DOWNLOAD PDF NEIGHBOURHOODS THAT CARE: DIGNITY AND WELL BEING FOR OLDER PEOPLE

Chapter 1 : How to Promote Dignity in Care: 9 Tips for your Care Home

This paper reports the findings of 89 focus groups and 18 individual interviews (involving older people in 6 European countries) that were held to explore how older people view human dignity in their lives.

Cultural and geographic differences[edit] A nurse at a nursing home in Norway The form of care provided for older adults varies greatly among countries and is changing rapidly. One must also account for an increasingly large proportion older people worldwide, especially in developing nations, as continued pressure is put on limiting fertility and decreasing family size. There were more than 36, assisted living facilities in the United States in , according to the Assisted Living Federation of America [12] in More than 1 million senior citizens are served by these assisted living facilities. It costs less than nursing home care but is still considered expensive for most people. One relatively new service in the United States that can help keep older people in their homes longer is respite care. Another unique type of care cropping in U. In these care homes, elderly Canadians may pay for their care on a sliding scale, based on annual income. The scale that they are charged on depends on whether they are considered "Long Term Care" or "Assisted Living. An Australian statutory authority , the Productivity Commission , conducted a review of aged care commencing in and reporting in Around a million people received government-subsidised aged care services, most of these receiving low-level community care support, with people in permanent residential care. This culminated in the Productivity Commission report and subsequent reform proposals. People who have minimal savings or other assets are provided with care either in the home from visiting carers or by moving to a residential care home or nursing home. This is true for both those who will receive state funding for their care and those who will have to pay for it themselves out of savings or by selling other assets. Larger numbers of old people need help because of an aging population and medical advances, but less is being paid out by the government to help them. A million people who need care get neither formal nor informal help. OAA provides a monthly stipend to all citizens over 70 and widows over These day care services are very expensive and out of reach for the general public. Thailand[edit] Thailand has observed global patterns of an enlarging elderly class: Private care is tough to follow, often based on assumptions. Because children are less likely to care for their parents, private caretakers are in demand. Parents are typically cared for by their children into old age, most commonly by their sons. Traditional values demand honor and respect for older, wiser people. Reports of poor health were clustered among the poor, single, lower-educated and economically inactive groups. Article 41 of the Indian Constitution states that elderly citizens will be guaranteed Social Security support for health care and welfare. Barely existent now, both institutional and community-based services will need to expand to meet the growing need. China is still at an earlier stage in economic development and will be challenged to build these services and train staff. Medicare does not pay unless skilled-nursing care is needed and given in certified skilled nursing facilities or by a skilled nursing agency in the home. However, Medicare pays for some skilled care if the elderly person meets the requirements for the Medicare home health benefit. Similarly, in the United Kingdom the National Health Service provides medical care for the elderly, as for all, free at the point of use, but social care is paid for by the state only in Scotland. England, Wales and Northern Ireland have failed to introduce any legislation on the matter and so social care is not funded by public authorities unless a person has exhausted their private resources, such as by selling the home. L Experts claim that vulnerable UK people do not get what they need. If residents are confused or have communication difficulties, it may be very difficult for relatives or other concerned parties to be sure of the standard of care being given, and the possibility of elder abuse is a continuing source of concern. The Adult Protective Services Agency, a component of the human service agency in most states, is typically responsible for investigating reports of domestic elder abuse and providing families with help and guidance. Other professionals who may be able to help include doctors or nurses, police officers, lawyers, and social workers. Dignity of risk Promoting independence in self-care can provide older adults with the capability to maintain independence longer and

can leave them with a sense of achievement when they complete a task unaided. Older adults that require assistance with activities of daily living are at a greater risk of losing their independence with self-care tasks as dependent personal behaviours are often met with reinforcement from caregivers. Caregivers need to be conscious of actions and behaviors that cause older adults to become dependent on them and need to allow older patients to maintain as much independence as possible. Providing information to the older patient on why it is important to perform self-care may allow them to see the benefit in performing self-care independently. If the older adult is able to complete self-care activities on their own, or even if they need supervision, encourage them in their efforts as maintaining independence can provide them with a sense of accomplishment and the ability to maintain independence longer. As adults lose the ability to walk, to climb stairs, and to rise from a chair, they become completely disabled. The problem cannot be ignored because people over 65 constitute the fastest growing segment of the U. Therapy designed to improve mobility in elderly patients is usually built around diagnosing and treating specific impairments, such as reduced strength or poor balance. It is appropriate to compare older adults seeking to improve their mobility to athletes seeking to improve their split times. People in both groups perform best when they measure their progress and work toward specific goals related to strength, aerobic capacity , and other physical qualities. Today, many caregivers choose to focus on leg strength and balance. New research suggests that limb velocity and core strength may also be important factors in mobility. The family is one of the most important providers for the elderly. In fact, the majority of caregivers for the elderly are often members of their own family, most often a daughter or a granddaughter. Family and friends can provide a home i. Hyponatremia is the most common electrolyte disorder encountered in the elderly patient population. Studies have shown that older patients are more prone to hyponatremia as a result of multiple factors including physiologic changes associated with aging such as decreases in glomerular filtration rate, a tendency for defective sodium conservation, and increased vasopressin activity. Mild hyponatremia ups the risk of fracture in elderly patients because hyponatremia has been shown to cause subtle neurologic impairment that affects gait and attention, similar to that of moderate alcohol intake. It requires that a person file a petition with the local courts, stating the elderly person lacks the capacity to carry out activities that include making medical decisions, voting, making gifts, seeking public benefits, marrying, managing property and financial affairs, choosing where to live and who they socialize with. A less restrictive alternative to legal incapacity is the use of "advance directives," powers of attorney, trusts , living wills and healthcare directives. The person who has such documents in place should have prepared them with their attorney when that person had capacity. Then, if the time comes that the person lacks capacity to carry out the tasks laid out in the documents, the person they named their agent can step in to make decisions on their behalf. The agent has a duty to act as that person would have done so and to act in their best interest.

Chapter 2 : Elderly care - Wikipedia

Young People and Safe Neighbourhoods 7. Neighbourhoods that Care: Dignity and Well Being for Older People 8. Faith, Ethnicity and Identity show more. Review quote.

References Overview of selected research: What dignity means Despite being widely used and discussed, dignity has seemed a difficult term to pin down. It is often linked with respect from others and with privacy, autonomy and control, with self-respect and with a sense of who you are. Threats to dignity have been identified with a very wide range of issues: And the impact of factors linked to disadvantage and discrimination of all kinds further complicate the picture. The provisional meaning of dignity used for this guide is based on a standard dictionary definition: A state, quality or manner worthy of esteem or respect; and by extension self-respect. One article in the nursing press Haddock, concluded that dignity depended both on the interaction between an internal sense of identity and self-esteem, and the external respect with which a person is treated by others. A study by Jacelon and colleagues Jacelon et al. But it was also an inherent part of being human: The first phase of the project involved a review of relevant philosophical and professional literature. These were then tested in a series of studies in each of the countries involving older people, people of all ages, and health and social care professionals. The four types of dignity identified by the DOE research team: Nearly older people were involved in focus groups and interviews Bayer et al. Older people across Europe identified three key themes: You feel more valued, when someone takes care of you. In the discussions and interviews with older people, research team members found that, of the four types of dignity identified, the last two - relating to personal identity and universal human worth - were the most often mentioned. Similar, but not identical, results were reported by Woolhead and others Woolhead et al. Findings fell into three categories: Human rights Participants emphasised the intrinsic dignity of all human beings, and the importance of being treated as an equal, regardless of age. Older people want to choose how they live, and how they die for example, through the use of living wills: Autonomy Participants wanted to retain independent control over their lives for as long as possible. Some felt that resisting the inevitable â€" nursing home care, for example,was itself undignified. For those who had accepted the necessity of nursing home care, their priorities shifted to maintaining their dignity by being helped to remain clean and tidy. Other parts of the Dignity and Older Europeans study provide the opportunity to compare the views of older participants with the general public and with the views of professionals involved in caring: More than five hundred people in the six countries, aged between 13 and 59 years, took part in focus groups and discussed their views on old age, and caring for older people. Many participants had negative views of the health and social care available to older people. Stratton and Tadd, In interviews and discussion, providers of care came up with definitions of dignity that were broadly similar to those of people using services, and agreed that dignity and respect were important for people of all ages. However, the standard of care was not always what it should be. Levels of training, staff and other shortages, and lack of time were all cited as reasons for dignity becoming a low priority. One part of this looked specifically at the views of older people who were living in long-term care homes in Scotland, and compared them with the views of nursing staff. On privacy, the evidence was mixed. Encouragingly, both nurses and patients agreed on the importance of privacy, and there was strong agreement about the extent to which privacy was protected in some situations. But in others - for example, in relation to protecting privacy while giving an enema, nurses felt that they successfully protected privacy, but patients disagreed. There was also disagreement about informed consent. In general, nurses reported that they were satisfied that informed consent had been sought and given in appropriate situations. Patients were much less certain that this was the case. This is discussed within the framework of a covenant between people giving and receiving care - an idea which is taken up by many other studies which see this reciprocal relationship and the quality of communication which it supports as key contributors to dignity in care Woolhead et al. This has been developed over more than a decade by Nolan and colleagues, and has been tested in a variety of care

settings for older people Nolan, The validity of the research depends, of course, on the extent to which all potential shades of opinion and cultural difference are represented among the people interviewed. Despite some gaps in the research and identified differences of emphasis depending on ethnicity and culture, extensive research in the EU, Norway, Canada, and the USA has uncovered a number of consistent, overlapping themes, as summarised in the box. The meanings of dignity Research with older people, their carers and careworkers has identified five overlapping ideas of dignity: Respect, shown to you as a human being and as an individual, by others, and demonstrated by courtesy, good communication and taking time. More recently, Billings has suggested that the concept, used rigidly, is in danger of overriding other, important elements in end of life care. This division has been found useful by other researchers Thompson and Chochinov, Others have confirmed the well-researched fact that â€" whatever its theoretical difficulties or shortcomings â€" the concept has real, important meaning for older people receiving care services in different countries and cultures. The debate, for many, has moved on to consider how dignity can be promoted, preserved, monitored and evaluated in practice Anderberg, Lepp et al.

Chapter 3 : Dignity in care - Overview of selected research: What dignity means

Dignity and wellbeing for older people in need of care and assistance With the rise in life expectancy and the ageing of the population, the number of older Europeans in need of long-term care and assistance is rapidly increasing in Europe.

This article has been cited by other articles in PMC. Ian Philp This series will explore key issues in the quality of health care for older people. The basis of these articles is the extensive literature reviews undertaken to inform the development of a national service framework for NHS care of older people in England. As a result of an investigation by the Observer newspaper in , the UK Health Advisory Service published a report with 17 recommendations, 1 including the establishment of the national service framework, made up of key indicators of quality care and service provision. Background work for the framework covered evidence about quality in the organisation and delivery of health care for older people. It included health promotion; disease prevention; primary health care; general hospital care; specialist care by geriatric, psychogeriatric, and palliative care services; intermediate care and long term care in the community; and residential and nursing homes. Detailed attention was also given to the care of older people with stroke, falls and their consequences, depression, and dementia. Advice was based not only on evidence based practice but also on the value of fair access to care, a person centred approach, and whole systems working. This series will focus on four areas relating to health care for older people. This first article examines issues relating to the dignity and autonomy of older people. Although the empirical evidence on dignity is limited, many valuable qualitative data are available. Owing to the anecdotal nature of the data, it is difficult to assess how widespread such bad practice is. Dignity refers to an individual maintaining self respect and being valued by others. Autonomy refers to individual control of decision making and other activities. The literature suggests that both the dignity and the autonomy of older people are often undermined in healthcare settings. One way is to examine the examples of good practice that exist and identify elements that can be generalised to health services globally. Much of the qualitative information already mentioned, along with several documents focusing specifically on good practice, reports positive comments made by older people and their carers about care received see box. Such comments shed light on elements of service provision that allow older people to feel that they are retaining their dignity and autonomy. The feedback shows that information provision and the quality of interactions between staff and patients are key issues. They are key, too, in the findings of research into good practice in acute hospitals in England. This is a concept well supported by scientific literature: One study reported that more positive attitudes towards older people were found among nurses working in elderly care than among those working in acute care which covers all ages and attributed this to a more specialised training in gerontology. In fact, the evidence shows that mere exposure to certain groups of older people is beneficial. Older students and those with grandparents as role models have been found to have better attitudes towards older people. Information provision Older people and their carers need to be given adequate information to enable them to make informed choices about care. The second article in this series will examine health promotion and disease prevention in old age; the third article will discuss quality in the care of older people with mental health problems; and the final article will examine physical frailty in old age, in particular the prevention and management of falls. Notes This is the first in a series of four articles Footnotes Competing interests: Not because they are old. An independent inquiry into the care of older people on acute wards in general hospital. Standards of medical care for older people. University of Utah; Turning your back on us. Help the Aged; Analysis of letters [unpublished data] 6. The views of older people on hospital care. Carers National Association; Moriarty J, Webb S. Part of their lives. Community care for older people with dementia. Attitudes towards self-determination in health care: Eur J Public Health. Rosin AJ, Sonnenblick M. Autonomy versus compulsion in the care of dependent older people. Health Care in Later Life. Royal College of Physicians; Are older people satisfied with discharge information? Doctor-patient communication about drugs: A new perspective on threatened autonomy in elderly persons: Selected quotes from letters to Help the

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Chapter 4 : Getting Older in Community - calendrierdelascience.com

Promote older people's well being at home Ensure high-quality care by involving a wide range of stakeholders â€¢ The European Charter for older people in need of.

Received Oct 15; Accepted Nov This article has been cited by other articles in PMC. Abstract Background Despite well established national and local policies championing the need to provide dignity in care for older people, there continues to be a wealth of empirical evidence documenting how we are failing to deliver this. In-depth interviews and focus groups with health and social care professionals were carried out across four NHS Trusts in England, as part of a larger study, to investigate how dignified care for older people is understood and delivered. A total of 48 health professionals took part in in-depth interviews and 33 health and social care professionals participated in one of eight focus groups. Results Health and social care professionals defined the meaning of dignified care as: This suggests that policies around providing dignified care are being interpreted as an approach towards care and not with direct care provision. This limited interpretation of dignity may be one factor contributing to the continued neglect of older people in acute settings. Dignity, Health care professionals, Social care professionals, Older people, Ageing, Care, Hands on care Background The care that older people receive has been the focus of intense public concern across the United Kingdom UK over recent years. There is a growing body of evidence suggesting that dignified care of older people being cared for is still compromised [1 â€” 13]. In February Robert Francis, Inquiry Chairman, released a report into the serious failings at the Mid Staffordshire NHS Foundation Trust, which included numerous instances of appalling care of older patients [4]. The report highlights that between and the Trust failed to tackle a dangerous negative culture involving an acceptance of poor standards and a disengagement from managerial and leadership responsibilities. Scandals such as the Mid Staffordshire report unfortunately are not uncommon. The Parliamentary and Health Service Ombudsman report [7], for example, details 10 cases of older patients who died after being admitted to NHS hospitals but who did not receive the most basic standards of care such that they were left without food or water, were soaked in urine or lying in faeces and left on the floor after falling. While we know much about dignity, it remains a complex concept, subject to a range of different interpretations [15]. A philosophical model of dignity and its relevance to older people has been advanced by Nordenfelt [16] and his comprehensive analysis divides dignity into four types including: The first three types of dignity merit, moral status and personal identity are subjective and depend upon external influences. Dignity of identity is of the most relevance to discussion of dignity and ageing. This kind of dignity can be taken away from individuals by external events, by the acts of other people as well as by illness, injury and old age [16]. Thus, no individual can be treated with less respect than anybody else with regard to basic human rights. For example, an older patient in hospital should be treated in the same way as younger patients as they have the same basic human rights. Maintaining their dignity while in hospital is of paramount importance to older people [11] and treating an individual with dignified care may positively influence both their treatment and social outcomes [17]. However, they also emphasize the fundamental and vital aspects of care such as eating, nutrition, personal hygiene and toileting [11 , 17 â€” 22]. Limited in the research literature is the professional perspective on the meaning of dignity and delivering dignity in care and, more specifically, the educational, cultural and organisational factors which enable or hinder its delivery. This is an important oversight as it is the attitudes, skills and behaviour of frontline staff via the development of organisational culture, policies and practice which is critical to the tangible delivery of policy imperatives [27]. Participants were purposefully selected to represent different occupational groups, different levels of experience and seniority and the provision of care in different settings. Participants included medical, nursing, managerial, paramedical and social work professions from a range of settings, including hospital, residential and community. Similarly, Baillie [29] also carried out a qualitative study case study design investigating patient dignity in acute hospital settings. Both patients and ward-based staff took part in the study and they

identified the following feelings as being central to the meaning of dignity: Patients expressed feeling comfortable if they felt safe, happy, relaxed, not worried, did not feel embarrassed and had a sense of wellbeing. Helping patients regain their dignity was considered to be of central importance to nurses and they reported that dignity was a value that had to do with integrity, respect and worthiness; something the older patients were at risk of losing when being hospitalised. A total of professionals described the meaning of dignified care in terms of their relationships with patients including: This paper reports findings on a key research question from in-depth interviews and focus groups of health and social care professionals which forms part of a larger case study survey, interviews and focus groups exploring how dignified care for older people is understood and delivered by health and social care professionals and; how organisational structures and policies can promote and facilitate, or hinder, the delivery of dignified care. In order to do so, we first had to understand the meaning of dignified care from a professional perspective before addressing why these were considered important. The research question that forms the specific focus of this paper is as follows: Participants for focus groups and interviews were recruited from 4 different NHS sites. Focus groups Focus groups were arranged on-site i. Two researchers were present for each focus group, one to lead the discussion and one to observe and take field notes. Prior to commencing the discussion, the researchers DK and VW or WM introduced themselves, explained the tape recording and reiterated that the discussion would remain anonymous. Once consent was received from all participants, the tape recording commenced and one of the researchers started the discussion using an interview guide. Once consent was given, the interview commenced using an interview guide. All interviews were audio-recorded with the exception of two participants who requested that the researcher DK write notes instead. The purpose of the focus groups was to understand the professional group perspectives of dignity in care for older people and the organisational context of each site i. The qualitative data were managed using NVivo10 and analysed thematically. Audio recordings focus groups and interviews were reviewed and coded to determine key themes emerging from these data in relation to our research questions for example, what does dignified care mean to you? The process of analysis was ongoing and consisted of being immersed in the data and reading through it several times. A bottom-up approach was then used to see which categories and themes arose naturally from the data, rather than having prescribed categories and trying to fit data into these. The process of coding was initially carried out by the research fellow DK. A sub-set of the interviews and focus groups were also analysed by a second researcher VW. Each theme or category was verified by searching through the data for comparisons and challenges so that the themes could be refined and all the data accounted for. Results Profile of participants We anticipated carrying out a total of 13 focus groups and 50 interviews in order to obtain a sufficient breadth and depth of information from across the four trusts. During the process of data collection and analysis we felt that, after 8 focus groups and 48 in-depth interviews, no new information was emerging and therefore saturation had been reached and no further primary data was required. Focus groups A total of 33 health and social care professionals participated in one of eight focus groups. Focus groups consisted of between 3 and 6 participants. The remaining 6 participants included roles included one each of a diverse range of roles e.

Chapter 5 : Dignity in care - Overview of selected research: Background

10 Promoting health and well-being for older people 11 Older people should be able to access social care services of the right quality in the right place and at the right time.

Contact How Neighborhoods Affect the Health and Well-Being of Older Americans Neighborhood characteristics affect people of all ages, but older adultsâ€”classified here as adults over age 50â€”may be affected more than other groups. Older people typically experience higher levels of exposure to neighborhood conditions, often having spent decades in their communities. They have more physical and mental health vulnerabilities compared with younger adults, and are more likely to rely on community resources as a source of social support. As older adults become less mobile, their effective neighborhoods may shrink over time to include only the immediate areas near their homes Glass and Balfour This report summarizes recent research conducted by National Institute on Aging-supported researchers and others who have studied the association between neighborhood characteristics and the health and well-being of older adults. This research can inform policy decisions about community resource allocation and development planning. A growing body of research shows that living in disadvantaged neighborhoodsâ€”characterized by high povertyâ€”is associated with weak social ties, problems accessing health care and other services, reduced physical activity, health problems, mobility limitations, and high stress. This area of research is challenging because lower-income people tend to live in disadvantaged neighborhoods and many detrimental neighborhood features cluster together. Disadvantaged neighborhoods often have more crime, more pollution, poorer infrastructure, and fewer health care resourcesâ€”making it difficult to pinpoint which neighborhood feature is responsible for particular health outcomes. View the related infographic Some researchers continue to focus on a single neighborhood feature and may incorrectly attribute health effects to the wrong characteristics. Others have created scales consisting of multiple features that are found together, which can mask the features that matter the most. In addition, most results are based on cross-sectional data subjects interviewed at one point in time only and may reflect people with more resources and in better health moving out of disadvantaged neighborhoods and those with fewer resources and worse health moving in or staying Grafova et al. While existing research is not yet able to pinpoint exactly how neighborhoods cause changes in physical and cognitive health, researchers have identified a number of strong associations that point to possible pathways. Neighborhood Disadvantage and Health Neighborhood economic statusâ€”often measured by median household income or the share living below the poverty lineâ€”is one of the most widely studied and strongest predictors of the health and well-being of older adults. Older residents of economically disadvantaged neighborhoods are more likely to have chronic health and mobility issues and die at younger ages compared with older residents in more affluent communities. Freedman, Grafova, and Rogowski use data from the Health and Retirement Study HRS , which follows a nationally representative group of older adults, to look at the effects of neighborhood characteristics on six common chronic diseases: They find that women living in disadvantaged neighborhoods are more likely to develop heart disease, even after controlling for individual characteristics and aspects of the physical environment such as population density, pollution, and walkability. In another study using HRS data, Grafova and colleagues find that adults ages 55 and older living in more affluent neighborhoods are less likely to be obese, after accounting for individual differences and family characteristics. Using data from the Study of Asset and Health Dynamics Among the Oldest Old AHEAD , Wight and colleagues find that adults ages 70 and older living in economically disadvantaged neighborhoods are more likely than their peers living in wealthier neighborhoods to report being in poor health. In fact, living in a disadvantaged neighborhood has a greater negative association with self-rated health status than either cardiovascular disease or functional limitations. Compared with cross-sectional studies that interview subjects at only one point in time, studies that capture neighborhood socioeconomic conditions earlier in life and track individuals over many years provide stronger evidence of whether living in a disadvantaged neighborhood is associated with poorer health

later in life. Estimates based on the Panel Study of Income Dynamics show that living in low-income neighborhoods during young adulthood is strongly associated with poor health in later life Johnson, Schoeni, and Rogowski The researchers find that one-quarter of the variation in mid-to-late-life health is linked to neighborhood disadvantage after accounting for individual and family differences. In another study, Glymour and colleagues measure neighborhood disadvantage with a six-indicator index, using HRS data that tracked respondents ages 55 to 65 over 18 years. Focusing on respondents who were disease free before the study began and statistically accounting for neighborhood change, they find that living in a disadvantaged neighborhood is associated with a greater likelihood of reporting poor self-rated health, but not disability or elevated depressive symptoms. The level of income inequality in a local area may also influence health. Using HRS data, Choi and colleagues compare health outcomes of adults ages 50 and older with similar socioeconomic profiles in high-inequality and low-inequality U. They find that older adults in counties with high levels of inequality report worse health status and more psychiatric problems than older people in low-inequality counties. Effects on Mortality Extensive research has examined the link between neighborhood characteristics and mortality, but few studies have focused on this relationship among older adults. Wight and colleagues take this line of research a step further by examining the potential impact of multiple neighborhood characteristics on the risk of death among urban adults ages 70 and older, using data from the AHEAD study. Similar to Yao and Robert, they find no link between living in a disadvantaged neighborhood and risk of mortality after accounting for individual characteristics. People living in neighborhoods with a high proportion of Hispanic residents were at increased risk of mortalityâ€”a finding contrary to expectations that immigrant enclaves protect health by providing a source of social support for older adults. Ultimately, however, this risk was not significant after accounting for neighborhood affluence. Residents of affluent urban areas may be more aware of cutting-edge health care innovations and more likely to have the financial means to take advantage of them, the researchers suggest. Effects on Disability Neighborhood conditions can also affect the likelihood of older adults having functional limitations, such as difficulty walking. Freedman and colleagues look at the relationship between neighborhood conditions and disability among adults ages 55 years and older using HRS data. They find that older adults living in economically advantaged communities are less likely to develop problems with lower-body functioning compared with older adults in economically disadvantaged areas. Living in more affluent communities may help stave off functional problems during the early stages of disability, while living in disadvantaged communities may exacerbate functional limitations during the latter stages of decline. The authors argue that older people with greater wealth may be better able to prevent disease and disability, while those with limited income may be less able to fully recuperate or to adapt their homes to accommodate their functional decline. Most researchers have focused on the effects of current neighborhood characteristics on health. But results based on this type of point-in-time approach may underestimate the effects of neighborhood characteristics on individuals over the life course. Clarke and colleagues use data from the ACL study to investigate the cumulative effects of neighborhood characteristics on functional decline among adults ages 25 and older over a year period. Although the study focuses on adults of all ages, older adults may face higher risks because they are more likely to live in disadvantaged neighborhoods and are much more likely than younger adults to die or experience functional limitations over time. They link high levels of self-reported stress regarding personal safety to shorter telomeres and high levels of neighborhood satisfaction to longer telomeres. King, Morenoff, and House find that neighborhood affluence is associated with fewer biological risk factors for chronic disease such as high blood pressure and elevated cholesterol levels after adjusting for individual-level social and economic background, using data from the Chicago Community Adult Health Study CCAHS on adults of all ages. Also using the CCAHS, King links neighborhood walkability to lower concentrations of C-reactive protein CRP in adults of all agesâ€”a protein linked to inflammation, infection, and developing tissue damage and heart disease. But the same study links neighborhood density a neighborhood feature sometimes related to walkability to an increase in CRP, suggesting that aspects of densely populated neighborhoodsâ€”such as sleep-disturbing noise and

pollutionâ€”may take a toll on health over time. Effects on Cognitive Decline Clarke and colleagues show that living in an affluent community has a positive impact on the cognitive function of residents, after accounting for individual background, health, and risk factors. For the study, they use data from the Chicago Health and Aging Project CHAP , which surveyed a racially diverse group of more than 6, adults ages 65 and older over 18 years in three adjacent Chicago neighborhoods. Aneshensel and colleagues find similar results when they link HRS responses with census data on neighborhood characteristics. Their findings show that living among more advantaged neighbors is associated with higher levels of cognitive function among people ages 55 to 65 with low education and income levels. Conversely, they find that older people with low socioeconomic status living in impoverished neighborhoods face the highest risk of poor cognitive function. Certain neighborhoods that are less accessible are particularly challenging for older adults with disabilities. Tomey and colleagues find that neighborhood levels of sociability and walkability are positively linked to self-rated health among adults ages 45 to 84 in the Multi-Ethnic Study of Atherosclerosis MESA. Neighborhood walkability, as measured through street connectivityâ€”a higher number of intersections and fewer dead-end streets or cul-de-sacsâ€”has also been linked to a lower risk of self-reported disabilities and lower obesity rates Freedman et al. The condition of neighborhood streets and sidewalks can make a big difference in the mobility of adults who have difficulty walking, according to Clarke and colleagues Adults with severe impairments are four times more likely to report a mobility disability if they live in neighborhoods with numerous cracks, potholes, or broken curbs in streets and sidewalks, according to their analysis of the cross-sectional CCAHS. The researchers suggest that if street quality could be improved, adults at greatest risk for disability could remain mobile and function independently for a longer period of time. In a subsequent analysis using data from the ACL study, Clarke, Ailshire, and Lantz find that adults ages 75 and older living in compact neighborhoods with more accommodations for pedestrians are less likely, over a year period, to report a mobility disability compared with those living in neighborhoods that are less pedestrian-friendly. Among older adults with disabilities, well-designed neighborhoods can enhance outdoor activity. Older adults may be more likely to walk outside in pedestrian-friendly neighborhoods that they perceive as safe. For example, Satariano and colleagues find that older adults living in less compact residential areasâ€”such as sprawling suburban neighborhoodsâ€”spend less time walking per week compared with those living in mixed-use or commercial areas. The authors argue that more compact communities may provide more walking destinations for older adults. However, compact neighborhoods are not associated with walking among those with poor functional capacity, who may perceive these areas as being less safe. Similarly, Clarke and Gallagher find that older adults living in more accessible neighborhoods are more likely to walk outside in a typical week compared with those in less-accessible neighborhoods. Their study investigates the relationship between the built environment and mobility disability among adults ages 55 and older in Michigan. Additionally, a study by Gallagher, Clarke, and Gretebeck shows that poor sidewalk design and perception of crime are associated with shorter walks. Neighborhood Physical Environment and Cognitive Function The stress of living in disorderly neighborhoods measured by the presence of trash, vandalism, safety problems, and broken curbs and sidewalks appears to take a toll on the cognitive functioning of residents, according to Boardman and colleagues Using CHAP data, they showed that older adults who carry the APOE-E4 gene have lower levels of cognitive function that decline more rapidly over time than those without the gene. But they demonstrate that the gene has the largest impact on the cognitive function of carriers who live in the most orderly neighborhoods, suggesting that when negative social conditions are eliminated, the genetic influence on cognitive function becomes more apparent. After taking into account individual background and health conditions, Clarke and colleagues use CHAP data to show that older people living in neighborhoods with community centers, accessible public transit, and well-maintained public spaces such as sidewalks tend to experience slower cognitive decline than similar adults whose neighborhoods lack these features. Inhaling small particles can damage organs, including the brain. Those living in areas with high concentrations of fine particulate matter pollution made 50 percent more errors than those exposed to lower air pollution levels. In a

similar study using HRS data, Ailshire and Crimmins also find a link between fine particulate matter air pollution and cognition, particularly episodic memory. Neighborhood Food Environment and Health Neighborhood characteristics can also affect health by influencing the food residents eat. Kaiser and colleagues find that MESA participants who live in neighborhoods with healthier food environmentsâ€”greater access to fruits and vegetables and to low fat foodsâ€”have a lower risk of developing high blood pressure. For example, Morgenstern and colleagues document that living in a neighborhood with a higher density of fast food restaurants is associated with an increased risk of ischemic stroke among participants in the Brain Attack Surveillance in Corpus Christi BASIC project. Using HRS data, Latham and Clarke find that older adults in neighborhoods perceived as safe are more likely to recover from a mobility limitation. The social environment also plays a role in recovery: Older adults who socialize with their neighbors are most likely to partially or fully recover from a severe mobility limitation Latham, Clarke, and Pavela Those least likely to recover include women who have no neighborhood friends. However, older adults living in the same neighborhood as relatives are less likely to recover from a mobility limitation. Neighborhood safety is related to physical activity levels of older people of all socioeconomic backgrounds, report Tucker-Seeley and colleagues based on HRS data. Older people who perceive their neighborhoods as safe are more likely to engage in outdoor physical activity than those who consider their neighborhoods unsafe. The researchers suggest that programs designed to promote physical activity among older people should consider neighborhood safety concerns as potential barriers to participation. Subramanian, Elwert, and Christakis find that widowed men and women living in neighborhoods with high concentrations of older adults who have lost a spouse are less likely to die than those in neighborhoods with low concentrations. Data from the HRS show that residents of highly segregated Hispanic neighborhoods have higher levels of cognitive function Kovalchik et al. But over time, individuals living in neighborhoods with high concentrations of Hispanics are more likely to experience rapid cognitive decline than people living in more integrated settings. Osypuk and colleagues study Hispanics living in neighborhoods with high concentrations of Latin American-born immigrants and find low levels of high-fat foods in their diets but also low levels of physical activity. Using HRS data, Grafova and colleagues also find that older men living in immigrant enclaves are more likely to be obese. In another study using HRS data, Sudano and colleagues find that living in racially segregated neighborhoods those with high shares of minorities is linked to poor health largely because the older residents in these communities have less education, higher poverty rates, and lower levels of net worth compared with older adults in less segregated communities. Kershaw and colleagues document that segregation affects cardiovascular risk differently for whites and for racial minorities. They find that living in highly segregated black neighborhoods is linked to a higher risk of cardiovascular disease CVD among black MESA participants followed over 10 years. Conclusions Research on the ways neighborhood settings affect health, like all epidemiological research, allows researchers to describe risk factors and associations but not to estimate direct cause and effect. Nevertheless, the strong patterns identified by this research can help policymakers and planners design new health-promoting policies and better target intervention programs. The potential negative effects of living in disadvantaged neighborhoods for the physical and mental health of older adults point to the need for neighborhood improvements that expand the quantity, quality, and accessibility of community resources such as parks, libraries, and community centers and enhance walkability and safety. For others in more affluent communities, policies should help older adults age in place so that they can live independently longer, avoiding or postponing the need for costly long-term care. Some of the results suggest that different interventions may be needed for men versus women. For example, women are more likely to take long walksâ€”an excellent way to maintain physical fitnessâ€”if they have a particular destination, while men are more likely to take walks in pedestrian-friendly communities.

Chapter 6 : Care and support for older people and carers in Bradford | JRF

The notion of care is understood as "caring about" and is seen to be a key indicator of dignity. Moreover, both care and dignity were understood and, for many of the participants, were both conceptualised on a personal basis and shaped by a sense of identity that was, in part and to varying extents, communally m.

Albert The home environment is critical for maintaining health and well-being among the medically ill and people living with disabilities. Access to appropriate supportive care technologies and home health care services depends in part on where homes are located, what sorts of spaces are available for care in the home, and whether basic services such as utilities are reliable. These aspects of home environments are difficult to measure, even when features of homes are narrowly defined and only a single attribute, such as safety, is considered Gitlin, Measurement challenges become more complex when considering that each of these environmental features also has a cultural or social component. Homes are located in neighborhoods, where home health care providers may not feel welcome or safe because of crime in a low-income neighborhood and discrimination or suspicion in a higher income one. Homes differ in their spaces available for care but also in the willingness of families to make these spaces available, adapt them as needed, and work with home health staff to provide care. Also, utilities, telephone service, and access to services differ by community, with some communities well serviced and others shortchanged. Thus, the home environment is nested in social and cultural layers that may lead to different home care outcomes, even with similar patients and common home environments Barris et al. The cultural component is immediately visible in family adaptation to home care. Families differ in the degree to which they reorganize themselves and their living spaces to accommodate care for the disabled or medically unstable Albert, , with different tolerance for disorder and different strategies for reducing such disorder Rubinstein, Page Share Cite Suggested Citation: The National Academies Press. For some families, hospice and death in the home is unthinkable or perhaps not possible if home hospice services are unavailable. For other families, hospice and death in the home is the preferred outcome. The same may apply to other medical technologies, such as home infusion technologies, or to different types of care, such as managing the demented or incontinent patient at home. In this sense, cultural, social, and community environments must also be considered as human or ergonomic factors relevant to the adoption and successful use of home care technologies. Consider one model of technology adoption that has been applied to the use of consumer health information technology, the patient technology acceptance model Or et al. In this approach, key determinants of acceptance of Internet monitoring of health status among patients with cardiac disease included perceived usefulness of the technology performance expectancy , perceived ease of use effort expectancy , and the perceived sense that others would use such a technology in similar circumstances subjective norm. Each of these determinants has a cultural, social, or community component. Perceived ease of use depends on social support from families, whether families will help maintain technologies, and how receptive they are to instruction from home health care providers. Finally, subjective norms involve social influence and clearly depend on the kinds of social contact families have, where they live, and how insular they are in culture or language. The significance of this dimension of home care should not be underrated. One middle-aged African American caregiver followed in our research had adapted her home to accommodate advanced dementia care of her mother. The hospital bed was centrally placed in the living room. She had attached a crib mobile to the bed and replaced its objects with photographs of family members and other keepsakes important to her mother. A commode was placed near the bed, and she herself slept in an adjacent room to monitor her mother at night. The bookcases and closet served as storage spaces for medical supplies and adult diapers. Guests who visited had to pass by the elder as they entered the house and were expected to engage her in conversation. This kind of variation suggests a need to consider the full spectrum of social-ecological factors in home care. The social-ecological approach considers the interplay among individual factors, social relationships, and community environments McElroy et al. Visually, it can be

imagined as a series of concentric circles, with the individual in the smallest circle at the center. Progressively expanding circles radiate outward that first include social relationships and then community environments. Beyond the community sphere is a larger circle encompassing public policies and laws that regulate provision of home care. The value of this approach is its ability to show how actions in one domain depend on, or may influence, actions in another domain; thus, changes in the individual domain may depend on changes in family or social relationships. More particularly, how families think about the meaning of a home or household may affect decisions to bring certain medical technologies or services into the home. To examine the effect of cultural, social, and community environments on home care, I begin with a brief treatment of the social-ecological model as it applies to these home care environments. I focus particularly on culture as it may be relevant to home care, the least studied of these elements. The model stresses cross-level influences, in which community or organizational environments can shape individual behavior top-down effects , but also examines how individuals form groups or take actions that may affect higher level organizational or community spheres bottom-up effects. The Centers for Disease Control and Prevention has incorporated social-ecological models into a number of its health promotion and disease prevention efforts. The simple onion or Russian doll rendering of social-ecological relations as concentric circles is not in itself very informative. However, flowchart models based on such relationships can be useful for specifying hypothesized cross-level influences. One such flow diagram for decisions to adapt homes for advanced medical technology is shown in Figure The figure shows the four levels mentioned earlier: At each level, the relevant agent faces a challenge. Adaptation of homes for advanced medical technologies. At the level of the family and social relations, the challenge is potential disruption of family relations and reconciling the demands of home care with the needs of other family members. At the level of the community, the challenge is the availability of home health care providers for a neighborhood. The policy level includes constraints on home care involving program eligibility and insurance. Each of these challenges is addressed by resources or ineffectively managed because of particular obstacles specific to that level of social ecology. At the level of family social relations, family consensus, a supportive division of labor, and appropriate information gathering respond to the challenge of potential disruption of family relations. Similarly, community factors, such as neighborhood resources to support medical technology in homes, may lessen the impact of low availability of home health care agency services. Thus, family consensus, a supportive division of labor, and appropriate information gathering at the level of social relations may support individual cultural expectations about home care. These in turn will support cultural expectations for adapting homes to provide care. Few studies have examined the full range of determinants of home care specified in the social-ecological framework. Most studies cover only a few of the levels or paths linking levels. I turn now to features of each level in the social-ecological model relevant to home care. Consider the idea of partnership between families and nurses sought by home health care agencies. Similar effects of culture may be evident in the willingness of families to accept telehealth technology, express their degree of burden or need for help, or seek hospice care at the end of life. Culture leads people to categorize and assign meanings, expect certain behaviors, and act in particular ways. A simple example can be seen in ideas about gender and height. Americans for the most part prefer that husbands be taller than wives. People notice when this expectation is violated. Some may even make this a consideration in the choice of a spouse. This gendered approach to height may reflect other asymmetries between men and women, such as disparities in wages. While the strength of this cultural expectation may be waning and may vary across groups defined by socioeconomic status , it gives a feel for the subtle but powerful influence of culture. How do people identify these cultural expectations, and how might they be relevant for decisions about home care? Essentially, this approach extends investigation of folk taxonomies e. Early on, in such an investigation I conducted for caregiver tasks, I determined that caregivers distinguished among emotional, cognitive, and physical disability support Albert, More recently, the same technique has been used to elicit expectations regarding more abstract cultural domains, such as what makes success in life, leisure activity, social support, and family relationships Dressler et al. For the latter, Dressler and colleagues asked a sample of

Brazilians to list the goods or possessions people need to lead a good life, or the activities people typically engage in during their free time, or who they typically turn to for different kinds of support and subjected these lists to formal analysis designed to examine the degree of consensus across respondents. Notably, people whose lists or ratings were not consonant with the dominant cultural pattern were more likely to have poorer mental and physical health and even higher blood pressure. In the cultural domain of home care, it would be valuable to conduct a similar investigation. Some potential elicitation frames might include the following: What changes in your home would be appropriate when a family member is seriously ill and may die? What changes in your household would you need to make in order to provide quality care for a family member receiving home health care services? What aspects of a home make it hard or easy for a home health care worker to do his or her job? Family members with experience of home care would be likely to generate a long list of answers to the first elicitation, which might include hospice services, infusion technologies, a hospital bed, a commode, smart home telemonitoring, more reliable telephone or utility service, modifications to the home to increase access, a place to store medical supplies, a separate place for visitors or other family members, and perhaps others. Some caregivers would produce shorter lists, some longer, but it is likely that a single cultural consensus would emerge. This elicitation would allow a first look at the cultural domain of home care. A reasonable hypothesis would involve less efficient decision making and perhaps poorer outcomes for patients by caregivers who do not express the consensus view. This approach to culture does not involve differences among ethnicities or people who speak different languages but rather the operation of culture in Page Share Cite Suggested Citation: Family caregivers and health care professionals in a single culture may differ in expectations for care or home accommodation, but these differences may be less salient than cross-cultural differences associated with ethnicity, race, country, or language. A growing body of research suggests that expectations regarding care differ across cultures Sommer et al. For example, cultures differ in the degree to which pain, limitation in activity, or cognitive impairment is considered an appropriate cause for medical intervention. In the United States, minorities are less likely to use skilled nursing facilities and perhaps more likely to tolerate dementia and old-age disability at home Hinton and Levkoff, ; Whitehouse et al. The elicitation of home care culture described above can be used to identify subcultures and also differences across cultures. We turn now to some cross-cultural differences identified for expectations of home care. Commitment to Family Care Ethnic and cultural groups differ in their commitment to family care. African Americans are more likely than whites to endorse the primacy of family care Dilworth-Anderson et al. Similarly, Latinos delay institutionalization relative to whites; a higher cultural value assigned to family care leads to more positive views of family caregiving, which in turn leads to a negative evaluation of skilled nursing facilities as an option for dementia or end-of-life care Mausbach et al. Differences in commitment to family care are based on cultural norms of filial piety or obligation. The concept of xiao, or filial piety, is a well-developed element in Chinese culture. However, it is strongly gendered, so that the burden of such care falls on adult daughters or daughters-in-law, not sons Zhan, Norms of filial obligation are heavily influenced by education, with greater acceptability and use of skilled nursing home care evident among more highly educated people. As minorities advance through the educational and occupational ladders, these differences in recourse to skilled care may lessen. Little information is available for differences among cultural groups in receptivity to home adaptation. Given differences in recourse to institutional placement, as described earlier, cultures with a strong bias toward home care may be more receptive to adaptation of homes to accommodate medical technologies. However, these households may face other social or community constraints that make it difficult to deliver such technologies. I return to these points below.

Chapter 7 : Research on Aging: How Neighborhoods Affect the Health and Well-Being

Background. Despite well established national and local policies championing the need to provide dignity in care for older people, there continues to be a wealth of empirical evidence documenting how we are failing to deliver this.

Methods for upholding dignity are usually small, seemingly inconsequential things, but to a person who has resigned the majority of their independence to a stranger, they mean the world. Let people choose their own clothing. People have a strong sense of what style of clothing suits their personality and personal preferences, so to denying them the ability to choose is harmful to their dignity. With their approval you can help them dress, but let them pick what to wear. This includes the physical act of choosing. Give them time to select their own from the wardrobe. Involve them in decisions relating to their care. People appreciate being included as it gives them the sense that their opinion and preferences are respected. Therefore, be sure to involve them in any and all discussions that affect their care. This includes decisions about their medication e. Address the person properly. Therefore, making assumptions about which title or name a person would like to be addressed by â€" even if you think your assumption is the polite choice â€" is disrespectful to their identity, which in turn damages dignity. This is particularly important for the elderly, many of whom have certain expectations about how people should refer to them. Make food look and taste nice. For people in care â€" as for many people â€" mealtimes are the highlight of the day. Nothing is more disheartening than having a lousy lunch. Imagine being presented with an unappetising plate of food â€" both in terms of look and taste â€" every day for weeks, months, maybe even years on end. As mentioned earlier, involve people when creating meal plans â€" they can offer suggestions, including their favourite dishes. Make sure kitchen staff are skilled at cooking, receive fresh, quality ingredients, and make the effort to ensure food is well-presented. Respect personal space and possessions. You are caregiver and care resident, not mother and child. The simple act of asking makes people feel respected and more open to giving you permission, and instils trust. Handle hygiene activities sensitively. Understand that they will be self-conscious and very self-aware when undressed. Above all, you must ask for consent before you engage in any activities involving their body. Being in a care home can leave a person feeling shut off from the outside world. Particularly for those who have an extroverted personality, this can be extremely stifling and damaging to their identity and dignity. They may end up feeling like they are simply a task for caregivers to complete; like a burden. Having a social life instils them with a sense of purpose and satisfaction, thus improving their quality of life. So you should take it upon yourself to create opportunities for people in your care to engage in social activities, whether it be inside or outside the premises. Contact with family, eating out with friends, or getting involved in local groups are all good examples. Also, encourage them to adopt hobbies and provide them with the means and equipment to do so, such as knitting or art supplies. Know how to detect pain. Treating pain in care homes can be tricky. Older people are more likely to experience pain but less likely to complain or want medication. This combination can leave the elderly in a great deal of pain which will distract them and hinder their ability to enjoy the remainder of their life. Ideally you will be educated on how to identify signs of pain without being told. Restlessness, social isolation, and avoidance are just a few examples. Detecting pain is easier if the person is seen by the same caregiver regularly, since trends and changes in behaviour will be more apparent. Have a friendly chat. Your life as a caregiver probably feels very hectic, especially if you have to run back and forth between several people a day. But for a person in care, it could be quite boring or uneventful. A five or ten minute chat will fulfil their craving for social interaction and lift their spirits. Really listen and interact with them; show interest in what they have to share. And be sure to do so.

Chapter 8 : Table of contents for Going local

Background. Dignity has become a central concern in UK health policy in relation to older and vulnerable people. The empirical and theoretical literature relating to dignity is extensive and as likely to confound and confuse as to clarify the meaning of dignity for nurses in practice.

Legacy Project Community should celebrate and accommodate all ages By the year , 1 in every 5 Americans will be over We tend to have a pretty dismal image of older age in our society: The myth of aging is everywhere. The myth of aging is a powerful, destructive one that profoundly affects the community we create and the extent to which we involve the old in it. You can find many media items about the assistance â€" the "help," well-intentioned but often patronizing â€" the young give older adults. Boomers Can Prompt Change The fact is that older adults today, the Boomers, are better educated, healthier, and more financially secure than any other previous generation. Keeping older people involved in their community can substantially reduce the anticipated drain on financial, health care, and housing resources associated with an aging population. A key issue in aging is social integration, the extent to which a person is actively connected and engaged with their family and community. Cross-cultural evidence shows that older adults are able to maintain a fairly high level of physical and emotional well-being when they have something considered valuable by others in their society, whether it be customs, skills, knowledge, or economic resources. Meaning has to do with feeling that your life still matters to yourself, at the very least and that what you do makes sense. It has to do with the conviction that your life is about something more than simply surviving. Volunteer activities, for example, have been found to bring new meaning to the lives of men and women at midlife and beyond by allowing them not only to perform useful services but also to function as mentors for those who are younger. Older adults can also participate by helping to care for the young, like their grandchildren, and continuing to be involved in paid labor. But what about older adults with serious health problems, frail older adults, and the oldest old? The life issues faced by older adults who are well include living with loss, a need for meaningful activities, and the desire to be useful members of society and not be isolated. Frail and functionally limited older adults have the same needs, but require some special consideration for losses of physical strength and perhaps cognitive ability. In recent years, researchers have divided older adulthood into three general groups: This age group is growing faster than any other segment of the population. The oldest old have the highest potential for functional disabilities. Aging in Place Research tells us the vast majority of older adults want to "age in place," remaining in their own home â€" even if that home is no longer a comfortable place to live. As many as 8 out of 10 Boomers want to stay in their home for as long as possible. We humans develop "place attachment," a socioculturally mediated emotional connection to a particular physical location. In the face of instability and physical changes, illness, and other losses, we engage in an ongoing effort to create and preserve meaning through place-centered activity. We give meaning to places like our home, and our home in turn shapes the meaning available to us as we age. Environments not only place demands on individuals, but they also provide opportunities for growth and adaptation. For example, being in a multigenerational environment with family or friends can foster better functioning, whereas helplessness-inducing contexts like a nursing home have the opposite effect. What makes a good place to grow old? A community that promotes the physical and psychological well-being of community members throughout the life course. Answering Psychosocial Needs Major systems, such as housing and transportation, should be responsive to the changing needs and capabilities of residents as they get older. The community should also provide opportunities for fulfillment with regard to five major psychosocial developmental tasks of later life, as identified by researcher Andrew Scharlach Generations, journal of the American Society on Aging, Summer, Continuity â€" individuals are able to maintain lifelong relationships, activities, and interests even as they get older and may experience more limitations. Compensation â€" services and products exist to ensure that basic health and social needs of individuals with increasing limitations are met. Connection â€" relationships become more

important as we age. Individuals who have more actual and potential sources of social support have better physical and psychological well-being, and greater resilience in response to illness and other life stressors. Contribution â€" opportunities to develop and contribute life wisdom. We need to feel as though our life still has value, that we can add something to the world around us â€" if only a smile or hug. Challenge â€" the need for stimulation and growth remains important through the life course. As people search for a "good" place to grow old, they are imagining more varied options. For example, transgenerational design is getting more attention. Many homes need to be retrofitted to accommodate functional limitations. New homes should be designed for the entire life course, not just for the young. Aging in Community "Aging in community" has become a broader vision of aging in place. More and more of us live alone, without close family members living nearby. The need and the desire to come together with others who are approaching older adulthood is growing. People are making plans to buy a house and live together to take care of each other â€" intentional communal living. Variations include senior cohousing, shared households, and cooperative urban villages. The village concept has older adults in a community banding together and paying a monthly fee to obtain services that allow them to remain in their existing home. Remaining in their life-long home preserves neighborhood-based social relationships. It allows older people to stay connected with their community. Yet, to remain connected to their community, they need the support of their community. They need adequate healthcare. For many people growing old is defined by, and is a process of adapting to, declines in physical health. Once their health is adversely affected and a person is unable to receive adequate care, a rapid decline often follows. After healthcare, daily living supports are important. Even the oldest old can function to their maximum capabilities when the environment provides the context and supports consistent with their abilities. This includes help with items like transportation, home repairs, housework, meals, and personal care activities like bathing. Finding the needed services and paying for them are critical issues for most of the oldest old. When spouses or children are unable or unwilling to provide support, the oldest old look to neighbors and friends. The village concept formalizes the definition of a "neighbor" so that residents can call a single number to tap into the resources in the community and get whatever help they need. When it is possible to live with family, multigenerational living often answers needs for all generations. A century ago, children, parents, and grandparents commonly shared homes out of economic necessity. As Western society became more affluent and our cultural values shifted toward independence over connection, multigenerational habitation became less common. We lost children learning from their elders, parents getting the physical and emotional support of their parents, and elders feeling useful and connected to their families. We also lost the opportunity to use the family as a testing-ground for one of the biggest human challenges we face: Multigenerational living can also address the economic realities facing many families today; living together is cheaper than living apart. Many of the negatives associated with multigenerational co-habitation, like a loss of privacy and independence, are often the fault of poor design. Good multigenerational design supports the positives of living together and minimizes the negatives. Aging in Intergenerational Community Even though options like retirement communities offer community living with some supports, they are age-segregated. I live in a gated seniors community with all the amenities one could dream of â€" workshops, handicrafts, exercise. You name it, we have it. And yet I am longing, longing to walk to the corner coffee shop, to hear the sound of children playing, dogs barking. I want to see young people in love, watch mothers with their children in the park, young families, teens in the latest wild outfits. But I am excluded from the mainstream of life. I am not elderly and never will be; my mother never was and she died at We want to belong, not only to each other, with whom we may have only one common denominator, age, but to society in general. Segregation by race has come to an end. Now we can put an end to segregation by age. We need each other at every age. So many parents and grandparents just want to be with their children and grandchildren, to be a daily part of their lives. A morning hello, snippets of conversation and banter throughout the day, a hug before you head off to sleep, those are the things that make a day rich and comforting, especially as you face your own physical and emotional losses. The little things keep you connected to the spirit of life. We need homes and communities that are

multigenerational. They cannot be fragmented, with youths, adults, and elders going their separate ways. Rather, they should be age-inclusive, with different generations recognizing â€" and acting upon â€" their mutual interests in building family and community. They should also be intergenerational, with intentional opportunities for meaningful interaction between generations. Sometimes help is available, but older adults are hesitant to accept it. She had heart problems, breathing problems, you name it, just like I do now. And look at me! I want to stand on my own two feet. The other day, I let my granddaughter do a wash for me. You should have seen her face, so proud to be helping her grandma. I know this is the way it should be. For many of the oldest old, there may come a point where no amount of help allows them to remain in their own home. An assisted living facility or nursing home has traditionally been the next step. There are real questions about the long-term viability of traditional assisted living and nursing homes. Many of these facilities are old and in need of major renovations. More importantly, they are not providing the type of sanctuary that frail elders need in the last months or years of their lives. We approach nursing homes much the same way we approach schools: Nursing home residents, like children, are often isolated from their communities because of age and capabilities.

Chapter 9 : How our residential aged-care system doesn't care about older people's emotional needs

Working in communities and neighbourhoods dignity and well-being for older people Communities that care: dignity and well-being for older.

Findings from this study Shared expectations about service provision This study identified seven common expectations among participants when they received help from professional care providers: To get some help with everyday tasks which they find difficult due to their age. To establish a caring relationship in which the recipients do not simply have a passive role. They wanted their personal history and current needs to be heard, and responded to. To receive a flexible package of services tailored to their personal circumstances, needs and preferences and not decided by service providers on the basis of service priorities. To receive help that meets their high expectations of good practice i. To receive more information, preferably from a local source, on support and care they may be entitled to. To be able to receive care and support from care staff or neighbours from their own community, when this is preferred. Not to have to pay for service provision, particularly when older people are just above the threshold of having to pay and when the service is considered to be minimal or redundant. Older people resented being forced to draw on their life savings to pay for services. These expectations were common to people from all the ethnic groups interviewed. A major effort is needed by formal care providers to understand the personal experiences of older people. This understanding is relevant for two reasons: Common experiences of service provision For many participants, paying for help through the adult services department was a financial burden. They resented drawing from their savings to pay for services because they wished to leave their life savings to their families. Many participants reported very long waiting lists for ramps and stair lifts. Lack of information about the progress of their assessments led to frustration, and for many having to follow up needed and expected services and information was an added burden. Participants thought that, in recent years, the quality and extent of available services had become poorer. Social services do far less than they did twenty years ago. They would clean houses, they would do washing; they will not do those kind of jobs now. They help people get up from a chair, not lift them, because of health and safety. Polish female carer, 54, living with husband and disabled mother Some participants reported episodes in which they or others had been discharged from hospital late at night to empty houses, without a previous check as to whether there were support networks e. Participants also described experiences of poor coordination between different service providers, which were a source of major frustration and disappointment. Participants described how they had often missed out on services and entitlements through lack of information and follow-up communication. Many were not clear about whether they were eligible for services such as the local Access Bus, free TV licence, housing adaptations or Carers Allowance. Older people and their carers said they needed more help or time to think through the services they were offered, as they took longer to process complex and large amounts of information. They said they needed to be given information at different points in time, not just immediately after a health crisis as they often underestimated the impact on their life at this point. They also preferred to receive information at local places such as doctor surgeries. Older people and carers gave examples of ageist attitudes and assumptions about ethnic communities among GPs, in hospitals, and in care homes. BME older people did not expect care staff to replicate all behaviours relating to their cultural or religious beliefs, but did want respect and dignity. Specific needs and expectations about service provision Older people caring for non self-sufficient adults with learning difficulties felt strongly that a protocol was needed to take care of such dependent adults in case their only carer was taken away by ambulance and hospitalised. Those from minority ethnic communities expressed preference for a diet based on their own national food. Some older people experienced major financial constraints. This was particularly stressed by Bangladeshi older people. These study participants experienced poverty after their retirement and expressed frustration about not being able to receive help or information from services on this matter. Importance of emotional needs The study participants shared common views

about the importance of emotional needs, particularly communication and trust, to establish effective and lasting caring relationships. In addition, specific sub-groups of older people, such as widowed women and men, presented specific emotional needs beyond communication and trust. However, for older people of minority ethnic backgrounds who were not fluent in or could not speak English, communication also meant the removal of language barriers. Trust took time to develop, but could be facilitated if there was a previous connection between the older person and care staff. These connections did not necessarily imply a common ethnic background between care staff and the older person. Another strong theme was loneliness and social isolation, often aggravated by physical health problems. The wish to be able to get out and about was common. Older people living alone with no family nearby worried about becoming unwell if no one was available to help them. Conclusions This study identified a number of key messages for services to consider: Older people and carers share common expectations, regardless of their ethnic and cultural background, about the quality and equity of services. Older people have a common desire to retain their independence for as long as possible and not be a burden to others. Older people also have individual expectations, aspirations and desires based on their life experiences, cultural, religious and ethnic background. Older people and carers are concerned about the availability of help for older people who live alone, if they become unwell. Good communication should develop trust, ensure that information is timely and understood, and enable older people and carers to have control over their care packages. Older people need more time to process complex information about service entitlements and benefits. Many carers and older people miss out on benefits and services they would be entitled to because of the complexity of accessing them. City, Manningham, Little Horton and Shipley. The project explored the views of older people and their carers from ten ethnic communities within Bradford: The study had two distinct stages: The data collection was based on 21 focus groups with older people and 33 carers, followed by 53 interviews with 38 older people and 15 carers. The study participants were recruited through gate keepers at local community centres, where all the interviews were carried out. Sixteen interpreters were involved to assist study participants who were not fluent in or did not speak English. Downloads Downloads Findings Care and support for older people and carers in Bradford: