

NAME SHABANA TABASUM
STUDENT NO 23316399
MODEL NO EMPOWERING THE OLDER
PERSON BMHP 2027EMPOWERING THE
OLDER PERSON (BMHP6027_BIRM)
EMPOWERING THE OLDER PERSON
(BMHP6027_BIRM)
EMPOWERING THE OLDER PERSON
(BMHP6027_BIRM)

TUTOR NAME



INTRODUCTION AND PRESENTATION OVERVIEW

Ageing, independence and wellbeing

This presentation assesses the support provided by health and social care services for the independence, dignity and welfare of older people.

It defines ageing and applies Activity and Continuity ideas to practise in care environments.

Domiciliary and residential care is rated on accessibility, quality, funding and personal experience.

Legislation, technical breakthroughs and cases lead to practical recommendations.

The concept is that good care should help people to live meaningful lives rather than focus solely on reliance and risk management (WHO, 2015; Kitwood, 1997).



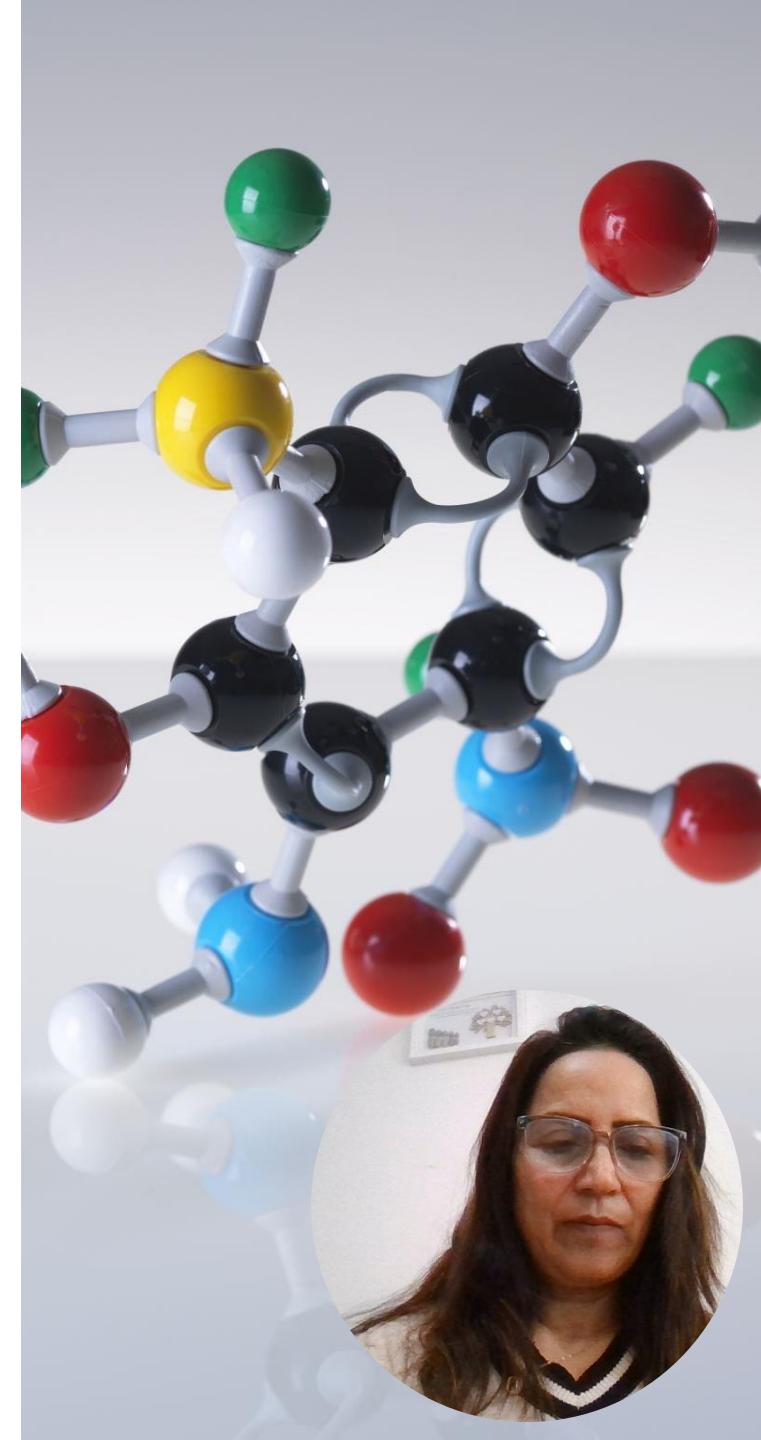
DEFINING AGEING

Biological ageing refers to the buildup of cellular and molecular damage, which can gradually impair physical performance. However, these changes are not consistent or determined solely by chronological age (WHO, 2015).

Cognitive functioning, emotional adjustment, and responses to life transitions all alter as people age.

Social ageing is concerned with changes in relationships, social roles, and participation, such as retirement and bereavement.

Healthy ageing is concerned with sustaining functional ability: what a person can do as a result of the interplay between their capacities and their surroundings (WHO, 2015).



Population Ageing, Global Perceptions and Ageism

BETWEEN MID-2023 AND MID-2024, THE NUMBER OF PERSONS AGED 65 AND UP INCREASED IN ALL UK COUNTRIES, EMPHASISING THE SIGNIFICANCE OF PLANNING SERVICES FOR LATER LIFE (ONS, 2025)

PREVENTIVE CARE, ACCESSIBLE SURROUNDINGS, REHABILITATION, AND COORDINATED SUPPORT BECOME INCREASINGLY IMPORTANT AS THE POPULATION AGES.

AGEING EXPERIENCES VARY BY SOCIETY AND INDIVIDUAL; OLDER PEOPLE SHOULD NOT BE CONSIDERED AS A SINGLE DEPENDENT GROUP (WHO, 2015).

AGEISM REFERS TO AGE-RELATED PREJUDICES, PREJUDICE, AND DISCRIMINATION, WHICH CAN LIMIT OPPORTUNITIES AND ALTER CARE EXPERIENCES (WHO, 2021).

SERVICES MUST CHALLENGE THE BELIEF THAT OLDER INDIVIDUALS CANNOT LEARN, MAKE DECISIONS, OR BENEFIT FROM ASSISTANCE.



THEORIES OF AGEING: EXPLANATION AND CRITICAL APPLICATION

Theories of Ageing:

Explanation and Critical Application Limitations when applying to practise.

According to Activity Theory, meaningful activities and social roles can lead to increased satisfaction. Care should encourage voluntary participation rather than taking over tasks (Havighurst, 1961). It can overvalue activity while ignoring infirmity, unequal opportunity, and preferences for peaceful living.

According to the continuity theory, adaption is facilitated by familiar routines, connections, and identities. Consistent carers and familiar surroundings can help maintain continuity (Atchley, 1989). Previous routines may become ineffective or undesirable; care must also accommodate change.

Both theories work best when applied flexibly: activity and familiarity should be accessible rather than imposed (Havighurst, 1961; Atchley, 1989).



OVERVIEW OF CURRENT CARE AND SUPPORT



Primary care, community nursing, rehabilitation, reablement, domiciliary care, residential care, day programs, and voluntary sector help are all available to older persons.

Instead of automatically giving ongoing task-based assistance, reablement assists persons in regaining or developing strategies to manage their daily tasks (SCIE, 2024).

In England, the Care Act of 2014 provides the adult social care framework, which includes wellbeing, needs assessment, and carer support.

However, staff shortages, financial constraints, and gaps in community ability can limit timely assistance (CQC, 2025).

As a result, service effectiveness is determined by a coordination, and personal outcomes rather than just



Domiciliary Care: Applying Continuity Theory

Application and Theory

Continuity Theory says older persons cope with ageing by maintaining identities, affiliations, and routines. Domiciliary care involves supporting the person's lifestyle rather than keeping them at home (Atchley, 1989). Atchley (1989) suggests that familiar environments and frequent carers might help maintain routines, identities, and connections.

Reablement helps people adapt to daily tasks, increasing participation rather than dependence (SCIE, 2024). Personal evaluation and care planning align with England's Care Act's wellbeing framework (Great Britain, 2014). Limitations and Critical Assessment Financial and staff constraints can hinder reliable support, and insufficient home-care capacity may delay hospital release (CQC, 2025).

Continuity Theory may overemphasise tradition; needs and preferences change.

Without real relationships or support, staying home is insufficient.

Overall evaluation

Regular, flexible home care protects what matters to the individual. We should assess success through choice, engagement, and well-being, not by remaining home alone.





UTILISING CONTINUITY THEORY TO ASSESS RESIDENTIAL CARE

According to Continuity Theory, older persons cope with ageing by maintaining identities, rituals, and relationships. Residential care residents may value familiar items, regular routines, family engagement, and constant providers (Atchley, 1989).- Strengths

People who need support outside the home can get it.

The personhood and continuous identity of dementia patients are recognised in person-centred care (Kitwood, 1997). While staff training and targeted interactions may enhance resident quality of life, the WHELD experiment found limited outcomes (Ballard et al., 2018). Limitations and critical evaluation

Relocation and routines might disrupt the familiarity emphasised by the Continuity Theory.

Maintaining routines should not prevent people from making new choices or responding to needs.

Workforce limitations and financial challenges can hinder customised service (CQC, 2019). Evaluation: Maintain your independence in a care home. It works best when it includes choice, connections, and engagement, not just housing and monitoring.



Biological, psychological and social needs of the Elderly

Areas of need, examples, and applications for care.

Biological needs include proper nourishment, hydration, movement, pain treatment, and assistance with sensory issues.

Evaluate individual skills; give appropriate meals, mobility support, and aid with daily tasks.

Psychological factors include emotional security, dignity, choice, cognitive support, and coping with loss.

Involve the person in decision-making, offer confidence, and encourage meaningful routines.

Social relationships, community activities, and participation chances.

Maintain family communication, facilitate desired activities, and remove barriers to social inclusion.

The needs of older people are interrelated, necessitating a person-centred assessment rather than age-based assumptions (WHO, 2025).



Framework Policy and Legislation in Practice Relevance to the care of older people



	Relevance to older people's care
Care Act 2014 – England	Promotes wellbeing and provides for assessment, care planning and carer support.
Equality Act 2010 – Great Britain	Protects against unlawful age and disability discrimination and includes reasonable-adjustment duties.
Mental Capacity Act 2005 – England and Wales	Requires a presumption of capacity, decision-making support and consideration of less restrictive alternatives.
NHS Long Term Plan 2019 – England	Established commitments to stronger community services and enhanced support for care-home residents.

(Care Act 2014; Equality Act 2010; Mental Capacity Act 2005; NHS England, 2019).





TECHNOLOGICAL INNOVATIONS:

Benefits and Limitations Innovation Potential benefit Limitation
Telecare and personal alarms Enable requests for assistance and may support confidence.

Depend on usability, reliability and an effective response. Sensors and remote monitoring Identify events or patterns requiring attention. May intrude on privacy without improving meaningful outcomes.

Dementia reminders and communication aids Support routines, activities and contact. May become confusing or unsuitable as needs change. (Meiland et al., 2017). Digital exclusion can arise when technology is inaccessible or continuing support is unavailable.

Technology should complement personal relationships rather than automate or replace them.

Monitoring decisions require appropriate involvement, decision-making support and consideration of less restrictive options (Mental Capacity Act 2005).





Case Study: Mrs. F, Aged 88.

Mrs. F is an 88-year-old widow living alone with early-stage dementia and limited mobility. She occasionally forgets food and medications and feels lonely. She wishes to stay at home.

Proposed support.

Domiciliary carers who are consistent encourage participants to stick to familiar routines.

A professional examination analyses appropriate reminder devices and a personal alarm.

Mrs. F chooses opportunities for social interaction and purposeful activity.

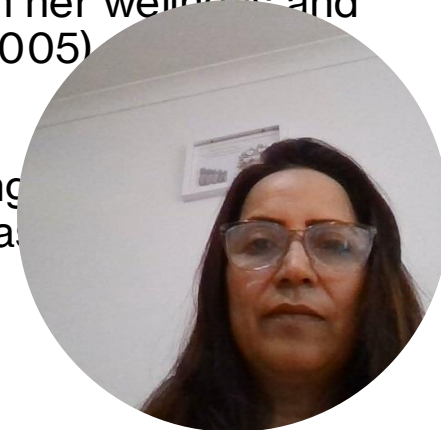
Theory and Policy

Familiar routines reflect Continuity Theory, whereas selected activities reflect Activity Theory (Atchley, 1989; Havighurst, 1961).

Instead of assuming incapacity, assessments should focus on her wellness and support her decisions (Care Act 2014; Mental Capacity Act 2005).

Evaluable outcomes

Examine nutrition, everyday engagement, emotional well-being and Mrs F's experience with choice. These are proposed measurable outcomes.



PROPOSED POLICY ENHANCEMENTS AND IMPLEMENTATION

Commissioners should consider continuity, meaningful engagement, and personal outcomes while evaluating service volume.

Care plans should record the individual's goals and clearly define roles for evaluation.

Technology provision should include usability testing, decision-making assistance, and a defined reaction plan.

These suggestions are consistent with welfare, nondiscrimination, and supported decision-making principles (Care Act 2014; Equality Act 2010; Mental Capacity Act 2005).

Workforce shortages, financial constraints, and administrative workload are among the barriers (CQC, 2025).

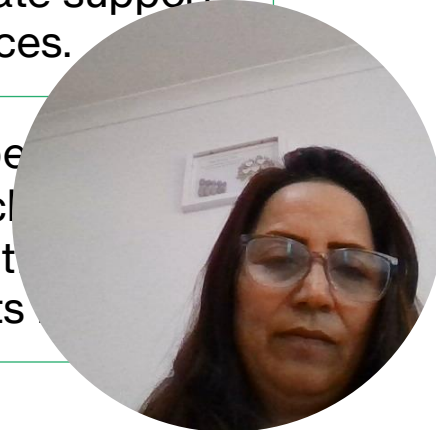
The proposed solutions include incorporating reviews into existing care planning, phased deployment, and employing a small number of meaningful outcome indicators.

Additional monitoring is only worthwhile when the results lead to actual improvements.



EVIDENCE-INFORMED RECOMMENDATIONS

Recommendation	Justification and in-text citation	Barrier	pProposed solution
Improve continuity and person-centred training.	Familiar relationships and meaningful interactions support good care (Atchley, 1989; Ballard et al., 2018).	Staff turnover and training costs.	Provide protected training time, regular supervision and care-champion roles.
Strengthen goal-based reablement.	Enables participation in daily activities rather than unnecessary dependence (SCIE, 2024).	Limited service capacity.	Agree achievable priorities with the person and coordinate support across services.
Trial and review technology individually.	Additional equipment does not necessarily improve outcomes (Gathercole et al., 2021).	Poor usability and difficulties using devices.	Involve the person in selecting technology, provide practical support and review its use.



CONCLUSION

Empowerment necessitates care that meets biological, psychological, and social requirements while preserving choice, dignity, and meaningful relationships.

As the population ages, it becomes increasingly important to provide accessible, coordinated care that challenges ageism rather than presuming that all older individuals have the same requirements.

Domiciliary care allows for the preservation of familiar routines, whereas residential care provides continuing support. Neither is generally preferred; outcomes are influenced by quality, staffing, funding, and personal preferences (CQC, 2025).

Integrating theory and policy transforms knowledge into action: continuity theory promotes familiar relationships, while wellbeing and equality duties guide individualised, non-discriminatory care (Atchley, 1989; Great Britain, 2010; 2014).

The tailored doll-therapy instance emphasises meaningful individual responses, whereas ATT questions the notion that more technology inevitably improves outcomes (Shouri Bidgoli and Darvishpour, 2026; Gathercole et al., 2021).

Better outcomes necessitate consistent caretakers, person-centred training, assistance for carers, and individually assessed technology, with non-digital access maintained (NICE, 2024).



HARVARD REFERENCE LIST:



- Atchley, R.C. (1989) 'A continuity theory of normal aging', *The Gerontologist*, 29(2), pp. 183–190. doi: 10.1093/geront/29.2.183.
- Ballard, C. et al. (2018) 'Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial', *PLOS Medicine*, 15(2), e1002500. doi: 10.1371/journal.pmed.1002500.
- *Care Act 2014*, c. 23.
- Care Quality Commission (CQC) (2025) *The state of health care and adult social care in England 2024/25*. Care Quality Commission.
- *Equality Act 2010*, c. 15.
- Gathercole, R. et al. (2021) 'Assistive technology and telecare to maintain independent living at home for people with dementia: the ATTILA RCT', *Health Technology Assessment*, 25(19), pp. 1–156. doi: 10.3310/hta25190.
- Havighurst, R.J. (1961) 'Successful aging', *The Gerontologist*, 1(1), pp. 8–13. doi: 10.1093/geront/1.1.8.
- Kitwood, T. (1997) *Dementia reconsidered: The person comes first*. Buckingham: Open University Press.





HARVARD REFERENCE LIST:

Meiland, F. et al. (2017) 'Technologies to support community-dwelling persons with dementia: A position paper on issues regarding development, usability, effectiveness and cost-effectiveness, deployment, and ethics', *JMIR Rehabilitation and Assistive Technologies*, 4(1), e1. doi: 10.2196/rehab.6376.

Mental Capacity Act 2005, c. 9.

NHS England (2019) *The NHS Long Term Plan*. London: NHS England.

Office for National Statistics (ONS) (2025) *Population estimates for the UK, England, Wales, Scotland and Northern Ireland: mid-2024*. Office for National Statistics.

Social Care Institute for Excellence (SCIE) (2024) *Reablement resource helps people live independently after hospital stay*. 10 September. Social Care Institute for Excellence.

World Health Organization (WHO) (2015) *World report on ageing and health*. Geneva: World Health Organization.

World Health Organization (WHO) (2021) *Global report on ageism*. Geneva: World Health Organization.

