Caring for our Elderly Patients: The Uniqueness of Older Adults

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June 2018

Myths of Old Age

- Greatest proportion of chronic illness found in the older population, however, it is a minority of the older population
- Sixty-five years of age is old?
- With health promotion and disease prevention, physical decline of normal aging may be delayed until eighth and ninth decades
- Mental ability depends on attitude, motivation, and health - not age

Sexuality

- Sexuality and intimacy are basic human needs
- An individual can survive without one or more of the other senses, but no one can survive without touch
- Sexuality is expressed through intimacy and touch
- When physical sexual needs are not met, physical need of intimacy more important
- The more intimacy needs are met, the higher quality of life


True love isn't Romeo and
Juliet who died together
It's Grandma and Grandpa
who grew old together
Unknown
Kahnswisewords.com

Heterogeneity

- Diverse in ability, education, skills, and individual talents
- No two people age in exactly the same way
- Aging is not programmed in the genes in the same way developmental processes are programmed
- Major problem in research is that older adults ranging from 65 to 100 are grouped into a single category


" Some people are old at 18 and some people are young at 90...Time is a concept that humans created." - Yoko Ono

Competence vs. Capacity

Competency

- Competence refers to a judge's ruling as to whether an individual has been deemed capable of making his or her own decisions
- An individual adjudicated to be incompetent must have a guardian appointed to make the decisions for the area/s in which the person has been found to be incompetent

Capacity

- Capacity is defined as the functional ability to understand, appreciate, and either take or direct certain actions
- Assessment of decisional capacity is made by a professional based on the patient's ability to make decisions

Capacity

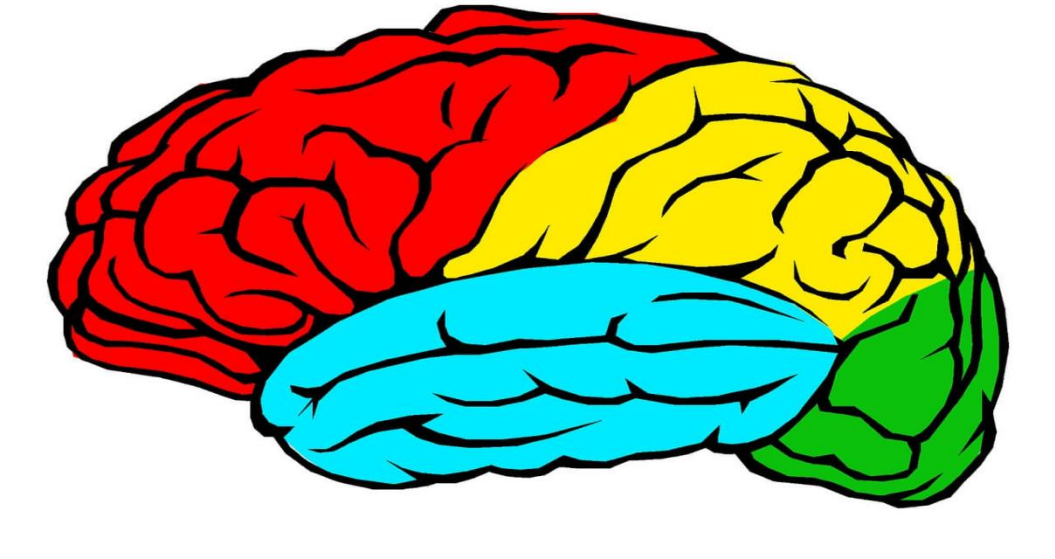
- Not a static entity but one that fluctuates over time in periods of health and illness
- Mild, moderate, severe dementia
- Delirium
  - Acute disorder of attention and global cognitive function
  - Neuro-psychiatric syndrome

Assessment of Capacity

- Must be able to understand the information being considered
  - Eliminate hearing impairment and language difference
- Must have the conceptual ability to understand the consequences of the decision
- Must be able to communicate the decision
- Consistency
  - Inconsistency may be a clue but does not negate a person's right to make decisions
- Rationality
  - A perceived irrational decision does not negate a person's right to self-determination

Determining Capacity

- Decision making centered in cortex and frontal lobes
- Specific testing
- Observation of person's decision making process



Determining Capacity

- Formal test scores not always necessary
  - Interview and documentation of areas patient unable to function sometimes sufficient
- Problems of Self Care
  - Cognitive impairment vs. denial
  - Testing and demonstrated inability to care for oneself
- Problems of Finances
  - Can maintain ability to make self care and medical decisions
  - Specific testing
  - Usually a demonstrated problem is sufficient

Determining Capacity

- Will and Testaments
  - Ability to make a Last Will and Testament is often retained after ability to make decisions and handle finances
  - Ability to remember estate plans and express some logic behind choice is sufficient
  - Courts are very liberal in allowing someone to change a will
- Living Will
  - Requires a higher level of cognitive function
  - However, cognitively impaired individuals can express wishes and desires

Care of the Older Adult

- Physical assessment
- Oral health assessment
- Vision and hearing assessment
- Functional assessment
- Mental status assessment
- Emotional health
- Assessment of social support
- Environmental safety
- Financial assessment

Multidisciplinary Team

- Managing the complex issues in care of older adults is beyond the training of one discipline
- Interdisciplinary teamwork is vital to the provision of comprehensive care
- Case management is necessary to ensure coordination and continuity of care
- Interdisciplinary care proven to be cost effective by reducing hospital readmissions and physician office visits

Geriatric Multidisciplinary Team

- Nursing
- Medicine
- Social Worker
- Psychiatrist
- Psychologist
- Pharmacist
- Occupational Therapist
- Physical Therapist
- Dietitian
- Patient/Family

Atypical Presentation of Disease in the Older Adult

- Coronary Heart Disease/MI
  - Vague dyspnea, abdominal pain, vomiting, fatigue/weakness, confusion, malaise, syncope,
- Heart Failure
  - Malaise, fatigue, confusion/delirium, irritability, sleep disturbance, anorexia, abdominal pain, nausea, diarrhea, urinary incontinence
- GERD
  - Dysphagia, chest pain, respiratory symptoms, vomiting
- Pneumonia
  - Confusion, anorexia, N/V, diarrhea, weakness, lethargy, myalgia, arthralgia, vague dyspnea, *increased respiratory rate

Urinary Tract Infection

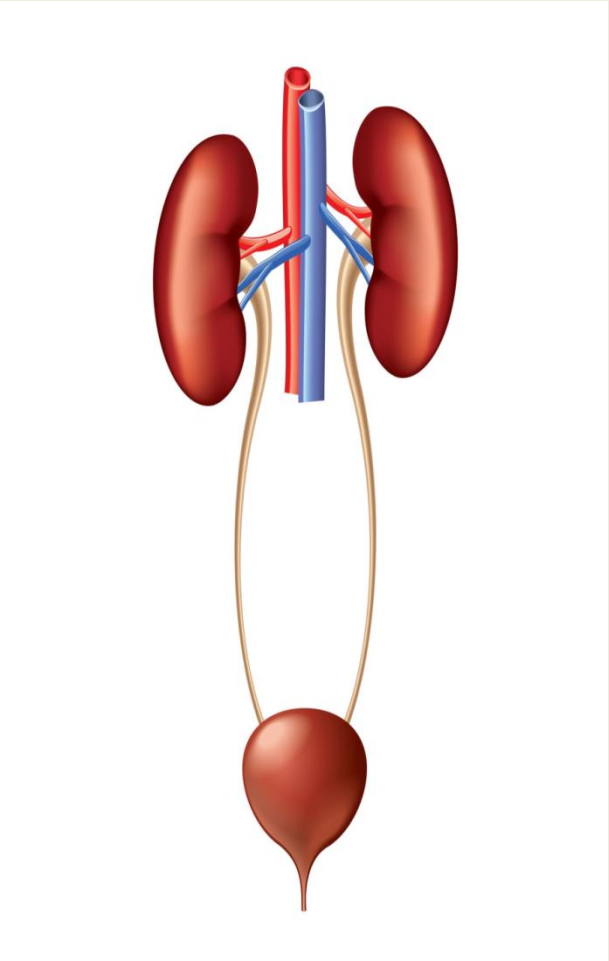
- The most frequent bacterial infection in the elderly population
- Treatment approaches differ
  - Women vs. men
  - Institutionalized vs. noninstitutionalized
  - Chronic indwelling catheters
- Acute lower tract infection (cystitis)
  - Frequency, urgency, suprapubic discomfort, dysuria, new or increased incontinence

Urinary Tract Infection

- Asymptomatic bacteriuria
  - Young women 2-3%
  - Women > 65 y.o. 10%
  - Institutionalized women 25-50%
  - Young men uncommon
  - Men > 70 y.o 5%
  - Institutionalized men 15-40%
  - Chronic indwelling catheter 100%

Urinary Tract Infection

- Cognitively impaired
  - Altered mental status
  - Confusion
  - Fall
  - Change in functional status
- Diagnostic dilemmas
  - ∅ positive urine culture
  - ∅ fever
  - ∅ urine odor



Urinary Tract Infection Treatment

- Urine culture for appropriate antibiotic
- Antimicrobial selection similar for elderly and younger populations
- Renal and hepatic function
- Allergies, cost, medications
- Duration of treatment
  - Women – up to 7 days
  - Men – up to 14 days

Geriatric Syndromes

- Clinical conditions in older adults that do not fit into specific disease categories
- Common in the older population
- Multifactorial
- Associated with morbidity, poor outcomes, quality of life, disability
- Most common shared risk factors
  - Advanced age, baseline cognitive impairment, baseline functional impairment, impaired mobility
- Synergistic interactions among risk factors

Geriatric Syndromes

- Failure to Thrive
- Syncope
- Dizziness
- Sleep Disorders
- Delirium
- Falls
- Incontinence
- Pressure Injuries

Delirium

- Delirium is to the elderly what fever is to the young
- Acute confusional state, acute brain failure
- Worse at night and may have lucid intervals
- Delusions, hallucinations, fear, anger, apathy
- Dementia follows a gradual course of impairment
- Delirium is acute and waxes and wanes
- Hyperactive or hypoactive

Causes of Delirium

- Cardiovascular Disease
- Infections
- Medications
- Metabolic Imbalances
- Neoplasm
- Postoperative state
- Trauma
- Vascular Disorders
- Seizures

Delirium

- Life-threatening
- Determine and treat the medical cause
- When treated promptly usually reversible
- If not reversed can lead to chronic brain impairment

Falls

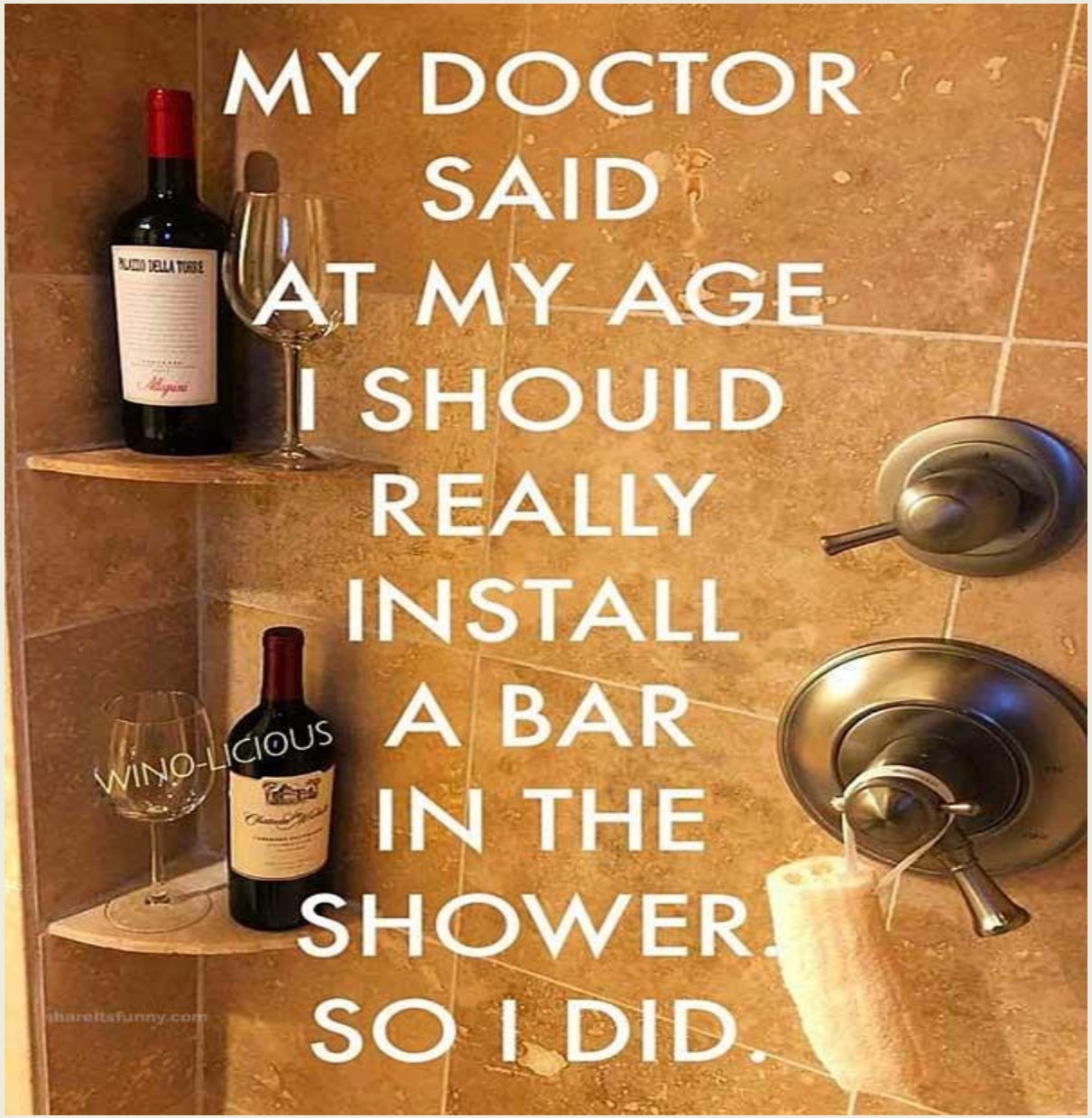
- Physical, psychosocial, and economic consequences
- A cluster of falls over a short period of time is a marker for general physical decline
- Multiple falls or hospitalization for injury r/t fall is a risk factor for institutionalization and morbidity
- Psychosocial consequences more debilitating than physical injuries

Risk Factors for Falls

- Sensory
- Neurological
- Musculoskeletal
- Cardiovascular
- Respiratory
- Gastrointestinal
- Metabolic
- Genitourinary
- Psychological
- Medications

Fall Prevention

- Identify risk factors
- Modify or correct risk factors
- Careful selection of medications
- Modify environment
- Avoid chemical and physical restraints
- Vitamin D
- Proper foot wear
- Exercise


MY DOCTOR
SAID
AT MY AGE
I SHOULD
REALLY
INSTALL
A BAR
IN THE
SHOWER.
SO I DID.
WINO-LICIOUS
sharetsfunny.com

Restraints

- Restraint free care is now the standard of care for older adults
- Use of physical restraints in nursing homes in the U.S. far exceeds that of other western countries
  - U.S. nursing homes – 41%
  - U.S. hospitals – 22%
  - Scotland – acute & long term care – 3.8%

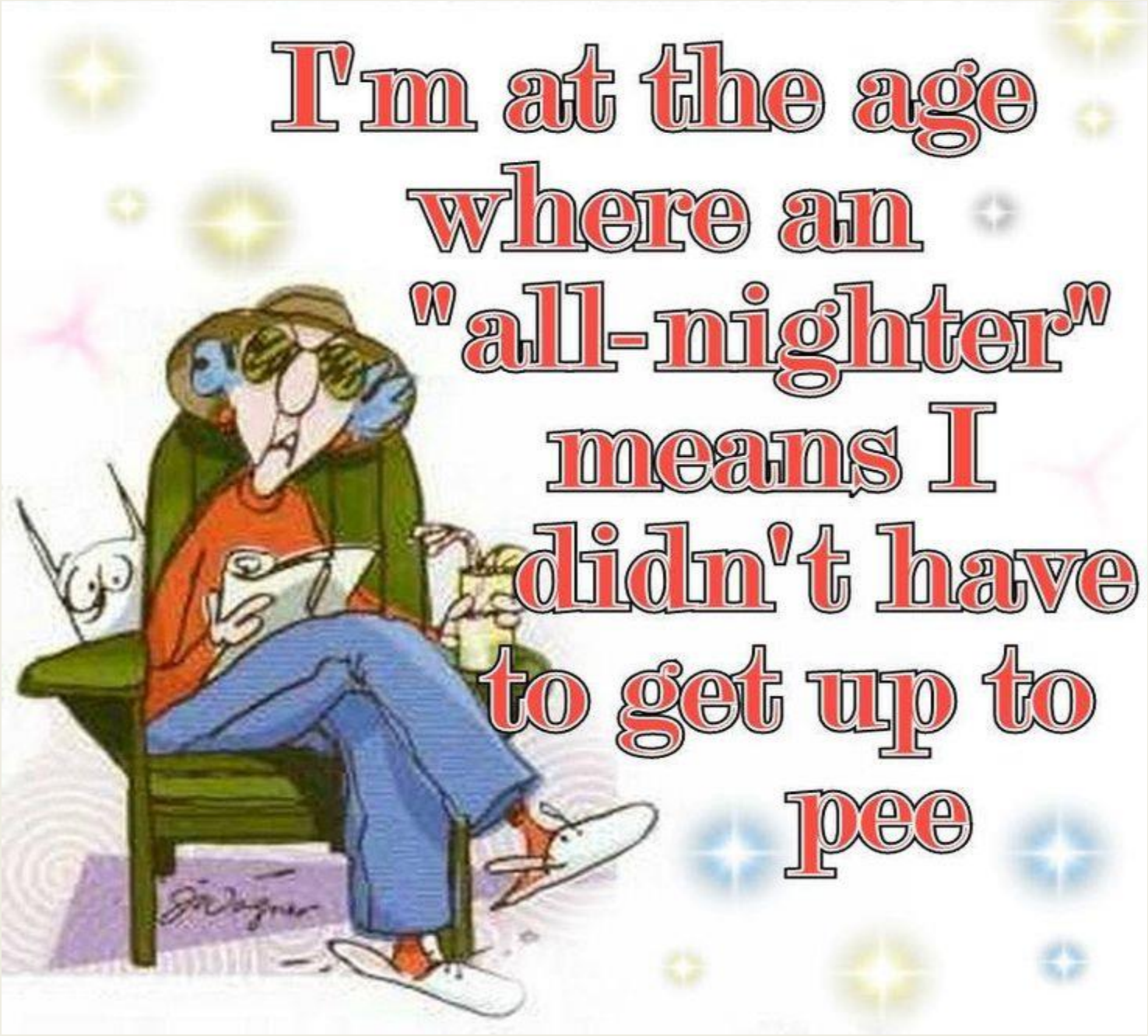
Effects of Physical Restraints

- Serious injuries from falls are greater when physical restraints used

Pressure Injuries	Incontinence
Infections	Agitated behaviors, resistance, delirium
Altered nutrition	Emotional desolation
Loss of functional capacity	Anger, fear, discomfort , confusion
Cardiac stress	Social isolation
Asphyxiation	Strangulation

Incontinence

- Physical, psychological, social, and economic consequences
- Age related changes
  - Decreased bladder capacity & increased residual
  - Uninhibited bladder contractions
  - Increased nocturnal production
  - Decreased estrogen
  - Benign prostatic hyperplasia
  - Decreased immune function
  - Impaired mobility, dexterity, and vision


I'm at the age
where an
"all-nighter"
means I
didn't have
to get up to
pee

Transient Incontinence

- **D – delirium**
- I – infection
- A – atrophic vaginitis/urethritis
- P – pharmaceuticals
- P – psychological
- E – excess fluid
- **R – restricted mobility**
- S – stool impaction

Functional Incontinence

- Caused by factors outside the urinary tract
- Cognitive, physical, psychological, and environmental factors
- Caused by inaccessible toilets, lack of caregiver, confusion, psychosis

Functional Incontinence Assessment

- Mobility – gait
- Dexterity – disrobe
- Distance to toilet
- Chair or bed egress
- Nocturnal micturition
- Delay in voiding
- Living arrangements
- Caregiver involvement


Shut Up I'm Still Talking
You know you're gettin' OLD when you can't walk past a bathroom without thinking "I may as well pee while I'm here."
www.facebook.com/ShutUpImStillTalking

Management of Functional Incontinence

- Physical Therapy – muscle strengthening, improved gait & balance
- Occupational Therapy – manual dexterity problems
- Accessible toilet
- Availability of caregivers
- Scheduled/prompted toileting
- Alterations to environment
- Limit fluid intake in evening
- Elevating legs in late afternoon and early evening
- Convenient scheduling of diuretics
- Complete bladder emptying
- Absorbent products

Pressure Injuries

Intensity & Duration of Pressure

- Mobility
- Activity
- Sensory perception

Tissue Tolerance

- Extrinsic
  - Moisture
  - Friction and shear
- Intrinsic
  - **Nutrition**
  - Older age
  - Low arteriolar pressure
  - Low oxygen tension

Compromised Nutrition

- Protein-calorie, iron, ascorbic acid, trace minerals deficiencies
- Hypocholesterolemia
- Fatty acid deficiencies
- Dental caries, periodontal disease, poorly fitting dentures
- Atrophy and fibrosis of salivary glands
- Swallowing disorders
- Medications
- Sensory impairment
- Malabsorption
- Poverty
- Restricted diets
- NPO/clear liquids
- Poor food palatability
- Loss of control over choices
- Cultural preferences
- Difficult to open containers
- Poor meal time ambiance
- Lack of assistance with feeding
- Cognitive or mental impairment

Medications that Suppress Appetite and Alter Olfactory Function

- Antidepressants
- Anti-inflammatories
- Cardiac, antihypertensives
- Lipid lowering drugs
- Antihistamines
- Antimicrobials
- Antineoplastics
- Bronchodilators, other asthma drugs
- Muscle relaxants
- Parkinson drugs
- Anticonvulsants
- Vasodilators

Feeding Tubes

- Withholding or withdrawing – morally equivalent but emotionally different
- Food is symbolic of caring and nurturing
- In contrast, it is accepted practice to withdraw ventilators when the burdens outweigh the benefits
- You do not “starve to death” a person in multi organ decline
- The issue is not one of eating but rather of artificial feeding
- Feeding tubes are medical interventions patients or surrogates may refuse
- Tube feeding in advanced dementia to prevent aspiration pneumonia, malnutrition, & infections provide few long term benefits & may contribute to further decline

Pressure Injury Prevention

- Early identification of declining nutritional status
- Early identification and treatment of malnutrition
- Inconclusive evidence regarding nutritional supplementation & pressure injury prevention

Food, Glorious Food

Pressure Injury Prevention

- Offer high protein oral supplements to those with nutritional and pressure injury risk due to acute or chronic conditions or following a surgical procedure (NPUAP)
- Liberalize dietary restrictions
- Food available around the clock
- Finger foods
- Offer fluids hourly and with snacks

Iatrogenesis

- Unintended, harmful, incidents or conditions that result from diagnostic, prophylactic, or therapeutic interventions or omissions
- Age is a major risk factor
- Number and severity of illnesses, healthcare providers attitudes/beliefs/skills/knowledge, environment of care, high technology, lack of services

Iatrogenic Conditions

- Infections
- Malnutrition
- Incontinence
- Accidents and Injuries
- Sleep-wake cycle disturbances
- Decline in mobility and function
- Excess disability

Iatrogenic Malnutrition

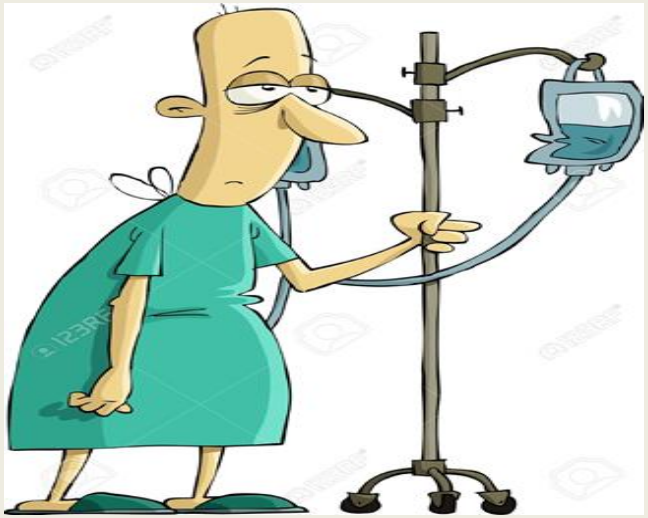
- Older adults often admitted in compromised nutritional status
- Physiological stress of illness or hospitalization
- Medical treatment
- Institutional policies
- Environmental factors

Prevention of Iatrogenic Malnutrition

- Early identification of nutritional deficit
- Nutritional supplementation
- Selection of medications with less side effects
- Optimal scheduling of procedures
- Mealtime assistance
- Occupational therapist
- Staff education

Iatrogenic Incontinence

- Unable to locate bathroom
- Shared bathroom not available when needed
- No bathroom break between procedures
- Inaccessible urinal or commode
- Delayed response to call light
- Restraints
- Medications
- Prolonged bedrest

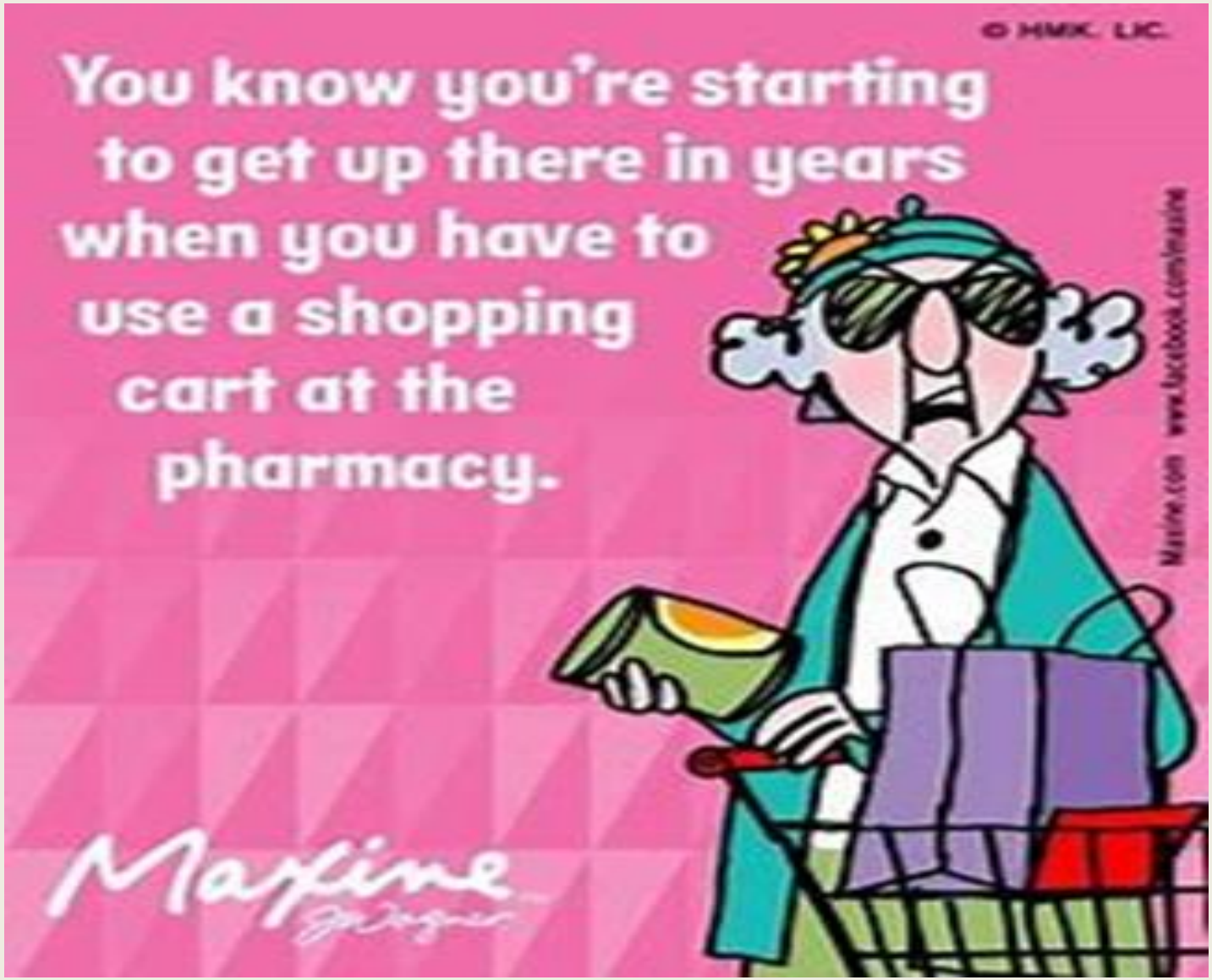


Prevention of Iatrogenic Incontinence

- Orienting to facilities
- Assisting promptly
- Urinals and bedpans within reach
- Commode chairs available
- Diuretics and laxatives scheduled when patients are near a bathroom or assistance is available
- Scheduled or prompted toileting

Polypharmacy

- Use of excessive or unnecessary medications
- Multiple medications of the same class
- Interacting medications
- Contraindicated medications
- Inappropriate dosage
- Drug therapy to treat adverse effects of other drugs


© HMK. LIC.
You know you're starting to get up there in years when you have to use a shopping cart at the pharmacy.
Maxine

Polypharmacy

- ≥ 65 y.o. largest users of prescription and OTC medications
- Multiple providers, inadequate communication
- Reluctance to discontinue drugs prescribed by someone else
- Not taking medications as prescribed
- Pharmacokinetic and pharmacodynamic changes that occur with aging and polypharmacy increase the risk of adverse drug reactions

Polypharmacy

- Potential for drug interaction or adverse drug reaction
  - 6% with two drugs
  - 50% with five drugs
  - 100% with eight or more drugs

Beers Criteria

- Mark Beers M.D. 1991
- Evidenced based, American Geriatrics Society
- Assist healthcare providers in improving medication safety in the geriatric patient
- Divides drugs into 3 categories:
  - Meds to always avoid
  - Potentially inappropriate - avoid in certain diseases or syndromes
  - Use with caution – benefit may offset the risk

Beers Criteria

- Beers Criteria for Potentially Inappropriate Medication Use in Older Adults
- Explicit list of medications, doses, and durations that should be avoided in geriatric patients
- For all patients ≥ 65 years of age
- Adopted by CMS in 1999 for nursing home patients

Beers List

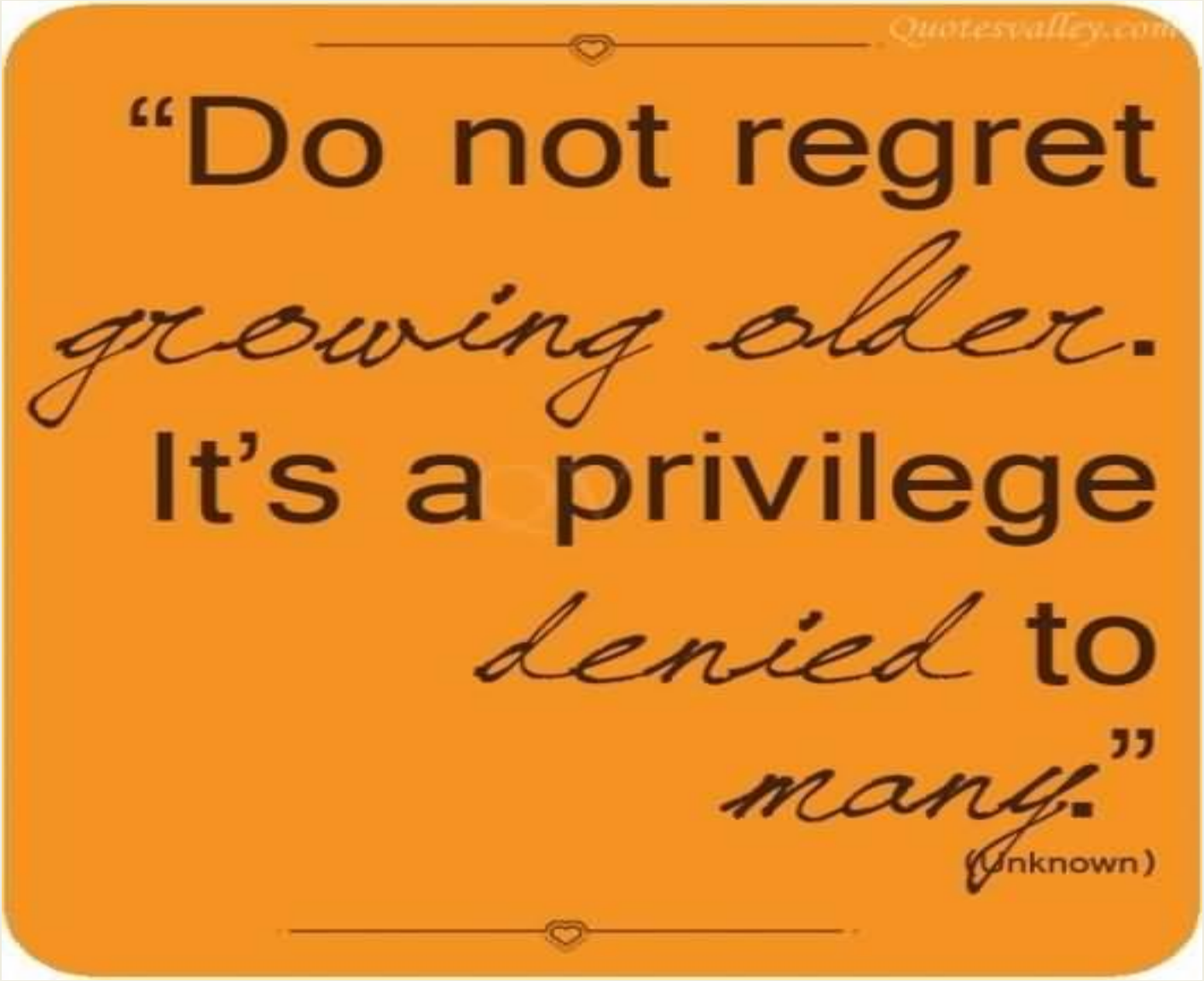
- Megace (megestrol)
- Benadryl (diphenhydramine)
- Digoxin
- Benzodiazepines
- Mineral oil
- Sliding scale insulin
- Non-COX selective NSAIDS – ibuprofen, naproxen

Beers List

- Drugs with strong anticholinergic properties
  - Antihistamines
  - Antidepressants
  - Antimuscarinics
  - Antiparkinson agents
  - Antipsychotics
  - Antispasmodics
  - Skeletal muscle relaxants

Beers List

- Oral antimuscarinics – Ditropan
  - Constipation
  - Avoid in men
  - Causes urinary retention
- Alpha blockers – Hytrin, Cardura, Minpress
  - Avoid in women
  - Relaxes smooth muscle of bladder neck
  - Risk for orthostatic hypotension


Quotesvalley.com
"Do not regret
growing older.
It's a privilege
denied to
many."
(Unknown)

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