

3. THE EFFECTS OF AGEING

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3.2 Introduction

- 3.2.1** Throughout life changes to body tissues and organs are occurring which are not due to disease but are part of the normal ageing process. An example of one of the earliest obvious changes is the need for reading glasses in mid-life; as a result of age, changes occur within the lens of the eye so that the lens is less able to focus on near objects. As age increases, other changes gradually becomes more obvious. These may include difficulty hearing in a crowded room, change in gait, which becomes wider based with smaller steps and more unsteady, and difficulties in passing urine, for men, due to enlargement of a gland situated near the neck of the bladder (prostate gland).
- 3.2.2** Ageing changes alone may result in increased care or mobility needs. Disability which in a younger person would be of a minor nature, can become very significant in the presence of changes due to ageing. Ageing changes occur in bones and joints, and may result in osteoporosis (thinning of the bones) and osteoarthritis. Muscle power and strength are generally reduced. An important change which occurs with increasing age is a change in gait and balance. Elderly people tend to walk with short, shuffling steps, with less tendency to swing their arms
- 3.2.3** Hearing and vision decline with age. Many elderly people with hearing impairment have difficulty in understanding speech in noisy surroundings, or when speech is less distinct or delivered a little faster than usual. Glaucoma and cataracts occur more commonly in older people, and may impair vision.
- 3.2.4** Mental changes occur with increasing age. Elderly people have a slower reaction time and may be slow to grasp new ideas. They may have difficulty in remembering new information, ie impairment of short-term memory, making them appear forgetful.

- 3.2.5** Older people are also more likely than younger people to be affected by more than one disabling condition at a time, and the interaction of the various conditions will have to be taken into account in considering their care and/or mobility needs [See also Chapter 2.]. For example, the effects of congestive heart failure, for which the treatment is water tablets (diuretics), are much greater on someone who suffers from incontinence of urine; long-standing rheumatoid arthritis may be combined with peripheral vascular disease which may lead to a lower limb pain or amputation and causes much greater mobility problems than would either condition alone; poor sight and poor hearing are a common and very disabling combination.
- 3.2.6** The effects of ageing on a person who already has an existing disability can be greater than would normally be the case in a younger person. For example, arthritic changes due to age in the shoulders of a wheelchair user may cause a significant reduction in mobility and general independence.

3.3 Falling

- 3.3.1** Elderly people are more prone than younger ones to unpredictable, unexpected falls. The risk of falling increases with advancing age. Some falls are due purely to external factors such as loose floor rugs or uneven pavements. Such falls are unlikely to recur once the cause has been dealt with. Other falls are associated with risk factors (see below) affecting posture and balance; falls due to such factors are likely to recur. As the older person's reaction time and reflexes are slower, older people may be less able to save themselves when they trip.
- 3.3.2** There are many possible risk factors associated with falls. Each factor may be trivial in itself, but they are often found in combination; the more factors present, the greater the risk of falls. These factors may be identifiable physical or mental impairments. They may include disorders of the lower limbs such as osteoarthritis of the knees or problems with the feet, abnormalities of balance or gait, weakness of the limbs due to a stroke, or dementia. Other factors may not be readily classifiable as specific disease entities, but are general results of ageing. These may include impaired vision, generalised muscle weakness, and changes in the control of balance and posture leading to increasing difficulty in staying upright if challenged, eg if they encounter a loose mat, unlit stairs or uneven pavement.
- 3.3.3** The effects of medication can also put elderly people at risk. Sedative drugs, such as sleeping pills, are particularly important. Anti-depressants and sedatives may slow the reaction time and thus may prevent the older person from responding quickly or appropriately. Drugs which lower the

blood pressure, either intentionally, eg medication for high blood pressure, or as a side effect, eg water tablets (diuretics), may cause a fall in blood pressure on standing, making the elderly person feel dizzy, and falls may result.

- 3.3.4** Many elderly people have a significant number of these factors present, thus placing them at considerable risk of falls.
- 3.3.5** A fall affecting an elderly person is often more serious than a similar fall in a younger person. One in ten of all admissions to a department of geriatric medicine is as a direct result of a fall. Reaction time is slower in elderly people so they have less chance of breaking their fall, eg by putting out a hand, in such a way as to minimise injury. Bones become more brittle with age, so there is a much greater risk of fractures, particularly of the hip, pelvis, backbone (vertebrae), ribs, wrist, and upper arm. Bones are softer, due to the ageing change of osteoporosis and this also may result in fractures. It may take longer to recover from bruising and damage to joints. Loss of confidence occurs easily and it may take time for an elderly person to recover, putting their independence in jeopardy in the meantime.
- 3.3.6** An elderly person may have difficulty getting up after a fall. This may result in the person lying on the floor for a long period, and being at risk of hypothermia or dehydration, and delay in treating any injuries if help is not at hand.
- 3.3.7** Very elderly, frail people are generally at risk of unpredictable falls with possible serious consequences. If there are also identifiable specific risk factors, the danger of frequent falls increases still further. The risk increases with advancing age, as does the likelihood of a person needing help to get up after a fall.

3.4 Continence

- 3.4.1** Many elderly people have problems with disturbances of urinary function. They have to empty their bladders more frequently, and wake up in the night more often to pass urine, particularly men with enlargement of the prostate gland. In addition, they may suddenly feel the desire to pass urine but may be unable to get to the toilet in time, partly because the feelings occur so suddenly and also due to their slower mobility and possibly weakness of bladder muscles. The reasons for incontinence of urine are many, but the result is embarrassing and worrying and limits the ability to take an active part in life.
- 3.4.2** Incontinence of urine is far commoner in people with dementing illness and cerebrovascular disease as this causes interference with the brain control of urinary function.
- 3.4.3** Lack of control of bowel movements (faecal incontinence) also occurs in old age. Although less common than urinary incontinence, it is even more

embarrassing.

- 3.4.4** It is important to remember that many people suffering incontinence find it so embarrassing that they do their best to conceal the fact from relatives, their doctors and others who could help them to cope with it. The problem may not be mentioned on a claim form, or even to an Examining Medical Practitioner (EMP).

3.5 Mental Changes in Old Age

- 3.5.1** Just as physical functions are altered by ageing, so too are mental and intellectual processes. This may result in apparent changes in personality and in difficulty in remembering new information or recalling recent events. Also, the ability to solve problems and draw conclusions from information may decline with age, although experience which has accumulated over years remains.
- 3.5.2** Elderly people wish to be accurate in what they do, so it may appear that they are slower in performing tasks. In addition, their reaction time is slower as they are less "ready" to perform tasks and less able to perform several simultaneously.
- 3.5.3** Elderly people are able to remember basic new information such as names and addresses but may have more difficulty with factual information such as what is in the paper or on television. New information, such as a great grandchild's birthday, is more difficult to retain but there is no problem with long-term memory such as which school they attended or their own children's dates of birth
- 3.5.4** Personality may change with age. There may be a tendency to introspection and personality traits demonstrated in earlier life may become enhanced eg temper, prejudices etc. However, if there is a major personality change in old age, this may well be the result of a series of small strokes, a mental illness such as depression or a dementing illness.
- 3.5.5** The terms "senile" and "senility" may be encountered in medical descriptions of old people. These usually imply the kinds of changes discussed above, and do not necessarily indicate that the person is suffering from dementia.

3.6 Confusion

- 3.6.1** Often, elderly people are said to be "confused". This may be the result of many conditions, the commonest of which is dementia, but also including cerebrovascular disease, mental illness such as depression or anxiety and chronic diseases such as congestive heart failure.

- 3.6.2** The reasons why elderly people are said to be confused are many. It may be that the person asks the same questions many times because they have impairment of recent memory, making them forget that they have asked a question five minutes ago, so it is asked again. This can be wearing for carers. Also, they may have difficulty understanding questions put to them, and so may make inappropriate responses. Hearing difficulties will, of course, add to these problems.
- 3.6.3** The time of the day can create a problem for elderly people with a degree of dementia, and they may not know the day of the week, the month, or the year. Younger people often have a good idea of the time without looking at the clock but in older people, and especially those with a dementing illness, this ability may be lost. For some elderly people this can be severe enough to cause them to confuse day with night, and hence make phone calls to carers in the early hours of the morning, or they "wander" from home in the middle of the night.
- 3.6.4** For some elderly people the appearance of confusion is more marked at night. They may sleep poorly and become restless at night. Consequently, they are more difficult to deal with, especially if they feel it is time to get up and go to work. This is often very difficult and wearing for carers, causing them loss of sleep and anxiety which have long-term consequences for the caring process.
- 3.6.5** Dementia or cerebrovascular disease can cause disturbances other than loss of memory or weakness of limbs. People may lose the ability to perform certain tasks such as preparing a meal, using a teapot, using the gas stove or putting clothes on in the correct sequence, which makes them appear very muddled.
- 3.6.6** The elderly person with dementia, cerebrovascular disease or confusion stemming from chronic illness may have difficulty understanding words, reading words, speaking and producing words. Anxiety and depression cause problems with the ability to concentrate, perform tasks and retain information. Any of these disturbances may present as general "confusion".
- 3.6.7** A very important cause of confusion is the true acute confusion (ie. of sudden onset) which occurs not uncommonly in elderly people as a result of a sudden illness such as a heart attack, pneumonia, bladder infection or stroke, or in response to medication. The sudden onset of confusion, with agitation, restlessness and the appearance of being muddled is a very important sign in elderly people which usually means that they have an acute illness requiring investigation.
- 3.6.8** Elderly people with memory loss may give plausible accounts of events,

since they truly believe they have no problems and can perform all tasks. Some elderly people may appreciate that they cannot do so, but they still retain the ability to "cover up". For this reason, there is often a need to obtain further evidence if the situation is unclear.

3.7 Care Needs

- 3.7.1** Elderly persons may need attention in connection with personal care or safety purely as a result of changes due to ageing, as described above. The likelihood of this being so increases with advancing years. The presence of other illnesses or disabilities will increase the need for care. Because of interaction between any disability and the changes of ageing, care is more likely to be needed by the elderly than by younger persons with the same type and level of disability.
- 3.7.2** The mental changes due to ageing, combined with other disorders, including mental health problems may mean that elderly people require supervision to prevent them from coming to harm by day or night or both; or attention to remind them to get up, wash, dress, eat meals etc.
- 3.7.3** Falls occur more frequently in elderly people than in younger ones, and they find it very difficult to get up without help. If assistance is not available they may lie for long periods, risking hypothermia and dehydration.

3.8 Duration of Needs

- 3.8.1** Needs arising in elderly people are likely to persist and increase with advancing age.
- 3.8.2** Even those which arise as a result of an acute episode, such as a stroke, a heart attack or pneumonia, will last longer than in younger people and may be lifelong, due to the problems of adaptation and rehabilitation in this age group.

3.9 Further Evidence

- 3.9.1** Needs in elderly people are often self-evident. However, some old people are extremely proud and independent and have a great ability to understate problems. This may be intentional, because they feel their problems are due to their age and therefore they should just "get on with things" or it may be due to dementia or an acute confusional state.
- 3.9.2** Further information may well be required and it may be obtained from the carer, GP, social or welfare worker, staff in a residential home, day centre

manager, physiotherapist, occupational therapist or hospital specialist. If there is uncertainty about an elderly person's mental state, an examining medical practitioner (EMP) can be asked specifically to assess mental function.