She was very much attached to her father. So, she still thinks about him and cry. At present she doesn't have any support from the family, and she does not have any property on her name. She is also physically disabled. So currently she is not able to go out even if she wishes so. She is also in medication for psychiatric illness.

9.6.1 Brainstorming Questions

1. How does a caretaker should treat this person?
2. What is the expected behavior of this kind of a resident with care takers?

9.7	**Activity and Role play**
ACTIVITY	Aim of the activity is to make participants understand the skills and techniques and its importance in care giving**.** All trainees are divided into 2 pairs. Then they are given 10-15 minutes to understand each other. The task given to them is to collect maximum information about the other person. After the interactive time, the trainer asks each of them to speak about their fellow members. This activity is to understand the communication skills. **A**ll trainees are divided into 2 pairs. Then the trainer gives instructions to one of the pair that they have to make their fellow member to do an activity. Trainer also given instruction to the other one of the pair that not to do the activity said by their pair. Therefore, one among the pair continuously tries to make the other person do the activity while the other person tries not to do it. This activity is done to understand observational skill and non-judgmental attitude of the participants. The trainer selects 4 people randomly from the group of participants. One participant is asked to act as a help seeking person and the others as care providers. Three scenarios are done one after the other and in which help seeking person is same and care provider changes after each scenario. When help seeking person approaches first care provider, he welcomes the help seeker with a smile, patiently listens to the problem and assures to help him. In the second scenario care provider shows arrogant behaviour and speaks with an angry tone with the help seeker. And in the third scenario the care provider acts as a disinterested careless man towards the help seeker. After the acts, the facilitator asks participants to identify the best care provider and reasons of it. This role-play helps the participants to understand the approach, behaviour and attitude of a good care provider in an institution. Materials needed for the activity are only chairs.

9.7.1 Instructions

- All participants should actively participate in the activity.

- Skills and techniques can be achieved only through continuous practice.
- Practice of these skills may be found less applicable in the beginning, later it will become part of their professional practice.

10. MANAGEMENT OF BIO-PSYCHO-SOICAL ISSUES AMONG ELDERLY IN OLD AGE HOMES

The bio-psycho-social issues among elderly are more in compared to other life stages. It needs specific consideration and professional skills to deal with.

Physical Health

It is suggested that people above the age of 60 years require adequate fitness level to maintain independence, recover from illness and reduce risk of many other illness. Many studies show that physical decline has an association with lack of physical activity. The human body responds to exercise in any age. Due to lack of regular exercise the people above the age of 60 years experiences vide range of health problems including: reduced muscles strength and physical endurance, coordination and balance, flexibility and mobility, bone strength, respiratory functions and increased blood pressure and fat levels ("Physical activity for seniors", 2020).

Mental health

There are multiple factors which lead to mental health issues in a person's life. The elder people may experience many stressors in common like a significant loss in capacities and decline in functional ability. Older people are more likely to experience bereavement, retirement and

desertion from family. All these stressors can result in isolation, loneliness or psychological distress in older people, for which they may require long-term care. Sometimes long-standing untreated symptoms will lead to depression, anxiety and other mental health issues ("Mental health of older adults", 2020). Yoga, Meditation, Sleep hygiene, Relaxation training, Externalization of interests and Finding a meaning in Life are some of the ways where we can deal with many of the mental health issues.

Social Health

Cognitive stimulation activities

Cognitive stimulation refers to a set of techniques and strategies that are directed to improve performance and efficacy of cognitive capabilities and executive functions such as working memory, attention, language, reasoning and planning, among others. More concretely, cognitive stimulation is oriented towards the improvement of cognitive functionality. Just as physical exercise strengthens and trains our bodies, cognitive training and exercise stimulate the brain. There are many cognitive stimulation activities for the adults such as: arts and crafts, card games, crossword puzzles, role play, sequencing and events picture card ("25 cognitive stimulation activities for elderly, seniors and adults", 2020).

Enhancing self esteem

Self-esteem is an important aspect of the adaptive process at all stages of life, but especially in older adults. In elderly self-esteem is social integration and adaptive capacities of a person to cope with life events When a person ages he or she begins to have health issues and loses confidence. Sharing of positive life experiences (life events/life cycle cards), positive life charts, celebration of past achievements and daily routine are the way to boost the self-esteem of an elderly (Alaphilippe, 2008).

10.1 Case Scenario:

A 59-year-old male has two daughters. He married them off well. He worked in a private firm and at the age of 60 years he got retired. So, he lost his company quarters where he was living. He was compelled to stay with his daughters. But he could not adjust with them. He felt that he cannot get along with other family members and he is a burden for his daughters. So with the help of ward counsellor, he took admission in an old age home.

10.1.1 Brainstorming Questions

1. Identify major bio-psycho- social problems in this case?
2. What are reasons for his helpless condition?

10.2	**Case details presentation and Group discussion**
ACTIVITY	Aim of the activity is to make the participants aware of various psychosocial problems among elderly and its management**.** Divide the participants into different groups. Then trainer presents a case study of an elderly. After the presentation, ask the group to conduct discussion on physical health issues, mental health issues and other issues seen in the case. Also ask the group members list out their own points within the groups and a representative from each group have to present those. The materials used in the activity are printed case details, paper and pen for listing out the points.

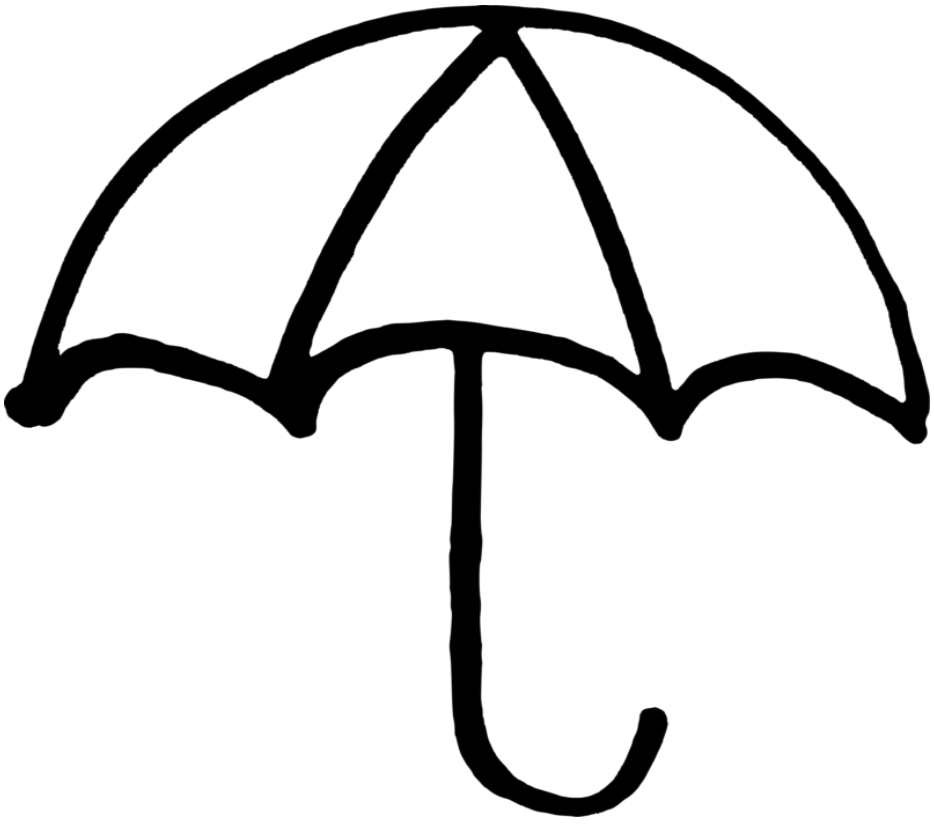
10.2.1 Instructions

1. Describe case details in simple language.
2. Print case details and give to all the participants.

- Bio-psycho -social issues among elderly are interrelated.
- Management of bio-psycho-social issues is a complex process; professional expertise is needed to handle it more effectively.

11. SPECTRUM OF SERVICE

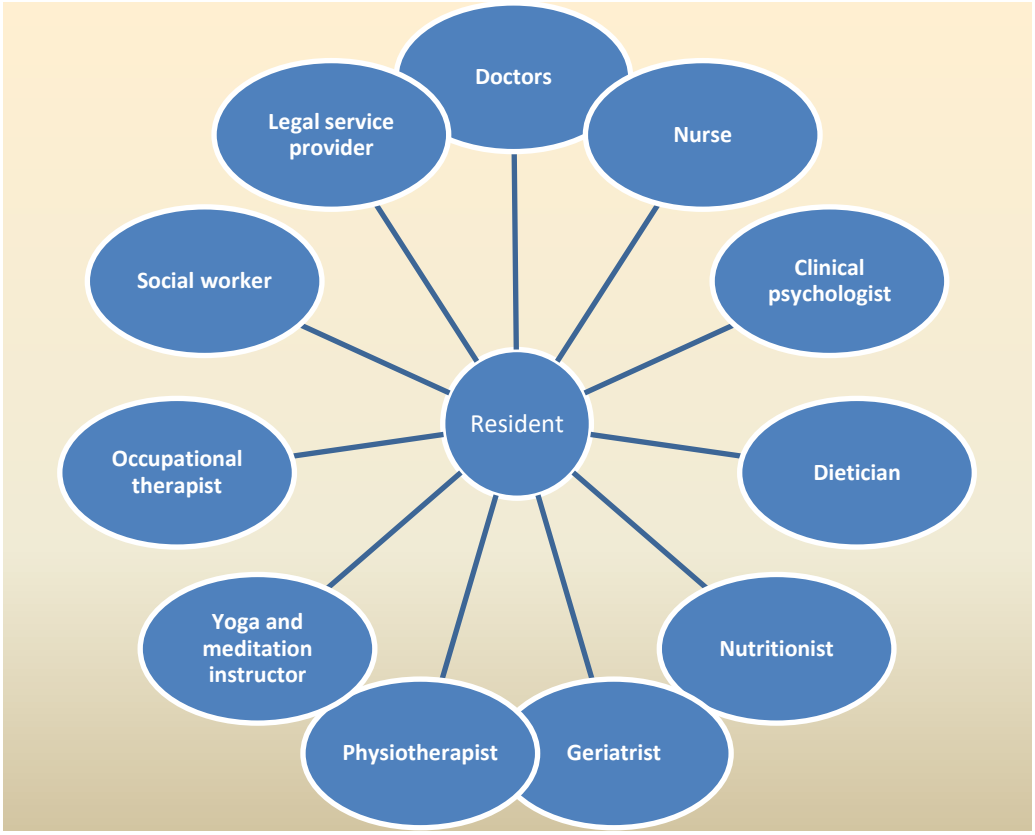
Decline in support from family, economic insecurity, social isolation, abuse, lack of social security, inadequate health care facilities, rehabilitation and lack of recreation are the challenges faced by the elderly. The physiological, psychological, social, emotional and financial needs are unavoidable in old age. These problems of ageing usually appear after the age of 60 years. Physiological problems are a part of old age (Han & Lee, 2015). The institutionalised elderly is the one who faces lot of stressors due to the lack of family support, and social contact. All of above-mentioned issues of elderly demand a variety of services by which service providers should act together and there should be a communication within them for the effectiveness of the care giving.



The spectrum of service means, bringing all the service together and form an effective communication pattern within them. An effective way of establishing a spectrum of service is the creation of multi-disciplinary team (the team consists of professionals with different backgrounds, e.g., Doctors, Nurses, Social Workers etc.) in each institution.

A multi-disciplinary team set-up or network should be initiated or formed by integrating the services of healthcare professionals like, doctors (neurologist, psychiatrist, cardiologist, ENT specialist, dentist), nurse, psychologist, dietician, nutritionist, geriatrist, physiotherapist, and other professionals like, yoga and meditation instructors, occupational therapist, legal service provider, social workers and members of various community organizations can constitute the comprehensive team.

When a person is admitted in the home after the psychosocial need identification, the collaboration and the consultation of professionals from the multi-disciplinary team should be ensured, while making intervention plan for each resident.



11.1 Case Scenario:

A 68-year-old male, from a financially sound family and worked in a private firm in a good position came to the old age home. His wife passed away a few years ago and his 2 children got married and settled. After the death of his wife, his property was taken and he was fully abandoned by his family members and relatives. They were not ready to look after him. His old colleagues and few other neighbours were the people who took the initiative and admitted him in the old age home. After coming to the old age home, he was diagnosed with heart disease, diabetics and arthritis. He is a person with very rigid behaviour and often complaints against staff. He is very much interested in reading books and playing chess. Currently more often, mood fluctuation can be observed in his behaviour and he seems to be very lonely.

11.1.1 Brainstorming Questions

1. Identify the areas where he needed services?
2. What are the professionals needed to provide that services?

11.2	**Case presentation and Role play**
ACTIVITY	Aim of the activity is to give the participants an idea about holistic approach in elderly care and to make them aware how each services or service providers need to connect with each other to provide effective care. One participant act as an elderly person in the role play and others play the role of various service providers. Then a case will be presented by the facilitator and each service provider has to identify their role in the case and each of them come forward and hold the part of a rope which is tied to the hand of the elderly person standing in the middle. After each service provider, the leftover rope will be passed to other service providers. At the end of the activity the elderly person will be in the middle and all the service providers will be around the elderly in the shape of an umbrella. Materials used for the activity are printed case detail and rope.

11.2.1 Instructions

- The language of case details should be simple.
- The long rope for the role play must be user friendly.

- A multi-disciplinary team is needed to provide holistic care to an elderly in the old age home.
- Each stake holder needs to perform their role adequately to ensure holistic care for the elderly.

12. MEASURES TO BE TAKEN FOR COMMUNICABLE DISEASES

Elderly is more likely to affect by communicable diseases due to the poor health condition and low immunity as compared to other people. So, taking preventive measures to communicable diseases is very important in institutions where a group of elderly lives together.

Communicable disease can be defined as an illness caused by another living agents such as bacteria, viruses, protozoa, fungi and parasites, or its products, that can be spread from one person to another (Babaie et al.,). An infectious agent may be transmitted from its natural reservoirs (human reservoirs, animal and environmental reservoirs) to a susceptible host (victim) in different ways. There are different classifications for modes of transmission

12.1 Contact transmission

Contact transmission occurs through skin-to-skin contact and sexual intercourse. Direct contact also refers to contact with soil or vegetation harbouring infectious organisms. Sexually transmitted diseases and hookworms are the best example for contact transmission.

12.2 Droplet transmission

Droplet transmission means, spray with relatively large or short-range aerosols (fine solid particles or liquid droplets) produced by sneezing, coughing, or even talking (from a host to other). Droplet spread can be considered as another form of direct transmission because transmission is by direct spray over a few feet, before the droplets fall to the ground.

12.3 Airborne transmission

Airborne transmission occurs when infectious agents are carried by dust or droplet particles in air. Airborne dust includes material that has settled on surfaces (ground, soil) and become suspended by air currents as well as infectious particles blown from the soil by the wind**.** In relation to droplets that fall to the ground within a few feet like in droplets transmission, droplet nuclei may remain suspended in the air for long period in airborne transmission example is Measles

12.4 Vehicles transmission

It is an indirect transmission mode whereby may transmit an infectious agent through food, water, biologic products such as blood and other body fluids and inanimate objects such as handkerchiefs, bedding, or surgical scalpels. A vehicle may passively carry a pathogen as food or water may carry hepatitis A virus. The vehicle may provide an environment in which the agent grows, multiplies, or produces toxin.

12.5 Vectors transmission

Vectors such as mosquitoes, fleas, and ticks may carry an infectious agent. Examples of mechanical transmission are flies carrying Shigella and fleas carrying Yersinia pestis, the causative agent of plague. Other examples are malaria or guinea worm disease (Principles of Epidemiology | Lesson 1 - Section 10, 2018).

12.6 Preventive measures

Individual level	Institutional
Wash hands often Cough and sneeze in the sleeves Wear masks and other measures when it is an emergency Avoid close contact Maintain personal hygiene Do exercise Eat healthy diet	Safe food preparation and water supply Clean or disinfect common places Provide nutritious food Provide preventive medicines Time allocation for exercise

12.7 Case Scenario:

A 72-year-old man was wandering on the streets for years and police brought him to the old age home. It is mandatory to have fitness certificate during admission in the old age home. Since it was an emergency situation, this man got admission to the old age home without the fitness certificate. And the man was shifted to dormitory, after the general physical examination and the staff started providing services to this man. After the detailed medical check-up in general hospital, it is found that he has a communicable illness.

12.7.1 Brainstorming Questions

1. What are the preliminary measures to be taken while giving care to a person with a communicable disease?
2. How do you educate other residents for the prevention of a communicable illness?

12.8	**Lecture method**
ACTIVITY	Aim of the activity is to introduce the measures to be taken for preventing communicable diseases in elderly institutions. Lecture method is used to make the participants understand the measures. At the beginning of the session, the trainer explains about the chain of infections, infective agents, source of infections and its transmission modes. Then present about seasonal infections which are commonly seen in elderly setting also present about the different types of infections and its mode of transmissions with examples. Materials used in the activity are Power Point presentation.

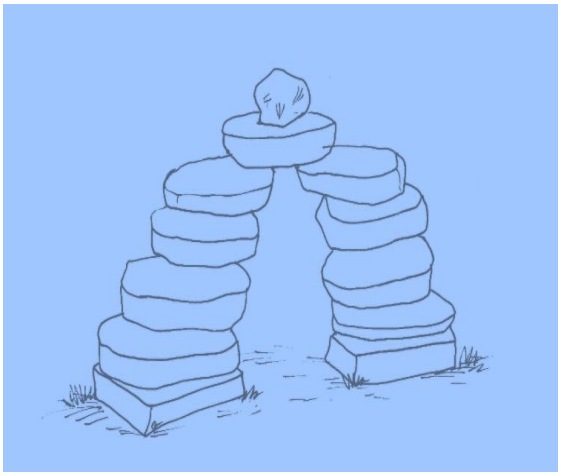
12.8.1 Instructions

- Please note the important notes during the class
- Active participation of the participants is needed for the session

- Senior citizens are more prone to communicable diseases.
- Do not bring in, do not take out, and do not spread!

13. FALL PREVENTION

Falls are a major cause of morbidity and mortality and the leading cause of fatal and nonfatal injuries among older adults. A fall is an unintentional event that results in the person coming to rest on the ground or another lower level. Falls in turn diminish function by causing injury, activity limitations, fear of falling, and loss of mobility. Most injuries in the elderly are the result of falls; fractures of the hip, forearm, humerus, and pelvis usually result from the combined effect of falls and osteoporosis (Berg and Cassells, 1992). Conditions which are the risk factor for fall is explained below:



13.1 Balance and Gait

Gait and balance disorders are among the most common causes of falls in older adults and often lead to injury, disability, loss of independence and limitations in quality of life. Good balance is a result of rapid flow of interaction between various physiological and cognitive functions that allow rapid and precise response to any confusion or disturbance. It is a complex relationship between systems that allow for rapid and precise changes to prevent a fall. However, any disturbance in the system can lead in to abnormal gait.

13.2 Vision

The issue of vision impairment and blindness increases with age and poor vision as a risk factor for falls is sometimes don't get much attention because the process of decreasing vision is very slow and may even be unnoticeable for some older individuals. Visual impairment increases the risk of falls and injuries

13.3 Medications

The use of multiple or heavy dose medications and specific classes of medications can lead to gait and balance disorders and increased rate of falls. Health professionals need to understand that many medications, especially those with central nervous system need to be used with

caution in elderly individuals because, these could have altering their reaction time, memory and balance (Ramon cuevas, 2020).

13.4 Environment

Environmental factors include poor stairway design and lack of timely repair, inadequate lighting, untidy space coverage, slippery floors, unsecured mats and rugs, and lack of non-skid surfaces in bathrooms etc. we cannot generalize the fact that these are the reasons for fall among elderly. However, persons with functional disabilities may be especially susceptible to a poorly designed environment (Berg & Cassells, 1992).

13.5 Cognitive impairment

The elderly with cognitive impairment (mild or severe) shows an increased risk of falls compared with other cognitively intact peers. The increased rate of dementia and degrees of cognitive impairment in older adults has increased the risk of falls in this population. Neurocognitive dysfunctions also result in increased risk of falls in older adults (Ramon cuevas, 2020).

Prevention of fall among older adults includes:

- Promote exercise and physical activity among elderly.
- Conduct rehabilitative therapies with the help of physiotherapist like balance and gait training.
- Providing proper medications
- Environmental modification and providing assistive devices
- Educating the elderly.

13.6 Case Scenario:

An old man, 75 years of age is admitted in the old age home. At first everything was normal, and then he lost his body balance, slipped and fell down a few times. This badly affected his physical and mental health as well as his daily routine. Institution staffs are clueless that they do not know how to fix this issue. Exercise needs to be done regularly as the patient has lifestyle diseases. He wants to exercise but his weak body does not allow it. Attempting to exercise can lead again to slips, falls and worsen health. Staffs are in a crisis without knowing how to solve this problem.

13.6.1 Brainstorming Questions

1. How are falls commonly seen in elder persons?
2. How can you prevent/ manage these kinds of falls in your institution?
3. What changes will happen in an elder person after a fall down?
4. What kind of emergency services are required for an elderly person suffering a fall related injury?

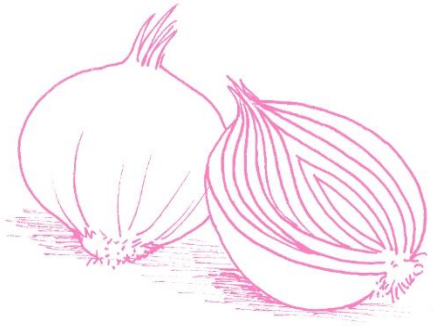
13.7	Case discussion, PPT presentation and practice-oriented activity.
ACTIVITY	Aim of the activity is to make the participants understand about fall among elderly and its impact among elderly. The trainer begins the session with a case presentation. Trainer discusses the same case with participants and asks some questions regarding this case. Then start a PPT presentation about "Falling and its impacts on elderly" for making the participants aware regarding this subject. The presentation includes the scientific definitions and pictures of the subject. Then the trainer starts the practical part of the session with the help of participants. Invite some volunteers among the participants and demonstrate all the fall prevention methods that described in the PPT. Tell the participants to practice it there and make them ready to implement in their institutions. Materials used for the activity is printed case details and a PowerPoint presentation.

- Falls are a leading cause of injury among elders
- Issues of fall can be modified by early risk assessment providing assistive devices, modification of infrastructure and balance training.

14. PROCESS OF PSYCHOSOCIAL CARE

14.1 Admission & Intake

- Residents of the home can be selected in accordance with the procedures stated in Provision 19 (18) of the Kerala Government 2009 Rules.
- Ensuring age limitation (60 years and above) at the time of admission
- The applicants will put on the waiting list incase if vacancy is not present
- Providing the pamphlet containing rules and regulations followed by the resident and receiving of written consent/signed declaration from applicant/relative



- On admission each resident will be provided with an identity card including photo, name, age, address and blood group
- Interview with the new resident at the time of admission by the superintendent in the presence of social worker
- Ensuring primary level personal hygiene of the new resident, including bathing, cropping hair, cutting nails etc.
- The new resident will be provided with necessary items for meeting their daily life needs
- Sensitizing the new resident about the institution by superintendent, or social worker about the institution, daily routine, facilities and its usages, rules and regulations in operation, ways/pattern of behavior towards other residents and officials
- A welcome party for the new resident by the resident committee
- New comer should be kept in observation room for a particular period to understand his/her physical & mental health status
- A primary medical checkup and behavior assessment of the new resident during observation period

- A detailed psychosocial assessment should carry out by the social worker after the observation period using standardized scientific tools along with socio demographic details and socio-bio-psychological assessment. Those tools are: Mini Mental State Examination, Depression Anxiety Stress Scale, Loneliness measurement tool and Everyday Ability scale
- Enquiry and evaluation of the family background of the new resident by the social worker or probation officer.
- Detailed medical examination of the new resident within seven days of admission.
- In case if the new resident diagnosed with some contagious disease or other illness which is threat full for other residents, the person will be provided with proper treatment at first and only after producing a fitness certificate issued by a doctor he or she will be re-admitted to the home.
- Preparation of care plan for each resident with the collaboration of Multi-disciplinary team
- Supervising and evaluating the works of the staffs towards the fulfillment of care plan
- Reviewing the admission and evaluation of ICP in quarterly meeting with DSJO

14.2 Care Plan – Preparation

- The Care Plan is a document containing the individual characteristics of the new entrant and the measures required to give him protection and rehabilitation. Each resident should have a Care Plan. His problems and needs should be carefully studied and recommendation for their remedies should be contained in the Plan.
- The enquiries and reports of the Social Worker, Counselor and Probation Officer as also the Medical Report on him, bio-psycho-social assessment report should form the basis of the Care Plan. The special services if any and measures for his rehabilitation should be contained in the Plan.
- The recommendation of experts, if any, also should be taken into account in preparing the Care Plan. The responsibility for preparing the Care Plan of residents will be that of the Social Worker and if his services are not available, the Superintendent himself should do this work.
- The Care Plan should be evaluated by the head of the institution. He could suggest modification if he feels that these are necessary.

14.3 Evaluation, **Updating** & **Follow up of ICP**

- The responsibility of preparing the ICP and monitoring it lies to the social worker.
- As mentioned earlier, after the implementation of ICP, it is the duty of the social worker to monitor the ICP through pre and post assessment before and after providing them with an intervention plan
- After the post assessment, the collected information should be analyzed and bring necessary changes in the intervention plan if any gaps are identified.
- The social worker should mark of every progress of intervention plan and other gaps identified in the ICP and should keep those as a referral document for every other health care professional, multi-disciplinary team and stake holders and similarly, the result or the information of the intervention plan should be updated in the ICP.
- Monthly and quarterly review meetings with internal committee should be done and continue the process through the identification of any other emerging needs through pre assessment and also through post assessment for improving the existing intervention strategy or plan.

14.4 Case Scenario:

A 65 years old man, who was referred from District Social Justice Department, came to the old age home for getting the admission. The institution superintendent has talked with him and collected the materials those he had. Then superintendent provided the primary materials from the institution to the new member and directly admitted him in a dormitory. In the day time, the staffs have seen his behaviour as calm and peaceful, but at the midnight he cried loudly and physically attacked other residents. Also, he verbally abused the staffs and tried to run outside. The staff observed that the person is showing some psychological illness at that time. They produce him in front of a psychiatrist on the next day. The doctor has opined that the new resident has psychological symptoms like Delusions and Visual hallucinations. Psychiatrist referred him for better treatment.

14.4.1 Brainstorming Questions

What are the problems that you observed in this case?

Are these procedures enough for admitting a person in an old age home?

What are the procedures that you know for admitting a person in an old age home?

14.5	**Case discussion**
ACTIVITY	Aim of the activity is to make the participants understand about the procedures of admission in an institution. The trainer starts the session with a case study discussion with participants. The questions after the case discussion led the session to PPT presentation. The trainer explains all procedures with the help of a PPT. This PPT must include the admission criteria of Old Age Home manual 2016. Materials used for the activity is printed case details.

14.5.1 Instructions

- The seating arrangement should be in "U" shape manner for better participation.
- Sharing of experience by the participants will make the session more informative.

- The psycho-social assessments and care start from the admission of a resident till the termination or the death of that resident.
- Individual care plan is an important document maintained in an institution.

15. COMMON CHALLENGES DURING CARE GIVING

The caregivers need large amount of energy, empathy and patience. However, sometimes the challenges during care giving can interrupt these professional qualities and will result in many problems. The care giver often faces few challenges that leave them overwhelmed, anxious and intimidated by their duties. Some of these challenges are described below:

15.1 Care givers stress

Care giving in elderly care homes can be very stressful because the care giver has to complete lot of tasks and also to manage medications and helping the bed-ridden residents with getting dressed or bathing. Providing care giving for the elderly with chronic conditions like dementia or Alzheimer's disease seems to cause very high physical burden and emotional stress (3 Challenges Caregivers Face – and How to Conquer them - Own Your Health, n.d.).

15.2 Lack of personal time

Caregivers often have very less time for themselves and their family members. More often they spend so much time or busy with caregiving duties and they will end up sacrificing the things they enjoy such as; hobbies, tours and spending time with family. They will face trouble balancing work schedules around caregiving.

15.3 Conflicts, Anger & Frustration

Like said before, working in an old age institution needs immense and endless energy and patience. However, sometimes due to the stress, work load and lack of knowledge about elderly behaviour can lead to conflicts between care giver and care recipients, which ultimately results in loss of trust between care giver and care recipients.

15.4 Lack of experience and training

For providing elderly care one has to achieve certain skills, follow principles and should have basic knowledge about elderly conditions. Care givers often face challenges such as work stress, conflicts and lack of confidence due to the lack of experience and appropriate training.

15.5 Being afraid to ask for help.

There is a chance that caregivers often have the tendency to feel ashamed to ask for help from others. They may take up the full caregiver burden and may also feel that asking for some assistance may be a sign of weakness. The caregiver in turn starts to feel guilty that they aren't providing the best care that they could (The Challenges Facing a Family Caregiver | ASC Blog, 2015).

15.6 Workload

Sometimes the increased number of residents and a smaller number of care givers can lead to high workload and fatigue. A rise in the work burden of care givers can subsequently lead to the other work related adjustment problems.

15.7 Health issues

The physical or mental health issues of care givers can be a bigger challenge for providing care giving. However, the work stress also affects caregivers which include: burnout, depression and anxiety. Women who are caregivers are more likely than men to develop symptoms of anxiety and depression. The physical burden, work stress and other associated mental health issues can increase the risk for other health problems, such as heart disease and stroke. (Caregiver stress | womenshealth.gov, 2015)

15.8 Case Scenario:

An inexperienced young female care giver in the old age home is facing trouble in doing her work. She is uncertain about the unfriendly behaviour of few residents. Due to this she was becoming easily irritated and upset, so she often feels frightened to deal with them. Although she is emotionally attached with a few residents and often shares details of her personal life to them and she faced issues due to this behaviour. She also has back pain, sometimes, she is not able to lift the bedridden residents which results in heated argument with her colleagues.

15.8.1 Brainstorming Questions

1. List out the challenges faced by the care giver in this scenario.
2. How can you handle such situation in a better way?

15.9	**Case discussion and tree of sustenance**
ACTIVITY	Aim of the activity is to make the participants understand about the common challenges during care giving**.** The trainer starts the session with challenges faced by the particular case discussed previously. Then the trainer starts the activity called "tree of sustenance" given in the work book. The trainer can guide the participants to write the name of the people, in the roots of the tree, who are close to them and reliable at any difficult time in their life like, parents, spouse or friends. Next, in the green leaves the participant has to write their strengths that harvest their productivity in work such as helping others, hope, confidence, love for others etc. and in yellow leaves, they have to write the negative qualities that hinders or affect their overall work i.e., poor concentration, lack of self-care, lack of confidence, financial problems, personal issues etc. In the clouds, they have to write their hobbies. After the whole activity, explain the participants about how to strengthen their roots by establishing more connection with the people in their life and harvest their positive qualities by finding the time for self-care and do pleasurable hobbies.

15.9.1 Instructions

- All participants need to carry a paper, pencil and pen
- Participation of all the trainees is compulsory

- Health of the care giver and care recipient is equally important

16. CARE GIVERS BURNOUT

When care givers fail to practice self-care habits, that will further contribute to the stress caregivers feel and the problems they may experience with their own physical, mental and emotional health. The likely outcome or consequence for a caregiver who fails in taking care of him or her due to various reasons, is burnout. Burnout is a state of emotional exhaustion that results from failing, wearing out, or feeling totally used up due to many demands in one's energy, strength, or resources.

16.1 Symptoms of care givers burnout

Withdrawal from friends and family

Loss of interest in activities you used to enjoy

Feeling of hopelessness and helpless

Changes in appetite, weight, or both

Changes in sleep patterns

Getting sick more often

Emotional and physical exhaustion

Using alcohol and/or sleep medications too much

Feelings of wanting to hurt yourself or the person for whom you are caring (What is Caregiver Burnout?, n.d.)

16.2 Causes of caregiver burnout may include:

- **Excessive demands resulting from the care receivers' condition.**

  When there is much more physical and emotional care is needed for the care receiver and due to the work load, a care giver cannot meet all that needs, often results in conflicts or being not able to work properly

- **Confusing job roles and demands.**

  The demands of work life and personal life and also the variety of job roles can make a care giver confused or exhausted and will lead to conflict and stress.

- **Workload**

  The excessive amount of work can lead a care giver in to burnout.

- **Unrealistic expectations**

The care giver may expect their care to have a positive effect on the health and happiness of the person they care for. This may be unrealistic for institutionalised elderly who have many psychosocial stressors, progressive disease such as Parkinson's or Alzheimer's and personality issues.

16.3 **Case Scenario:**

A middle-aged female care giver in an old age home had many financial difficulties at her home. Due to her work pattern, she spent most of her time in the institution. She was seen as depressed or lonely. She is having constant troubles and issues with the residents. Many residents often complained about her for being aggressive towards them. She also often complained against a few residents. She is repeatedly making the statements that she cannot work for them anymore. She is struggling with tiredness, lack of sleep and fatigue. Her relationship with her family members were badly affected.

16.3.1 Brainstorming Questions

1. List out signs of burnout.

2. Do the personal problems of a care giver affect the quality of his or her services?

16.4	**Name of the activity –** Case discussion and Zarit Burden interview scale
ACTIVITY	**Aim of the activity -** To make the participants understand about the mental state "Burn Out" and how we can assess it. **Activity –** The trainer does start the session with a case presentation. After the presentation, he should ask some questions regarding the subject and give some time for a healthy discussion. Then the trainer starts the activity of Burn out assessment by Zarit Burden scale. Trainer gives the participants the printed scale and tells them to fill it by themselves, after filling it the trainer helps them to analyses the mental state of each participants. **Materials used for the activity** are 1. Printed case sheets for all participants, 2. Printed Zarit Burden scale for each participant and Pen

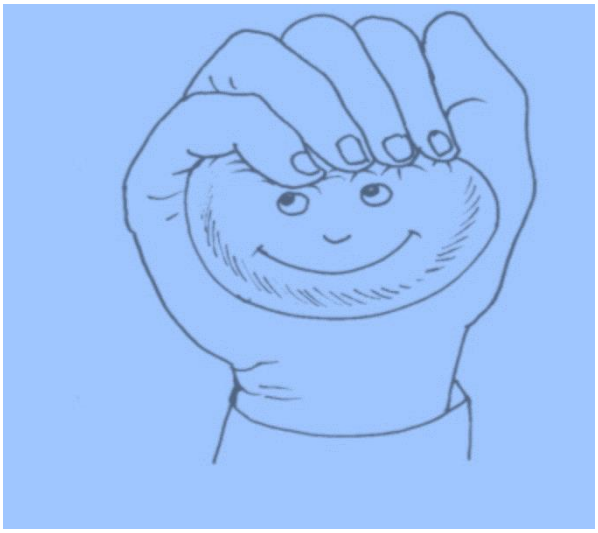
16.4.1 Instructions

- All participants should contribute to the activity and share their experiences.
- Doubts regarding the activity need to be clarified on the spot.

- Identification of Burn out is the most emergency call.

17. MANAGING STRESS AT WORK PLACE

Headache, stomach-ache, sleep disturbances, short temper and difficulty concentrating are the common problems seen in people with stressful work environment. Chronic stress can result in anxiety, insomnia, high blood pressure, and a weakened immune system. It can also contribute to health conditions such as depression, obesity and heart disease. According to American psychological Association, there are few important steps to manage stress at work place are:



1. **Track stressors**: Make a note of most stressful situations or events and how you respond to them for at least a week. Also note your thoughts, feeling during the time of stress and the people, physical settings involved in the situation.

2. **Develop healthy responses**: Many people fight stress with fast food or alcohol do however make healthy choices when you feel more tensed. Exercise, yoga and any kind of physical activity is a great stress-buster and beneficial. Also find time for hobbies and favourite activities like listening to music, writing diary.

3. Establish boundaries: It is important make a boundary between work life and personal life. If you are taking the same stress to your home will harm your personal relationship with the family members. Establishing boundaries will help to reduce work-life conflict and the stress that goes with it.

4. **Take time to recharge:** To avoid the negative effects of chronic stress and burnout, we need time to return to our pre-stress level of functioning. This recovery process requires "switching off" from work by having time gap which is not involved in work. For example, take a holiday and give time to your needs and preferences.

5. **Learn how to relax:** Techniques such as meditation, deep breathing exercises, and mindfulness (a state of being observed the present experiences and thoughts without judging

them) can help melt away stress. Start by taking a few minutes to focus on a simple activity like breathing, walking, or enjoying a meal.

6. Talk to your superior: Employee's health has been linked to productivity at work, so your authority has to create a good work environment. You can also have an open conversation with your higher authority to come up with an effective plan for managing the stressors you've identified.

7. Get some support. Accepting help from trusted friends and family members can improve your ability to manage stress. It is also recommended to take professional help from counsellors or mental health professions if needed (Coping with stress at work, 2020)

17.1 Case Scenario:

A resident aged 68 years having psychiatric issues, living in an old age home misbehaved and shouted at 32 years aged multi-task care provider unnecessarily and he complained about her to the superintendent. Since the MTCP was put into such a situation for a reason she wasn't responsible for, she became mentally down as she was forced to go through all these. The MTCP wanted to stay away from her workplace but she had three more days to complete her job and therefore couldn't. It affected her physically and mentally, resulting in less performance of her duty.

17.1.1 Brainstorming Questions

- Have you ever faced this kind of situation in your professional life?
- As a co-worker what kind of solutions are you given to that person?

17.2	**Name of the activity –** Case discussion and role play

ACTIVITY	Aim of the activity is to make understand the participants about the stress and how can manage it at work place. Trainer has to present a case first. Then trainer discusses the doubts about the case with participants. Equal participation of the participants is very important. Trainer should clear their doubts with the help of some examples. Best ways or techniques to tackle these kinds of issues must be described by the trainer here. Next part is a role play. Select a pair of participants. First member expresses his stressors or problems at workplace. Second one tries to understand the problem clearly and select an appropriate activity or technique to tackle the problem effectively. He must convey it to the first one (the needy person) in a scientific and professional way. Continue the role play with three other pairs. Trainer has to describe four different stress related issues through the role play. Materials used for the activity are printed case for all participants, printed stressful situation cards for four groups.

17.2.1 Instructions

- Encourage equal participation among the participants.
- Give five minutes for the role play to each pair.

It is very normal to have stress at work place.

Professional help can be taken if the stress is unmanageable by the care giver.

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APPENDIX

Zarit burden interview scale

Please circle the response the best describes how you feel.

0: NEVER
1: RARELY
2: SOMETIMES
3: QUITE FREQUENTLY
4: NEARLY ALWAYS

S. No	Questions	Question Score
1	Do you feel that your relative asks for more help than he/she needs?	**0 1 2 3 4**
2	Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?	**0 1 2 3 4**
3	Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?	**0 1 2 3 4**
4	Do you feel embarrassed over your relative's behaviour?	**0 1 2 3 4**
5	Do you feel angry when you are around your relative?	**0 1 2 3 4**
6	Do you feel that your relative currently affects our relationships with other family members or friends in a negative way?	**0 1 2 3 4**
7	Are you afraid what the future holds for your relative?	**0 1 2 3 4**
8	Do you feel your relative is dependent on you?	**0 1 2 3 4**
9	Do you feel strained when you are around your relative?	**0 1 2 3 4**
10	Do you feel your health has suffered because of your involvement with your relative?	**0 1 2 3 4**
11	Do you feel that you don't have as much privacy as you would like because of your relative?	**0 1 2 3 4**
12	Do you feel that your social life has suffered because you are caring for your relative?	**0 1 2 3 4**
13	Do you feel uncomfortable about having friends over because of	**0 1 2 3 4**

	your relative?	
14	Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on?	**0 1 2 3 4**
15	Do you feel that you don't have enough money to take care of your relative in addition to the rest of your expenses?	**0 1 2 3 4**
16	Do you feel that you will be unable to take care of your relative much longer?	**0 1 2 3 4**
17	Do you feel you have lost control of your life since your relative's illness?	**0 1 2 3 4**
18	Do you wish you could leave the care of your relative to someone else?	**0 1 2 3 4**
19	Do you feel uncertain about what to do about your relative?	**0 1 2 3 4**
20	Do you feel you should be doing more for your relative?	**0 1 2 3 4**
21	Do you feel you could do a better job in caring for your relative?	**0 1 2 3 4**
22	Overall, how burdened do you feel in caring for your relative?	**0 1 2 3 4**

Model ICP format

INDIVIDUAL CARE PLAN										
Sec.01. DETAILS OF THE CASE		**Date of data collection**					**Date of Entry**			
1.1 Name of Referring Authority/Details of referring letter			***1.2 Admission no:***			***1.3 Date of Admission***				
1.4 Who Brought to Home(Details)				***1.5 Reason for Admission***						
1.6 Details of person/guardian to be contacted in case of any emergency	***Name:***		***Age***		***Gender***		***Occupation***		***Relationship with Case***	
1.7 Contact details of guardian	***Address***		***Phone:***							

1.8 Case Summery by Superintendent												
Sec.02. SOCIO DEMOGRAPHIC PROFILE		**Date of data collection**						**Date of entry**				
2.1.Name			*2.2 Age*		*2.3. Gender*			*2.4. Education*				
2.5. Religion		*2.6 Date of Birth*		*2.7. Caste*				*2.8. Past occupation*				
2.9 Marital status		*2.10.Scio-Economic Status*										
2.11.Identification Marks												
2.12. Domicile			*2.13. Address(Country/State/District)*						*2.14 Phone no if any*			
Sec.03. PERSONAL DETAILS		**Date of data collection**						**Date of entry**				
3.1 Details of pension/Grants(Amount, type, authority)			*Amount*		*Type*		*Authority*		*Current status (receiving or not)*			
			Frequency of receiving		*Other grants if any*							
3.2 Details of personal assets (Money, gold, doccument of properties etc.)			*Details of assets*		*Quantity*			*Details, if any personal belongings were lost*				
3.3 Details of police case if any:			*Case number & Case summary*		*Police station*			*Current status*		*Remarks*		
3.4 Details of Identification proofs /Certificates (Item name, number)			*Item name*		*Identification number*			*Details of documents/ID proof lost or absent*				

3.5 Legal issues if any	*Summary of the problem/complaint*	*Any legal help acquired or not*	*Name of authority/ person providing support*	*Current status*	*Follow up details*	
Sec.04 DETAILS OF FAMILY MEMBERS	**Date of data collection**			**Date of Entry**		
Name	*Age (mention if person died)*	*Gender*	*Relationship*	*Education*	*Occupation*	*Bonding /attachment (Mention as; Strong, Satisfactory, Weak)*
Sec.05. FAMILY HISTORY	**Date of data collection**				**Date of entry**	
Details of family members with Physical/Mental illness/Disability, if any	*Name*	*Criteria/type*	*Remarks*			
Details of family members with criminal background / police case, if any	*Name*	*Details*	*Remarks*			
Details of family members with drug/ substance abuse	*Name*	*Details*	*Remarks*			
Details of any problematic/ traumatic events faced by the family	*Nature of the problem*	*Attempts of addressing the problem*	*outcome*			
Relationship between couples	*Within parents*	*Within the individual and spouse*	*Within children and their spouses*			

Family values			***Religious beliefs***		***Believes about gender role***		***Parenting style practices***		***Decision Making/ power roles***		***Remarks***
Family interaction pattern (Mention interaction type as; Direct, Indirect and Switch board)			***Interaction type***				***Remarks***				
Sec.06. OBSERVATION REPORT BY NURSE/OTHER HEALTH CARE PROFFESIONAL		**Date of data collection**							**Date of entry**		
If any presenting complaints (mention the date)						***History of present illness if any***					
Past history of physical illness (H/O HTN, DM, Asthma,)						***Treatment history (including the details of surgery if occurred)***					
Personal history											
Diet		***Bowel***		***Sleep***		***Appetite***		***Urine***		***Substance abuse /addiction***	
Any others, Specify						***Remarks***					
General health check-up details											
BMI		***Pulse***		***Respiration***		***Temperature***		***BP***		***GRBS***	
Pallor		***Cyanosis***		***Jaundice***		***Clubbing***		***Head to Foot Examination(mention if any disability)***		***Marks of Wound/physical abuse***	
Any others, Specify						***Remarks***					
Details of currently consuming medications						***Mention if any drug allergy***				***Indicate Reaction***	
Detailed health check-up details (results of blood/ body check-up)									***Entry date***		
Check-up date & hospital		***Results/ Diagnosis***				***Prescribed medications***			***Remarks***		

name											
Sec.07. HOME VISIT REPORT-SOCIAL WORKER	**Date of visit**						**Date of Entry**				
Sec.08- PSYCHOSOCIAL ISSUES IDENTIFIED	**Date of data collection**						**Date of entry**				
Any Presenting psychiatric complaints (mention the Date)				***Signs & Symptoms observed***							
History of Present mental illness				***Details of currently consuming medications, if any***							
If available, history of past mental illness				***Treatment history (with date)***							
Personal history (Mention as; Good, Satisfactory, Poor)											
Childhood		***Peers & Play***		***Education***		***Occupation***		***Remarks***			
Social Engagement Status (mention as; Engaged, partially engaged & not engaged)											
Daily Activities		***Educational & entertainment***		***General meetings***		***Interaction with inmates***		***Remarks***			
4.2. Physical Functional Abilities (Mention as; Self supervision, Need assistance, Completely dependent)											
Dressing		***Eating***		***Ambulating***		***Get in/out of bed***		***Toileting***		***Hygiene***	
Remarks											
4.3. Sensory/Expressive Impairment (mention as; No impairment, Partially impaired, fully impaired)											

Auditory		***Visual***		***Speech***		***Remarks***	

4.6. MMSE	***Mild***	Moderate	Severe	***Extremely severe***	
4.7. EASI					
Loneliness Measurement Tools					

The campaign to end loneliness measurement tool				***The De Jong Gierveld Loneliness Scale***			***The UCLA Loneliness Scale***		
sense of loneliness	***Feeling of loneliness***	***Most sense of loneliness***		***Socially Lonely***	***Emotionally lonely***		***Not lonely***	***Lonely***	

4.8. DASS					
4.8.1Depression	***Mild***	***Moderate***	***Severe***	***Extremely severe***	
4.8.2Anxiety	***Mild***	***Moderate***	***Severe***	***Extremely severe***	
4.8.3Stress	***Mild***	***Moderate***	***Severe***	***Extremely severe***	

Overall Impression	

Sec.09-GENERAL INTERVENTION PLANS		**Date of entry**			

Area of Intervention	***Intervention Plan***	***Implementation strategy & Resources needed***	***Assigned professionals /staff***	***implementation status (mention as; Completed, Ongoing, Not initiated)***	***Changes observed***
First quarter (Date of Intervention)					

Sec.10- INTERVENTION PLAN FOR BIOLOGICAL & PSYCHOLOGICAL ISSUES		**Date of entry**		

Area of Intervention	***Intervention Plan***	***Implementation strategy & Resources needed***	***Assigned professionals /staff***	***implementation status (mention as; Completed, Ongoing, Not initiated)***	***Changes observed***
First quarter (Date of Intervention)					

Sec.11- INTERVENTION PLANS FOR LEGAL SUPPORT					**Date of entry**			
Complaints	***Background investigation details***	***Date of filing complaint & Authority name***	***Assigned professionals /staff***	***Case status (mention as; Completed, Ongoing, Not initiated)***	***Outcome***			
First quarter (Date of Intervention)								
Sec.12- INTERVENTION PLANS FOR SOCIAL ISSUES EXPERIENCED BY ELDERLY					**Date of entry**			
Area of Intervention	***Intervention Plan***	***Implementation strategy & Resources needed***	***Assigned professionals /staff***	***implementation status (mention as; Completed, Ongoing, Not initiated)***	***Changes observed***			
First quarter (Date of Intervention)								
Sec.13- GROUP WORK WITH ELDERLY IN NEED					**Date of Entry**			
Stages of group work		***Sessions***		***OUTPUTS***				
Forming		***Session1***						
		Session2						
		Session3						
		Session4						
		Session5						
Sec.14- DAILY ROUTINE PLANNING					**Date of Entry**			
	Activity time				***Execution***			
Activity planned	***Morning***	***Day time***	***afternoon***	***Evening***	***Late evening & Night***	***Yes***	***No***	***Remarks***

Sec. 15- INDIVIDUAL COUNSELING/ THERAPY SESSION WITH ELDERLY							**Date of entry**			
Date	***Therapy***	***Objective***	***Number of Days taken for each phase***			***Participation (1= Good,2= Average, 3=Poor) in each Phases***			***Outcome***	***Any Referral needed***
			Phase 1	***Phase 2***	***Phase 3***	***Phase 1***	***Phase 2***	***Phase 3***		

Sec. 16 - LIFE SKILL EDUCATION/PSYCHO EDUCATION FOR THE ELDERLY					**Date of Entry**		
Day	***Date***	***Life skills/Psycho-education***	***Participation (1= Good,2= Average, 3=Poor)***			***Major outputs from the session***	
Day 1			*1*	*2*	*3*		
Day 2			*1*	*2*	*3*		
Day 3			*1*	*2*	*3*		

Sec. 17- NETWORKING WITH OTHER GOVERNMENT AND NON-GOVERNMENT AGENCIES DEPARTMENTS AND OFFFICES		**Date of Entry**			
Date	***Agency***	***Purpose***			***Remarks***

Sec.18- After Death				**Date of entry**	
Date and time		***Reason for Death***		***Remarks***	
Time of Information passed	***To Superintendent***	***To Relatives***	***To DSJO***	***Body accepted by:***	

Time					
Death certificate details	***issue date***	***certificate No***	***Reporting & submitting to***		

Sec. 19 - QUARTERLY REVIEW BY SOCIAL JUSTICE DEPARTMENT	**Date of entry**			

Quarter	***Observation***
Quarter 1	
Intervention completed by: (Name and Designation)	