A NATIONAL EPIDEMIC

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Purpose and Goals

The purpose and goals of this course is to stimulate the health professional toward positive yet realistic attitude toward care of the aging adult. It offers some essential tools in caring for the aging patient, including psychosocial, physical and emotional needs.

Instructional Objectives

1. Explain ways to promote improved quality of life in the elderly.
2. Describe nursing interventions that will promote safety in the elderly.
3. Discuss nursing assessment and interventions with clients who have memory loss.
4. Describe ways the burden of chronic illnesses affect the elderly.
5. Identify ways vulnerable elderly are abused.
6. Outline the various ways the nurse may screen for abuse.
7. Describe ways the nurse may assist the elderly and their families with end of life decisions and care.

Introduction

Twentieth-century advances in protecting and promoting health among older adults have provided many opportunities for overcoming the challenges of an aging society. This course includes promoting prevention, improving the health and well being of older adults, and reducing behaviors that contribute to premature death and disability. In addition, the course highlights mobility (referring to movement in all of its forms) and how optimal mobility is fundamental to healthy aging.

Demographic changes create an urgent need. The growth in the number and proportion of older adults is unprecedented in the history of the United States. Two factors—longer life spans and aging baby boomers—will combine to double the population of Americans aged 65 years or older during the next 25 years to about 72 million.

By 2030, older adults will account for roughly 20% of the U.S. population. Chronic conditions present a strong economic incentive for action. During the past century, a major shift occurred in the leading causes of death for all age groups, including older adults, from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses.

More than a quarter of all Americans and two out of every three older Americans have multiple chronic conditions, and treatment for this population accounts for 66% of the country’s health care budget.

Remember how important you are to the elderly person with whom you work. Through an appraisal of your involvement with the person living through the last developmental stage, you will grow in self-knowledge, self-acceptance and fulfillment. These qualities, which indicate a personal depth and integrity, may then become the basis for further compassionate, caring and knowledgeable nursing.

Opportunities for Improving Quality of Life

There are several areas of concern that, if effectively addressed, will significantly improve the quality of life for older adults.

Mobility

Mobility is fundamental to everyday life and central to an understanding of health and well being among older populations. Impaired mobility is associated with a variety of adverse health outcomes. As the age of the U.S. population continues to increase, aging and public health professionals have a role to play in improving mobility for older adults. There are critical gaps in the assessment and measurement of mobility among older adults who live in the community, particularly those who have physical disabilities or cognitive impairments. By changing physical environments and creating unique integrated interventions across various disciplines, we can improve mobility for older adults.

The Need for Patience

Patience is the key to communicating with an elderly client. He may respond slowly to your questions. Don’t confuse patience with patronizing behavior. Your client will easily perceive such behavior and may interpret it as a lack of genuine concern for him. Keep your questions concise, rephrase those he doesn’t understand and use nonverbal techniques in a meaningful way.

To further foster your elderly client’s cooperation, take a little extra time to help him see the relevance of your questions. You may need to repeat this explanation several times as the interview progresses but don’t repeat questions unnecessarily. Ask only for information that is relevant to the condition. For example, you wouldn’t obtain a detailed obstetric history from a 75-year-old woman who doesn’t have a gynecological problem.

Once you have obtained an elderly client’s cooperation, you may have some trouble getting him to keep the story brief. He has a lot of history to relate and may reminisce during the interview. Try to find time for this. Let the client talk. You may obtain valuable clues about the current physical, mental and spiritual health. If you must keep the history brief, let him know before the interview how much time you have set aside for it. Offer to come back another time to chat with him informally.

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Communication

The way health professionals communicate can set the tone for the patient’s experience in general, and influence the outcome of medical interventions. Age-related hearing and sight deficits may contribute to misconceptions, confusion, and a sense of isolation in patients with dementia. Use basic therapeutic communication strategies when communicating with the person, making sure eyeglasses and hearing aids are clean and adjusted correctly. Have a good source of light that reveals your face—be aware of back lighting as it may hinder the person seeing you. Be sure you identify yourself early, this is especially true for the visually impaired. Sit in front of them instead of standing above them. This allows you to maintain good eye contact, Speak up, but do not shout and use a lower pitch voice. Speak slowly and clearly.

Should we then be surprised at the fear and helplessness an elderly person may feel when admitted to the hospital? In today’s world of medicine, even the hospital room can be scary to the uninformed at any age or mental status. Of course, there are always those elderly patients that break all the rules when it comes to knowledge of medical facts and facilities. In fact, there are many elderly adults (in their 80s and 90s) that can run circles around the most energetic healthcare professional! The point is to assess the patient’s level of knowledge and then communicate on their level. This can alleviate much of the confusion they feel in relation to their surroundings.

See Figure 1 for strategies in communicating with dementia or older patients.

Specific Interventions

Interventions should focus on priority patient care issues. Safety, privacy, reduction of stimuli, and reality orientation are important areas when planning the care of the aging patient. Safety is one of the most important foundations of good patient care. How to keep an elderly patient safe may be the biggest job, especially if confusion leads to significant agitation.

Safety Issues

Potential for injury from a fall is another major safety concern for the elderly patient. The majority of lawsuits filed for negligence in health care facilities are falls. On admission, your assessment is to determine if the person is at high risk for falls. There are good assessment scales such as the Hendrich II fall risk model. This scale has been validated by a large study and is used in many hospitals and skilled care facilities. However, risk to fall scales should not be replaced, but only to complement the judgment of the nurse performing the assessments.

There are many other factors that contribute to the risk for falls, including, but not limited to: diagnosis of osteoporosis, medications that affect judgment, and reduce reflexes; deconditioning of the patient; history of falls and/or fractures; and advancing age. Nursing interventions include bed in low position, call bell within reach, and bed and chair alarms. Communication is essential for all people providing care for the patient including the family.

Many falls occur when the patient tries to get to the bathroom, so a regular toileting schedule can help (e.g., every two hours; or in the morning, after meals, and at bedtime.) A physical therapy consult can be obtained to address strength and balance issues, and the need for assistive devices. The patient may be positioned where staff can observe him easily, or family members can be asked to sit with him. Whatever approach is used should be frequently evaluated for effectiveness and/or adverse reactions.

To read “Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Models go to: http://consultgerirn.org/uploads/File/trythis/try_this_8.pdf

Privacy

Privacy is another essential aspect of interventions. Confidentiality must be maintained and only essential information about health care needs should be shared with other health care workers. According to the U.S. Department of Health and Human Services, the HIPAA Privacy Rule establishes “national standards to protect individuals’ medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections”.

The right to privacy isn’t reserved to just our medical history, but also to our right to be treated with dignity. All have heard, at one time or another, jokes regarding hospital gowns. However funny as they may be, they are an invasion of privacy even if the patients don’t intend for them to be. Try to maintain the patient’s privacy as much as possible and avoid embarrassment. Think again about the age range of most of your elderly patients. Not all will be embarrassed easily, but we should treat everyone as if they would be.

Helpful Strategies for Communicating with Dementia or Older Patients

- Speak using simple, concrete nouns and positive messages: “Your shirt is on the chair.” Instead of “Here it is” or “Stay sitting in the chair” is clearer than “Don’t get up.”
- Watch what you do. Patients with dementia have an uncanny ability to pick up on body language and mood. Use your body and voice to send calming messages. Slow down to prevent agitation.
- Look for hidden emotions masked in the patient’s words. If they say, “When is mommy going to be here?” they may mean, “I want to go home, I am scared of this strange place.”
- Don’t argue, scold or quiz your patient. Use distraction to prevent a situation from escalating into agitation, or drop the topic of discussion if she appears upset and try again in 15 to 30 minutes.
- Don’t use ambiguous words or slang such as “Jump into bed”, say directly, “Lie down on the bed.”
Sensory Overload

Reduction of stimuli may be a more difficult intervention to ensure. Although a LTC facility does not have the traffic flow of a hospital, it is still noisier than living with only one or two other people. If equipment is added to the scenario, noise is also added. The number of visitors permitted at a time should be determined based on the reaction of the patient, unless the facility has strict rules regarding visitors. It may also be necessary to monitor the reaction of the patient to a specific visitor. If a person seems to upset or agitate the aging patient, there is a chance the confusion may worsen when that person is present.

Orientation x 3

Perhaps the most frequently taught intervention is orientation, sometimes termed reality orientation. Over the years there have been changes in the furnishing of hospital and nursing home rooms with orientation in mind. The large wall clocks and calendars in the intensive care units are one example of the attention orientation has been given. Techniques have also undergone some changes over the years.

The professional should remember, however, that many elderly patients have difficulty remembering details such as the specific date and the specific time. Time and date orientation is better evaluated on the time of day (daytime or nighttime) and the month or season of the year. Almost all patients should be able to tell you their name, although you may need to separate the truly confused from those who think the question is silly and will give you some ridiculous answer.

Most patients should also be able to tell you where they are, perhaps not precisely, but enough to say either hospital or nursing home (or similar response).

If the patient offers incorrect information, the professional must use good judgment in determining how much correction to give. Some confused patients will react with agitation to attempt to correct their misperception, causing disruptions in relationships and difficulty with care. A good rule of thumb is to push the issue of reorientation only if doing so is critical to the health and well being of the patient.

Another way to implement orientation is to introduce yourself when you enter the room, and include orientation information in the course of conversation with the patient. You can then use the evaluation tool of asking the patient what your name is to assess his present level of orientation and memory.

Cognitive Characteristics in Later Life

Contrary to the stereotype, the person in later years does not automatically degenerate in intellectual function. Assessment and care must be directed toward the healthy characteristics as well as the limitations that may exist.

Cognitive functions refer to mental and intellectual processes of drive, perception, interest, motivation, memory, reasoning, thought, learning, problem solving and judgment. These functions include the ability to examine a situation; take in, process and recall information; orient self in time and place; organize complex data; and respond appropriately to stimuli.

Chronological age is rarely a reliable index of the elderly person’s mental development. The initial level of ability is crucial; those with high IQ scores as children show progressive gains in general information, comprehension, vocabulary and arithmetic when retested later in life. A bright 20 year old, all things being equal, will be a bright 70 year old, and the bright 70 year old will function better in certain cognitive skills than the average 20 year old.

Factors that Influence Cognitive Response

Many factors must be considered when you assess the intellectual level, problem-solving ability, creativity, reaction time or memory of the older person, including the following:
1. Interest in living and in events about him.
2. Sensory impairments that interfere with integration of sensory input into proper perception.
3. Amount of time since he was in school or in an intellectually demanding position.
4. Educational level, past involvement in informal learning activities or earlier cognitive incapacities.
5. Amount of deliberate caution, that is, using more time to answer or do a task, which can be interpreted as not knowing.
6. Presence of adaptive mechanisms to conserve energy rather than showing assertion or time consciousness.
7. Degree of motivation to please those around him or to participate in a testing situation.

Previous lifestyle, present behavior patterns and general coping mechanisms all affect cognitive function and must be considered in assessment. Observe behavior in a variety of situations and listen to the person’s conversation and reminiscences. Talk with family members or friends. Consider the total, unique individual physically, emotionally and socially so that you can increase the accuracy of your cognitive assessment.

Memory

A progressive loss of memory, the ability to retain or recall past thoughts, images, ideas or experiences, does not necessarily occur in later maturity, although memory loss affects more people as they get older. Loss of short-term memory (recall for recent events) is more likely to occur than loss of remote memory (recall of events that occurred in the past).

The person’s permanent memory is an organized network of concepts interrelated in specific ways. If the relationship between these concepts cannot be used because of loss, decreased retrieval, or slower access, the person loses conceptual richness or spontaneous use of memory links. Such loss is more likely to occur in older people than in younger people and in persons institutionalized than in persons living in the community, apparently because of the number of life crises and less intellectual stimulation for the former group.

Memory prompts can take many forms and can be used in home, hospital, adult home and long-term care settings. Some memory prompts will be helpful in the early stages of the disease when the ability to read and comprehend instructions is still reasonably intact; other suggestions may help jog the memory when verbal communication is no longer possible.

When the patient does not fully comprehend what is happening, facial expression, touch, and tone of voice can create a more comfortable atmosphere. Frequently, all that the elderly patient needs is extra time and patience or, truly, some “tender loving care.”
The Alzheimer’s Association describes the progression of dementia through seven defined stages, from mild to severe, over an average span of 4–8 years. To learn more about the stages visit: www.alz.org/alzheimers_disease_stages_of_alzheimers.asp

Other Interventions for Persons with Memory Loss

Doing one thing at a time; have the patient complete the task at hand before performing another. For example, complete brushing the teeth before beginning to comb the hair.

Keep all instructions simple, check for comprehension, and allow time for repetition.

Tell the patient everything that will happen before it happens, even if he does not seem alert enough to understand.

Avoid startling the elderly patient. For example, speak gently and pleasantly as you approach the bedside. If possible, be sure the patient can see you, and establish eye contact.

Pay attention to complaints of hunger and thirst even if the patient has just eaten. Offer a drink of juice or milk and a cracker if possible. To tell the patient “you can’t be hungry” or “you just finished lunch” is to imply that he does not know what he is talking about. The same thing applies if the patient complains of being tired or in pain.

Distract the patient who is showing signs of agitation. For example, say, “I like that new plant. Do you have plants at home?” or, “Do you like music?” This distraction should not be done until the person is assessed for what is causing the agitation (see Diversionary Tactics for more information about reducing agitation and medical reasons for agitation).

Stop what you are doing whenever the patient is resisting all your efforts to provide care. Anything else is futile. Maybe it’s time for more “TLC”. If the patient speaks in a loud voice, wait for an opportunity to speak and then do so in a soft voice.

When the patient is confused, the dilemma is not necessarily the confusion, but the agitation and lack of cooperation that go with it.

Thorough basic care helps alleviate agitation by eliminating a number of potential causes of increased confusion. For example, deep breathing and moving the extremities increase circulation and blood supply to the brain.

Diversionary Tactics

Diversionary tactics that will comfort the older patient can be used as an alternative to restraints and may be used with all types of institutionalized patients.

Music Therapy — Can music help us heal? There is the old saying, “Music soothes the savage beast.” It seems to calm and trigger positive emotions. The great classical composer, Beethoven once said, “I leave my music to heal the world.” Music has the power to heal wounded minds and spirits. One of the first recorded uses of music as an instrument of healing is found in the Old Testament of the Bible. King Saul called upon David, the shepherd boy to play his music to soothe Saul’s spiritual and emotional distress. Saul was so pleased with the ‘music therapy’ that he requested that David stay in his service (1 Samuel 16:14-23).

The belief in the healing power of music has continued throughout history. In the 1920’s, “background” music with the purpose of being relaxing (but not distracting) was developed by the company Muzak. Muzak started piping music into elevators to calm people’s fears of using this new invention. During WWII, music performers entertained wounded soldiers. Why? It was discovered that music not only entertained, but also improved morale, decreased depression and kept the injured grounded in reality.

Reminiscence — Talk to your patients about happy events in their life and recall past experiences. Have family members get involved by bringing in old pictures of familiar faces and events.

Visual Aids — Provide books and magazines with colorful, landscape pictures with few words; pictures of babies and animals or family photo albums can help calm them.

Repetitive Hand Activities — Have them do things to keep their minds and hands busy. Consider the value of a “rummage box” (similar to a rummage drawer but portable) filled with soft things like washcloths and towels, balls of yarn, and stuffed animals. Many residents in LTC facilities and home situations will be content to simply take things out of boxes and replace them; towels and washcloths may be folded and refolded and yarn wound and unwound. Rummage boxes can be used in lounge areas and in the person’s own room.

Games — Large checkers, simple games and large print playing cards are great. They provide an outlet for energy and promote interaction with other residents.

Using simple techniques can reduce restraint use and agitation in confused patients.

Reduce Agitation — The agitation often seen in this group of patients more often than not, is a response of fear of the unknown or an expression of physical or emotional pain and discomfort. If the patient is able to verbalize his needs, listen and validate, then correct the problem as soon as possible.

Basic care requires that the patient is kept warm, dry, and comfortable, and some creativity may be required to assess the source of discomfort. Agitation and confusion may signal an impending medical problem.

Before instituting distraction, assess for illness. Elderly women may have a urinary tract infection and the usual symptoms are not there or the woman cannot verbalize her pain. Collect a specimen and test for presence of bacteria. For many patients the source of agitation may be the presence of a tube somewhere on or in his body; and removal of the offending device may not be an acceptable option. If the patient pulls at an IV, the arm and site can be wrapped with an elastic compression bandage, and consider use of a capped IV line. One of the most aggravating devices seems to be the urinary catheter; for everyone’s sake, they should be removed as soon as possible. In the meantime, the tubing may be hidden by placing the tube between the legs, and the bag at the foot of the bed. Leg bags can also be used if appropriate.

Tolerance of a nasal cannula can be improved by keeping the oxygen humidified and the patient’s nares lubricated. Consider a nasal tube stabilizer or taping the cannula to the patient’s cheeks. For an abdominal tube, one can use a tube stabilizer, an abdominal binder, or both.

The Burden of Chronic Disease for Older Adults

According to the National Institute on Aging (NIA), research in 2013 found clinicians treating older patients know that most have multiple chronic conditions (MCCs), for which they receive multiple
interventions. In fact, about 75 percent of people 65 and older have two or more chronic conditions—such as heart disease, diabetes, chronic lung disease, arthritis, and some cancers—which significantly affect their health and well-being. Guidance based on clinical research is critical to treating people with MCCs, as treatment for one condition may have negative effects on coexisting conditions and may interact with other treatments.

As a result, the NIA and the Agency for Healthcare Research and Quality convened a Consensus Panel in September 2011 to recommend a core set of outcome measures for evaluating and determining the need for and success of MCC treatments that could be widely used in research and in healthcare delivery. In addition to measurement of gait speed, the panel recommended three possible composite outcome assessments that could be administered in a physician’s office or clinic, focusing on function in the following areas:

- General health
- Pain
- Fatigue/energy
- Physical function
- Sleep
- Mental health
- Social role

Depending on the results, clinicians could follow up with additional questions and diagnostic tools to determine the most pressing issues and devise a plan to treat or alleviate symptoms. The recommended composite outcome measures can be found in Universal Outcome Measures for Older Persons with Multiple Chronic Conditions, Journal of the American Geriatrics Society, December 2012. Go to http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3521090/

Elder Abuse and Maltreatment

Every year hundreds of thousands of adults over the age of 65 are neglected, abused, and/or exploited by family members and others. In general, elder abuse is an umbrella term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.

The Centers for Disease Control and Prevention (CDC) recognizes elder abuse as an epidemic and a major public health issue because of associated pain, suffering, and diminished quality of life. The personal costs of elder abuse are catastrophic and include loss of independence, health, security, and dignity. Unfortunately, the problem of elder abuse is likely to get worse as the percentage of older adults increases.

As many as 5 million older adults are abused in the United States annually and approximately 85% of these cases are never reported. Most elder abuse victims are female and about 40% are over the age of 80. Although the vast majority of elder abuse occurs in the home, it also takes place in extended care facilities and assisted living facilities.

Many victims are people who are older, frail, and vulnerable and cannot help themselves and depend on others to meet their most basic needs. Abusers of older adults are both women and men, and may be family members, friends, or “trusted others.”

Legislatures in all 50 states have passed some form of elder abuse prevention laws. For example, Texas has a mandatory requirement for all nurses who provide care to older adults.

However, no federal law specifically dedicated to preventing elder abuse exists. Inconsistencies in elder abuse definitions between states make it hard to gain a clear description of what constitutes abuse. Additionally, no uniform elder abuse reporting system exists in the United States. As a result, no national standard for defining, identifying, reporting, or investigating elder abuse exists at this time. Therefore, broadly defined, abuse may be:

- **Physical Abuse**—inflicting physical pain or injury on a senior, e.g. slapping, bruising, or restraining by physical or chemical means.
- **Emotional Abuse**—inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts, e.g. humiliating, intimidating, or threatening.
- **Sexual Abuse**—non-consensual sexual contact of any kind.
- **Neglect**—the failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.
- **Exploitation**—the illegal taking, misuse, or concealment of funds, property, or assets of a senior for someone else’s benefit.
- **Abandonment**—desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.
- **Self-neglect**—characterized as the failure of a person to perform essential, self-care tasks and that such failure threatens his/her own health or safety.

When abuse is suspected, it’s important to be nonjudgmental and allow plenty of time to interact with the elder. Interview and assess the victim in a private setting to make the elder more comfortable with discussing his or her situation.

In early 2013, The United States Preventive Services Task Force (USPSTF) released its updated standards for screening older or physically or mentally dysfunctional adults for abuse and neglect. The conclusion? “Recommendation I—current evidence is insufficient to assess the balance of benefits and harms of the service.”

What does this mean? There are varying interpretations—but the wrong interpretation is that we should forego screening for abuse and neglect in vulnerable older patients. As the CDC report notes, few studies have evaluated the accuracy and outcomes of specific screening strategies in older adults.

Assessment of the patient by the healthcare professional is critical when you suspect elder abuse. It is important to interview the patient privately, especially if you suspect the caregiver is the abuser. First, ask some questions indirectly and then get more direct.

Below find sample questions to determine if abuse is occurring:

**Instructions:** Request family members step outside the room and use the opportunity to interview the patient alone. Begin the conversation with the question, “How are things at home?” “Do you feel safe where you live?“ “Who prepares your food?” and then follow with the more specific questions.

**Physical Abuse**

1. Are you afraid of anyone at home?
2. Have you been struck, slapped or kicked?
3. Have you been tied down or locked in a room?
4. Has anyone touched you without your permission?
Screening Tools


Caregiver Abuse Screen: http://www. psychindex.com/behaviour/caregiver- abuse-screen-case


Hwalek-Sengstock Elder Abuse Screening Test: http://www.medicine.uiowa.edu/ uploadedFiles/Departments/FamilyMedicine/ Content/Research/Research_Projects/ hwalek.pdf

Screen for Various Types of Abuse or Neglect, Screening Tools and Referral Protocol: http:// www.who.int/ ageing/publications/Discussing_Elder_Abuseweb.pdf

Vulnerability to Abuse Screening Scale: http://www.medicine.uiowa.edu/uploadedFiles/Departments/FamilyMedicine/ Content/Research/Research_Projects/ vulnerability.pdf

Figure 2

Emotional Abuse
5. Do you ever feel alone?
6. Have you been threatened with punishment, deprivation, or institutionalization?
7. Have you received the “silent treatment”?
8. Have you been force fed?
9. What happens when you and your caregiver disagree?

Neglect
10. Do you lack aids such as eyeglasses, hearing aids, or false teeth?
11. Have you been left alone for long periods?
12. If you need assistance, how do you obtain it?
13. How do you get help?

Financial Abuse
14. Does your caregiver depend on you for shelter or financial support?
15. Has money been stolen from you?

As mandatory reporters of abuse and neglect, healthcare professionals have both an ethical and legal responsibility to advocate for victims of abuse by screening, identifying, and reporting cases of abuse. Education and training to help healthcare professionals recognize signs of abuse and intervene appropriately are essential. For additional screening tools access the links in Figure 2.

Preparing For The End-of-Life

Few of us are comfortable talking about death, whether our own or a loved one’s. It is a scary, even taboo, subject for many. The end of a life, no matter how long and well lived, can bring with it a sense of loss and sadness. It can also be a reminder of our own mortality, so we may avoid even thinking about death.

This is normal -- but death is normal, too. All of us will face it at some point.

Defining the End-of-Life

The end of life and how people die has changed a great deal in the past century. Thanks in large part to advances in public health, medicine, and healthcare, most Americans no longer die suddenly from injury or infection. Instead, we live longer and, more often than not, die after a period of chronic illness.

As a result, it is hard to know when the dying process begins. Some people pass quickly, while others recover from severe illness several times before death. Even people who are the same age and sex, with the same disease and state of health, are unlikely to reach the end of life at the same time.

We often rely on health care providers to tell us when the end of life is near. But even the most experienced health care provider may find it hard to predict when someone will die. An expert may say the end is within weeks or months, but the dying person slips away much sooner or survives for a year or more.

Preferences for the End-of-Life

Because the end of life is hard to predict, it is best to plan ahead. You might want to start by asking yourself or a loved one, “What is the best way to plan for the end of life?”

The answer will differ from person to person. Some people want to spend their final days at home, surrounded by family and friends. Others may prefer to be alone, or to be in a hospital receiving treatments for an illness until the very end.

The answer may also change over time -- the person who wanted everything possible done to prolong life may decide to change focus to comfort. Someone else who originally declined treatment may agree to an experimental therapy that may benefit future patients with the same condition.

No matter how a person chooses to approach the end of their life, there are some common hopes -- nearly everyone says they do not want to die in pain or to lose their dignity. Planning for end-of-life care, also known as advance care planning, can help ensure such hopes are fulfilled. The person may wish to prepare a legal document, “Advance Care Directive, or Health Care Directive” formerly known as a “Living Will” to state wishes of specific care such as resuscitation and artificially provided nutrition and hydration. Others may also want to have a “Durable Power of Attorney for Property Management and Health Care” in which the person states a name of a person to make decisions for health and financial situations at a time when the person cannot make his or her own decisions.

Hospice Care

One of the ways end-of-life care is provided is through hospice. Hospice, as defined by the Center for Medicare and Medicaid Services, is a program of care and support for a dying person whose doctor and a hospice medical director certify has less than six months to live.

The focus of hospice is on comfort, not cure. Currently, patients must be willing to give up curative treatments to receive Medicare coverage for hospice care. (Medicare continues to pay for any covered health problems that are unrelated to the dying person’s terminal illness.)

Palliative Care

Unlike hospice care, you do not have to be dying or give up curative treatments to receive palliative care. The term “palliative care” is sometimes mistakenly used to mean end-of-life care, but palliative care is a treatment available to anyone of any age who is suffering from the discomforts, symptoms, and stress of a serious illness.

Palliative care is used effectively to provide relief from many chronic conditions and their treatments, too. Older persons who are living with one or more chronic illnesses may benefit from palliative care long before they need end-of-life or hospice care. Unlike hospice care, palliative care may be used for as long as necessary.
To learn more about hospice and palliative care, other courses provided by the National Center of Continuing Education, # 2013 Palliative Care: Essentials, #432 End-of-Life Care, or #430 Death and Dying a Christian Approach.

Questions To Ask As the End of Life Approaches

Regardless of a person’s choices for treatment and care at the end of life, it is important to maintain the quality of a dying person’s life. To better understand the care options available for someone who is approaching death, you may wish to ask the dying person’s health care provider the following questions.

1. Since the illness is worsening, what will happen next?
2. Why are you suggesting this test or treatment?
3. Will the treatment bring physical comfort?
4. Will the treatment speed up or slow down the dying process?
5. What can we expect to happen in the coming days or weeks?

Summary

We marvel at the 80-year-old who still gets up every day and goes to work. And, it is a genuine thrill to celebrate a relative’s 100th birthday. Yet our feelings about aging and care for the elderly are complex.

We may want to live forever, but who looks forward to getting old? We hope we’re vigorous right up until the very end. From the beginning of time, people have tried to understand aging. Almost every culture has a mythology to explain it. As we grow up, tales of eternal youth pique our curiosity.

There’s the little girl, excited to visit her grandmother, who asks her parents how someone so spunky and fun could be so old. Or, the 3rd grader who, after watching in awe as a caterpillar spins a cocoon and then days later emerges as a butterfly, hounds the teacher with questions about this magical transformation. These are the types of questions and kinds of experiences that could stimulate a lifelong quest to explore what happens as we age.

Healthcare professionals are in a unique position to positively influence the growing population of older adults. We are also able to advocate and promote safety and quality of life as this special generation completes their journey at the end of life.

Elder abuse is a violation of human rights that affects every aspect of the older person’s life. Health professionals play an important role in identifying, preventing and managing its occurrence by increasing the level of trust with patients, implementing routine screening practice and effectively working with other services in the community. Beyond scientific and legal responsibilities, a humanitarian approach to care of the elderly is needed for all aspects of care.

References


