

The Ageing Process

Guidelines for Recognition in People with Learning Disabilities

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Acknowledgements

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Introduction

Life expectancy of people with learning disability is continuing to increase so we can expect more older people experiencing the physical consequences of ageing.

More needs to be known about the nature of ageing in learning disability by carers and managers. Early detection is needed so that successful support systems can be introduced at a time when people may well be able to take part in decision making for their own futures.

The physical aspects of ageing such as poor vision, unsteadiness etc., are readily observable to good carers. Changes in cognitive and psychological function however, which may be obvious to long term carers are sometimes less apparent in support systems with changing carers. Thus treatable and preventable problems can be overlooked, e.g., thyroid deficiency, which has a higher incidence in people with Downs syndrome.

There are three sub groups which need to be considered:

1. People with learning disability only.

This group tend to have a normal life expectancy with the same patterns of ageing as the general population. Early detection is needed for people who frequently lack the skills to report their changing abilities to their carers e.g., pain and stiffness in joints causing walking difficulties.

2. People with Downs syndrome.

This group not only show premature physical ageing signs e.g., hearing loss, thyroid disorders, skin changes etc., but autopsies have shown that their brains are showing evidence of Alzheimer's disease from as early as 30-35 years of age (although only a minority develop dementia).

Carers need skills in recognising psychological and cognitive change occurring at an earlier age than within the general population. They must then produce evidence to convince managers that full investigation and early supportive actions are needed.

3. People with associated severe physical handicap with or without epilepsy.

These people rarely reach old age, most dying as young adults frequently from respiratory disease. This group does not figure largely in planning services for the older people with learning disabilities.

The following guidelines are meant to assist carers to an understanding of ageing. The major tools for early detection, so that potentially preventable problems are recognised and early support action taken, must always be:

- accurate and detailed records of skills and abilities, symptoms and signs compiled by people familiar with a standardised method of recording
- a recognition that there should be continuity to staffing to avoid disruptive changes for a doubly vulnerable group.

The notes below give a brief outline of the physical and mental changes that occur in people as they grow older.¹ In those who already have learning disabilities the effects of ageing will be superimposed on whatever these disabilities are.

When vulnerable people become ill and require medical and nursing attention, their survival may depend on those who care for them being seen to show concern for their welfare. Better quality health care tends to be given when health staff know that a patient is loved by someone. Visitors to patients in hospital can act to safeguard a person's survival by communicating to both medical and nursing staff their interest in the person's well-being.

¹ For more detailed guidance see: Hall, M R P., McLennon, W J., Lye, M D W., *Medical Care of the Elderly*, Wiley.

Physical Aspects of Ageing

Balance deteriorates, especially when changing position and turning quickly.

Bones Weakening of the bones is common and is usually due to osteoporosis in which bone mass density is reduced. Fractures become more common especially, fractures of the hip.

Co-ordination may decline. Movements slow up and shaking may occur. Co-ordinated movements become more clumsy.

Hair may become white and sparse; hair loss increases.

Hearing is often impaired, especially for higher pitched sounds and conversation.

Height The body often shrinks and there is a loss of height averaging two and a half inches. Much of this is due to changes in the bones (the vertebrae) which make up the spine causing curvature of the spine.

Immunity The natural immunity system may become less responsive. Resistance to infections may diminish and repair processes are slower.

Joints stiffen up, even in the absence of a recognisable form of arthritis. The soft tissues surrounding the joint (ligaments, tendons etc.,) become stiffer with ageing.

Muscles tend to weaken and waste, though regular exercise will delay this process as well as an adequate intake of protein in the diet.

Nails become thicker, more brittle but harder to cut.

Skin usually becomes dry and wrinkled.

Speech The voice gets weaker. Clarity of speech may be affected by strokes or denture problems etc.

Stamina may lessen - to a varying degree. 'Staying power' is less. Older people tire more easily.

Teeth Jaw may shrink and cause problems with dentures, which no longer fit properly. Inflammation of gums may lead to loosening of existing teeth.

Temperature Body responds less well to changes of temperature. Danger of hypothermia in cold weather.

Vision Cataracts, glaucoma and degeneration of any part of the retina become commoner, with resultant impairment of vision.

Weight tends to decrease after the age of 75 years even in the absence of any specific illness.

Psychological Aspects of Ageing

Concentration is often impaired.

Confusion More apt to occur after injuries, operations or as a symptom of many different illnesses and as a side effect of drugs, especially sedatives, tranquillisers and anti-depressants.

Depression occurs more commonly, often in association with physical disease, or in the early stages of Alzheimer's disease or other dementing processes.

Emotional Instability occurs more often.

Intellectual Changes Thought processes become slow; it is more difficult to solve problems and the ability to deal with large amounts of information is reduced.

Memory often becomes less efficient, especially after the age of 60, though certain people show very little deterioration even into extreme old age. Severe forgetfulness is always due to disease such as Alzheimer's disease or stroke illness.

Reliability is often better than in younger people.

Illness in Old Age

The Pattern of Illness in Old Age

Older people become ill, injured or disabled more frequently as they grow older.

Nevertheless, in one survey, nearly one quarter of people over 80 years said that they had no disabilities and three fifths of these claimed that they had 'good health in general'.

They are likely to suffer from several illnesses at once. For instance someone may have diabetes needing diet and insulin, osteoarthritis of the knees, varicose veins and impaired vision due to cataracts. Such a person may, of course, develop influenza or any other acute illness at any time.

Cancer and the so called degenerative diseases such as arteriosclerosis (hardening of the arteries) become more and more common with increasing age. The arterial disorder is responsible for such things as heart attacks, angina, strokes and gangrene of the lower limbs.

Recovery after acute illness or surgery is often very slow but improvement may continue for six months or more. This means that anyone who feels that convalescence after an acute illness or major illness is unduly long can be encouraged to expect a full recovery. Often, however, only partial recovery occurs.

They are more likely to develop unwanted effects from medication whether from single drugs or from the effects of interaction between drugs.

Unusual Symptoms in Older People

Some oddities which may occur:

- the organs sometimes suffer in silence, so that people may not feel:
 - thirst, even when severely dehydrated
 - pain, in such conditions as stomach ulcers or cancer, gall bladder disease or hip fractures.

There may also be:

- no fever in infections such as influenza or pneumonia
- no scalding on passing urine when there is cystitis.

Some Symptoms and Signs Which May Indicate Illness

In older people, mild to moderately severe illness may show itself in ways not seen in younger people and in the absence of pain or other symptoms indicating which organs are affected.

Some examples are as follows:

- 'Going off their legs'. This is a sudden inability to get up and walk about in someone previously fully ambulant.
- 'Falls'. 'Out of the blue'.
- 'Collapse'. Sudden onset of general weakness which prostrates a previously healthy person so that they feel barely able to move.
- 'Confusion and/or restlessness'. Suddenly being unable to distinguish time of day or night; getting lost in familiar surroundings; being unable to recognise staff or fellow residents; talking nonsense.

Any of these patterns of behaviour indicate that someone is ill. The cause may vary from something simple like influenza, a heavy cold or the onset of shingles to a stroke, heart attack or internal haemorrhage or severe depression. They may also be due to side effects (unwanted effects) of medication or other drugs e.g., alcohol. They are a signal that medical advice should be obtained.

It is useful to note whether changes develop slowly or suddenly. Sudden changes are likely to indicate medical emergencies. They should not be ignored as merely what is to be expected in old age.

Some common symptoms

Symptoms which are common are:

- constipation
- loss of appetite
- incontinence of urine
- immobility
- emotional upset.

If there are any such symptoms, check carefully that bowels are opened regularly as constipation itself **may** cause them (see also page 10).

Emotional Upset

Emotional upset associated with illness may be partly a reaction to the illness and partly a direct effect of the illness on emotional stability.

It can take the form of a mixture of feelings of:

- anger (from a mixture of fear and frustration)
- anxiety and apprehension
- depression
- paranoia.

Thus people may be irritable, demanding or querulous, verbally or physically aggressive, negativistic ('bloody minded'), withdrawn, silent, unsociable, uninterested in food, activities or other people, insomniac with early morning wakening, tearful, have feelings of guilt or of being a nuisance. Sometimes showing agitation and restlessness, suspicion, feeling persecuted, have a fear of being poisoned. They may be manipulative or attention seeking.

There are many causes of such emotional upset, but physical illness or side effects of drugs must always be considered. Sometimes it can be the earliest symptom of slowly developing disease in an older person.

Confusion

Many confusional states are temporary and reversible. Once an older person shows signs of being confused, mistaken assumptions are often made that the person has a progressive, irreversible dementia which is often not the case at all.

Major precipitants of confusional states are:

- Chest and upper respiratory tract infections.
- Prescribed medication. A number of drugs have been known to precipitate or exacerbate confusional states. This indicates the importance of regular medical check-ups and not re-ordering repeat prescriptions without check-ups and careful monitoring for side effects.
- Disorientation as a reaction to stressful situations e.g., loss of partner, moving from the familiar surroundings of home to a residential setting.
- Constipation.

The importance of knowing the person concerned and getting medical attention cannot be overestimated.

Some Common Ailments

Poor Mobility

This term describes the following common situations:

- Difficulty in moving about in bed unaided.
- Difficulty in standing up from the sitting position and sitting down again safely.
- Difficulty in transferring from bed to chair and from one chair to another, e.g., WC or commode.
- Difficulty in walking about within a room.
- Difficulty in walking longer distances.
- Difficulty in walking up and down stairs or steps.

Causes:

- Pain and stiffness in joints.
- Painful feet.
- Muscle weakness, inco-ordination (clumsiness), stiffness, abnormal movements.
- Poor balance.
- Being overweight.

Pain and Stiffness in Joints and Limbs

Arthritis - most frequently osteoarthritis (or osteoarthrosis) a degenerative disease of joints which is associated with injury or prolonged 'wear and tear'. This causes damage to the cartilage, a very smooth 'spongy' substance covering the ends of the bones which form the joint. It forms the bearing surface and acts as a shock absorber protecting underlying bone from damage. As it wears, it becomes thinner and rougher and, therefore, a less efficient shock absorber. This gradually leads to pain when the joint is used.

- Virtually any joint can be involved but weight bearing joints like hips, knees and ankles are commonly affected.
- In this condition, **too much use or exercise causes pain**. Pain may be worse in the night

or even in the day after the exercise. It usually improves with rest but it may take a long time if the joint is grossly over used.

- Too much inactivity or rest may cause **increasing stiffness** in more advanced disease. Stiffness is often temporarily worse after a period of inactivity but improves after gentle exercise or active movements.
- Each person, with advice if necessary, needs to find their own balance **between exercise and rest**. Pain killers, including anti-inflammatory drugs, relieve pain, but they do not cure the underlying condition.

Pain extending down the legs can be caused by spinal disorders when osteoarthritis of the many small joints in the spine combined with degeneration of the discs between the vertebrae, which are the individual bones which make up the spine, may cause pain referred to the legs. Sometimes pain is due to trapped nerves. Similar problems in the neck sometimes causes pain and/or pins and needles in the arms and hands with or without some weakness of muscles.

Painful Feet

Some causes:

- Ill fitting shoes.
- Toenails which need cutting or ingrowing toenails.
- Painful calluses.
- Arthritis in small joints of the feet - often the big toe joint.
- Some joint deformity such as bunions, hammer toes.
- Skin conditions like plantar warts or athletes foot.

Muscle Weakness, Stiffness, Inco-ordination (Clumsiness), Abnormal Movements

Any or more of these symptoms may occur at any one time.

Some causes:

- Brain damage, e.g., from strokes, congenital abnormality, head injury, Parkinson disease, advanced Alzheimer's disease, Huntington's disease.
- Spinal cord damage by disease - like multiple sclerosis or due to spinal injury.
- Damage to individual nerves from a variety of causes.

Generalised Muscle Weakness

A condition in which muscles tire easily.

Some causes:

- Heart disease associated with angina or shortness of breath from exertion.
- Severe chronic bronchitis and/or emphysema with shortness of breath.
- General diseases like severe anaemia, thyroid disorders. Often these can be treated very easily and satisfactorily. E.g., thyroid deficiency.
- Sometimes (temporary) after 'flu' like virus infections.

It is important to remember that if a patient is medically fit, encouragement of regular exercise will strengthen muscles in older people even if they are weakened by a stroke. If possible, the exercise should be carried out daily, if necessary after advice from a doctor or a physiotherapist depending on circumstances.

Poor Balance

All the conditions mentioned in the previous section **can** interfere with balance.

Good balance enables us to stand upright and walk without swaying from side to side, staggering or falling over.

When standing still, slight swaying occurs in normal people. This increases with age

especially after 60 years. This is why older people are more easily knocked down than the young.

After tripping over an obstacle, a series of automatic movements which depend on so called 'righting reflexes' enable us to recover balance. Righting reflexes deteriorate with age and after many forms of brain illness or damage.

Part of the inner ear is concerned with maintaining balance. Disorder, thereof, may cause vertigo (dizziness - with a sense of the world going round) and with this an unsteady gait.

Drugs - e.g., alcohol in excess and drugs which affect the brain such as sedatives and tranquillisers can make people unsteady on their feet and disturb righting reflexes. Major tranquillisers such as Chlorpromazine can cause stiffness and/or abnormal movements sometimes.

Bladder and Bowel Disorders

Continence of Urine

We remain continent of urine because we have a bladder which as it fills, automatically gives us warning signals which tell us when it needs to be emptied. There is normally no leakage of urine so that it can be emptied voluntarily when convenient. We also can feel when we are passing urine so that it cannot happen accidentally if we are conscious and alert, unless the bladder is very full indeed. This whole process is co-ordinated by the linkage of the bladder by nerve pathways to a series of interlinked centres in the brain and spinal cord. This forms a complex neural control system, damage to which causes various bladder problems.

The bladder itself is a muscular organ with an outlet called the urethra. The muscle in the wall of the bladder is programmed by the control system to relax gradually as the bladder fills with urine. As this happens, the muscle eventually starts to contract, gently at first then more strongly in a rhythmic fashion. These stronger contractions are experienced as a desire to pass urine which becomes more intense as time goes

on, as we all know. We also know from personal experience that this sensation comes in waves and then passes off for a time, recurring more strongly until it persists continuously. The desire to pass urine can be resisted for a time because the urethra is surrounded by a sort of circular muscular 'clamp' called the internal sphincter. This contracts automatically until we give it the signal to relax. The internal sphincter can be helped by a voluntary contraction of a second 'clamp' - the external sphincter. We can control this voluntarily. When the desire to pass urine becomes really urgent and circumstances are unfavourable, we can also contract pelvic muscles to assist the sphincters to prevent urine flowing. When circumstances are favourable, we are able to relax the external sphincter and the pelvic muscles voluntarily and contract our abdominal muscles. This gives the signal the internal sphincter has been waiting for; it relaxes; the bladder contracts; urine flows.

Incontinence of urine

There are five patterns of urinary incontinence in older people:

- Urge incontinence.
- Stress incontinence.
- Overflow incontinence.
- Heedless incontinence.
- Incontinence due to behaviour disorder and emotional disturbance.

Urge Incontinence

This form of incontinence is associated with what is called an unstable or overactive bladder. In this condition, the bladder as it fills, contracts in 'waves' which are much stronger and more erratic than normal. It starts to contract when there is only a small amount of urine present. There is often no awareness of these contractures until a very strong one produces a very strong and violent urge to pass urine which cannot be resisted successfully. In mild cases the only symptom may be a little urgency and the need to pass urine more frequently than normal, especially at night.

The unstable bladder is probably caused by damage to one of the centres in the brain, mentioned earlier. It often occurs in apparently

healthy people, more frequently in women, starting in the 50s and increasing in frequency with age. It is the commonest cause of incontinence in older people. It can also be caused by local irritation of the bladder by:

- Urinary infection.
- Enlarged prostate (common).
- Any other disease affecting the structure of the bladder, e.g., tumour or bladder stone etc.

Stress Incontinence

This is often associated with some degree of prolapse of the uterus caused by damage to the pelvic floor due to childbirth. It is characterised by leakage of urine on coughing, sneezing, straining or lifting heavy weights. It may occur together with urge incontinence due to an unstable bladder.

Overflow Incontinence

The condition is caused by paralysis of the bladder. This can be due to long standing chronic obstruction to urine flow by a stricture, enlarged prostate or other causes such as disease or injury to the brain, spinal cord or nerves to the bladder. The bladder fills passively becoming more and more distended until urine starts dribbling out continuously. There is often little or no bladder discomfort even when it reaches up to the umbilicus. In the context of the domiciliary care of older people, the commonest cause is faecal impaction. People who get this condition always have some damage to the nerve supply to the bladder. The hard faecal mass causes urinary obstruction by pressing on the urethra and may also temporarily damage nerves in the bladder muscle; it is usually easy to diagnose this condition by rectal examination. Slow drainage of the bladder by catheterisation and removal of the faecal mass will lead to recovery of bladder function.

Heedless Incontinence

This describes a form of incontinence in which the person concerned pays no attention at all when the bladder empties itself. This can be due to:

- Complete loss of consciousness.

- Impairment of consciousness with confusion due to disease or drugs especially sedatives and tranquillisers.
- Severe dementia e.g., in Alzheimer's Disease, with the complete lack of regard for the social consequences of bladder emptying, that may occur in this condition.
- Damage to the brain, spinal cord and/or the nerves of the bladder by injury or disease leading to **loss of sensation** of bladder filling and emptying.

It is most likely to occur after a severe stroke or Alzheimer's Disease.

Incontinence Due to Behaviour Disorder and Emotional Disturbances

In a person with a mild degree of unstable bladder, incontinence may be an expression of:

- Anger and frustration and resentment; it may be a protest - a profession of innocence - a plea for understanding or a 'getting my own back'.
- Unhappiness - sadness - sorrow - and feeling of rejection; it could be a plea for understanding, sympathy or a demand for friendship and companionship.
- Anxiety, apprehension and fear. Anxiety may act directly on the bladder by increasing instability or there may be an effect on behaviour with a fear of asking for urinal, bedpan, commode or the way to the toilet because people are 'busy'. Older people **are often very sensitive about being a 'nuisance'**. They may also forget where the loo is and be afraid to admit it.
- Depression can cause severe inertia - a feeling of worthlessness, uselessness and guilt - a feeling that no action is worthwhile. In severe depression this may lead to incontinence of urine.

Constipation

Very prolonged constipation may eventually lead to 'faecal impaction'. This is a condition in which the rectum is loaded with a mass of very hard faeces which cannot be evacuated unaided. It can cause:

- discomfort or pain
- faecal incontinence, due to leaking of mucus and faeces past the hard mass. This is known as spurious diarrhoea due to 'overflow' incontinence.

Faecal impaction often has to be dealt with by manual removal of faeces by a nurse and by repeated enemas for a few days (see also page 6).

Falls, Fits and Faints

Falls

Why do some older people fall and why do some fall repeatedly?

There are two principal predisposing causes.

The first is that they are unsteady on their feet - i.e., they have poor balance and often poor righting reflexes as well (see page 8).

The second is that they have 'blackouts'. A blackout is a convenient descriptive word for episodes of short lived loss of consciousness.

Poor Balance as a Cause of Falls

The cause of poor balance and poor 'righting reflexes' have been discussed on page 8.

You will usually know who is unsteady on their feet. As drowsiness, due to medication may make people unsteady, notice those who are drowsy during the day.

When falls do occur, notice if the person concerned trips over some object - or just falls to the ground for no apparent reason. Go to the help of any clients who **slip, trip or stumble** and make sure there has been no serious injury. Help them up and to a chair if they are able to stand. Ask them how they came to fall and whether they felt unwell or had any dizziness or other symptoms such as sharp pain or headache.

If they are in severe pain and obviously not fit to try to stand up, make them comfortable with a makeshift pillow and cover them with something warm. Then go for help or send someone else.

After such an incident, look around and see if there is any environmental hazard such as one of the following which may have led to the fall:

- wobbly furniture

- a loose mat, carpet or floorboard
- a highly polished or wet floor
- a step in a poorly lit passage
- some object lying on the floor.

Some of these hazards, if reported, may be able to be dealt with.

A walking frame - or regular use of a walking stick - may be helpful for some people, if they can be taught to use them reliably.

If some of the people who have repeated falls become clearly more drowsy or slower of thought and more unsteady than they normally are, it is a good thing to obtain medical advice. Medication (or alcohol) could be responsible. If so, it may be possible to change the dosage of the drug concerned, or the drug itself.

Night sedatives, major tranquillisers like Largactil or Haloperidol, anti-anxiety drugs like Diazepam (Vallium), anti-depressants, anti-convulsants and anti-Parkinsonism drugs can be to blame.

Blackouts

Those who have 'blackouts', or loss of consciousness, often just slump to the ground, sometimes after certain warning symptoms, sometimes without any. Some will be unconscious or semi conscious or stuporose when you reach them, but others may have had such a brief 'blackout' that they may have recovered consciousness. Such people **may or may not know** that they have been unconscious.

If you happen to be close enough to someone who falls, you may be in time to observe such a very brief 'blackout' and be able to report it. Such information can be vital to an attending doctor as it makes clear the reason for the fall and gives a lead to the correct diagnosis.

Short lived episodes of loss of consciousness can be due to:

- fits
- faints
- other causes.

'Fits'

This is a useful shorthand word for those epileptic seizures which cause loss of consciousness, whether or not this is associated with any of the other features of epilepsy.

Anyone who falls because of a sudden 'blackout' **may** have had a fit even if it is not accompanied by convulsions or abnormal movements.

'Faints'

A fainting attack is a 'blackout' brought about by an insufficient supply of blood to the brain due to a sudden fall in blood pressure.

Two common causes of such a fall in blood pressure are:

- 'pooling' of the blood in the veins and other capacity vessels in the abdomen and lower limbs
- faulty pump action - which is faulty action of the heart (a form of pump).

Pooling of the Blood

This is caused by excessive dilatation of the blood vessels in the abdomen and lower limbs. This reduces the amount of blood getting back to the heart so that it cannot pump out enough to keep the blood pressure from falling.

This pooling effect can be caused by such things as:

- sudden pain - even the slight pain of an injection can make some young adults feel faint
- the sight of blood or of someone severely injured
- a more common cause is standing still for long periods of time in a crowded room - or in the hot sun.

When people do have to stand still for long periods of time, shifting their body weight repeatedly from one foot to the other helps to prevent fainting. The contraction of muscles in the legs pumps more blood up veins towards the heart, supplying it with enough blood to keep blood pressure normal.

Sometimes fainting occurs within a few seconds of rising quickly from a chair. This is called postural fainting. It happens in some older people especially on getting out of bed in the morning.

Other causes:

- It may occur after severe diarrhoea where there is dehydration and loss of salts from the body.
- In older men, rising from a warm bed in the middle of the night and passing urine in the upright position.
- Drugs - an effect of those such as 'beta blockers' given for treatment of high blood pressure.
- As a side effect of:
 - anti depressants
 - major tranquillisers like Largactil and Haloperidol
 - anti anxiety drugs such as Diazepam (Valium)
 - sedatives
 - some drugs given for Parkinson's disease
 - 'water tablets' (diuretics) which can cause excessive loss of salts from the body if the dose is too high.

Faulty Pump Action

Two common causes of this are:

- Any disease of the heart which damages its muscles or other structures. Coronary artery disease is the commonest one in older people.
- Sudden changes in the rate of the heart beat, whether very slow (below 40 per minute) or very fast (above about 150 per minute). The

rhythm often becomes irregular at the same time, or there may be **cessation** of heart action for a few seconds when the rate is low; fainting then occurs with severe pallor and a pulse which cannot be felt. After a few seconds, the pulse returns - the patient flushes markedly and consciousness recovers.

What Does a Fainting Attack Look Like?

The person concerned feels faint, dizzy or hazy but without any sense of their head spinning around.

There may be dimness of vision - voices sound far away - there are sensations of heat and cold and some sweating. The face goes **very pale during the attack** - the skin clammy, the pulse may be slow.

The symptoms may continue for some minutes before loss of consciousness - and the person will fall if not supported. If the person lies down, the attack may be averted, but sometimes loss of consciousness is sudden and without warning. Recovery occurs in a few minutes.

If recovery of consciousness does not recur within four or five minutes when the subject is lying down, obtain medical advice. The 'fainting' **may** be a symptom of serious disease such as a heart attack ('myocardial infarction') or an internal haemorrhage.

A Future For People In Their Own Homes

Supporting people with learning disabilities to live in ordinary houses within their community, whether in shared accommodation or on their own, is now commonplace for the majority of people within the North West of England.

People who have moved from long stay hospitals and others living with ageing carers can either return or continue to live in neighbourhoods or communities. We all acknowledge this is where people should live, and enjoy life to the full.

People should feel it a right not a privilege to have their own house or flat, to have a job or career, or participate in rewarding, stimulating and exhilarating leisure activities; and to share these experiences with a variety of close friends and acquaintances. People should be assisted to live and participate in their communities throughout their lives. This is the challenge we face in the future.

As people with learning disabilities become older and more infirm, our services and support networks need to respond appropriately, enabling people to remain and participate in their community, for as long as possible. Why should anyone, particularly those who have experienced many years in large institutions, have to return to end their days in another similar institution or 'special' place? Very few people, and especially

those who have already experienced incarceration in institutions, would choose to spend the remainder of their life in such a place.

Purchasers, service workers, managers and planners must use their imaginations and influence to ensure that they can provide the practical and emotional support to people, and as often as possible do this in people's own homes. Our knowledge, skills, energies and resources need to be focused on providing appropriate assistance and support to enable people, regardless of their care needs, to remain at home and a full member of their community throughout their lives.

The person's immediate physical environment, transport systems and public facilities must be adapted and made easily accessible to enable people to remain as independent for as long as possible. This must be complemented by flexible support from multi-disciplinary teams, operating over 24 hours a day.

People, regardless of their age and support needs, should have an expectation of being supported throughout their lives in ordinary or valued housing. We must all work together in order that in generations to come this becomes a reality for everyone.