Common Concerns for Patients with Dementia

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Allan G. Hedberg, PhD, received his Master's in psychology from Northern Illinois University and his PhD in clinical psychology from Queen's University in Ontario, Canada. He has practiced clinical psychology in mental health centers, hospitals, and rehabilitation units as well as in private practice since 1969. More recently, he has maintained an active consultation service to patients and staff of nursing homes and assisted living facilities in the Central Valley of California. Over this time, Dr. Hedberg has consulted with staff, trained staff, and assisted in the establishment of appropriate programs for elderly patients with special needs, such as Alzheimer's disease.

Faculty Disclosure

Contributing faculty, Allan G. Hedberg, PhD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for nurses in a variety of practice settings who work with older patients.

Accreditations & Approvals

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Course Objective

The purpose of this course is to provide nurses with an overview of the physical and psychosocial problems encountered by patients with dementia, so they might intervene to protect their well-being.

Learning Objectives

Upon completion of this course, you should be able to:

1. Discuss the risks of elder abuse and suicide among patients with dementia.
2. Evaluate the potential risks of alcohol use and misuse among older adults, particularly those with dementia.
3. Describe additional risks that patients with dementia experience and steps nurses can take to monitor and facilitate the safety and welfare of these patients.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Dementia is a progressive and profound disruption in brain function and intellectual capacity. The primary signs include problems with memory, language, spatial-temporal reasoning, judgment, emotionality, thought disorder, and personality. Dementia is a subtle progressive loss of cognitive functioning, with memory loss as its hallmark impairment, particularly loss of short-term memory. The ability to concentrate, make judgments, problem solve, and engage in abstract thought processes is also impaired. Personality and mood changes distinct from previous experiences are likely to develop, such as depression, apathy, elation, and anger. Impulse control becomes a major impairment with associated difficulties in social and physical relationships. Finally, grandiose and persecutory delusions are fairly common, especially in the more advanced stages of dementia [1]. It is possible for a young person to have dementia, but this is usually a result of a neurologic traumatic event or major illness with neurologic corollaries.

Dementia is a physical illness as well. It progressively shuts down the body as the brain is attacked. The first signs of dementia are generally related to reduced physical agility and strength, not just cognitive skills. Dementia can continue for years, but in the advanced stages, life expectancy is similar to that seen with advanced terminal cancer [2]. Patients with various severities of dementia are at risk for a variety of health and mental health conditions. Nurses are in a position to recognize patients at risk for these conditions and to intervene to protect their safety and welfare.

ELDER ABUSE

Elder abuse is a real threat for patients with dementia [3]. They are at risk for financial, physical, emotional, and sexual abuse, particularly from caretakers, family members, and even healthcare providers. Any suspicion of abuse should be reported to the adult social services department of the state and county in which the patient is living. Abuse can be intended (e.g., physical abuse) or unintended (e.g., neglect). Perpetrators of elder abuse may be motivated by many different factors, from overwhelm and burnout to sadism [3]. Some perpetrators are financially dependent upon the victim, leading to an imbalance in the relationship and dangerous expectations. Financial abuse is common, for example, by a child or grandchild who has been dependent on the elder for years and is now seeing their "support funds" being terminated and bank accounts closed. Health and mental health providers should be vigilant for any signs of abuse or neglect.

Signs of financial abuse or neglect should be closely monitored. This can be done by monitoring the interaction of family members/carers with patients, particularly behaviors involving finances and/or signing documents such as wills, trusts, or bank accounts. If necessary, an ombudsman or the patient's attorney should be consulted. If the patient is in a care facility, the facility's attorney may be a resource.

SUICIDE

Older Americans are at an increased risk for suicide. Individuals older than 65 years of age comprise 16.8% of the population but represent 20.0% of all suicide deaths. The rate of suicides for older adults in 2021 was 17.3 per 100,000, with one suicide in this population every 54.5 minutes [4]. Persons older than 85 years of age, especially white men, have the highest rate. Although older adults attempt suicide less frequently than other age groups, they have a higher completion rate [4]. Common risk factors for suicide in older adults include [4]:

- Recent loss of a loved one
- Physical illness, uncontrollable pain, or fear of prolonged illness
- Perceived poor health
- Social isolation and loneliness
- Major changes in social roles (e.g., retirement)

A dementia diagnosis encompasses several of these risk factors, and these patients should be monitored closely and directed to appropriate professional help. The loss of health, purpose, or meaning must be addressed at all stages of aging, but even more so in the later years of life.

The U.S. Preventive Services Task Force recommends screening for depression in older adults.

(https://jamanetwork.com/journals/jama/fullarticle/2806144. Last accessed July 12, 2024.)

Level of Evidence: B (There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.)

Suicide among older adult patients with dementia may be subtle or camouflaged, manifesting as refusal to eat and/or drink water and fluids, rejection of prescribed medication, or intentional isolation from any social contact. These more passive suicide attempts are especially common among older persons in nursing homes or other care settings who have no other means.

ALCOHOL ABUSE

Alcohol abuse in the older adult population is generally a hidden problem. Many older adults do not disclose alcohol abuse because they are ashamed. This is compounded by healthcare professionals' reluctance to ask older adults about their alcohol use, mostly due to the prevalent images of young people misusing substances [5]. Older adults are more likely to hide their alcohol use and less likely to seek professional help, and their families, particularly adult children, are often in denial or are ashamed of the problem [6]. Additionally, the symptoms of alcohol use disorder can mimic or resemble conditions associated with aging, including dementia, thereby masking an underlying drinking or substance disorder [5; 6]. Finally, some older adults may be isolated, with minimal social contacts or networks to intervene in cases in which alcohol or substance use has become a problem.

According to the National Council on Alcoholism and Drug Dependence, older adults exhibiting symptoms of alcoholism comprised 6% to 11% hospital admissions, 20% of admissions to psychiatric services, and 14% of emergency room admissions [7].

The prevalence of alcoholism in the older population is estimated to be 10% to 18%. It is the second most frequent reason for admitting older adults to inpatient psychiatric facilities [8]. Less than 2% of all admissions for alcohol treatment are people older than 55 years of age [7]. Among nursing home residents, it is estimated that as many as one-half have problems related to alcohol [7; 8].

Late-onset alcoholism is common in older adults, and several risk factors may contribute to the development of alcohol use disorders in older age. Some may use alcohol to self-medicate physical symptoms, such as difficulty sleeping or chronic pain. Mourning a loved one, loss of social supports, and loneliness can also instigate alcoholism later in life [6].

One study found that the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5-TR) criteria for alcohol use disorder might be difficult to apply to older adults [9]. For example, age-related physiologic changes may change an individual's response to alcohol, increasing his or her sensitivity and lowering their levels of tolerance. These persons would not meet the DSM-5-TR criteria for alcohol use disorder, as they would require smaller amounts of alcohol to become intoxicated. In addition, the DSM-5-TR criterion of giving up activities or responsibilities as a result of substance use may not be appropriate for older adults because they may engage in fewer regular activities due to diminished vocational or social responsibilities [10].

After a diagnostic assessment, treatment of alcohol use disorder in older adults may include close monitoring, attendance at 12-step programs, group therapy, increased socialization, and/or medication. For patients with dementia, the urge to drink will likely be lost eventually, but it is important to prevent overconsumption, as it may exacerbate symptoms.

FALLS

Falls are common among older adults and can cause serious injury and even death. Decreased mobility, medication side effects, and confusion/disorientation can all predispose the patient with dementia to falls. Patients and their families should be counseled regarding the importance of fall prevention strategies. Older persons' medication profiles must be reviewed relative to their potential contribution to falling. The home environment should also be modified to decrease the risk of falls, keeping pathways cleared and well lit, removing unstable furniture, and eliminating throw rugs and extension cords. Referral to physical therapy for balance training and strengthening may be considered. In addition, occupational therapy is appropriate if modifications in the home are necessary.

INTIMACY

It is important for older people to feel loved and cared for. Romance, connection, physical touch, and sex remain important to people as they age and should be considered part of an individual's overall health and well-being. Individuals may be encouraged to explore new ways of spending time with other people and showing affection, including hand-holding, hugging, massage, and dancing. Some may benefit from education on positive aspects of interpersonal relationships. In some patients, hypersexuality may develop. This can be a manifestation of dementia (e.g., frontotemporal dementia) or the effect of medications.

WANDERING

Wandering behavior is relatively common among persons with dementia, especially at sundown [11]. It can be unintentionally dangerous, and it is important for all persons with dementia to carry some for of identification (e.g., medical bracelet) at all times. It can also be helpful to alert neighbors and local law enforcement of the possibility of wandering. Door should be kept locked whenever possible, with an alarm and/or a two-step lock including a deadbolt recommended.

AGGRESSION

Individuals with dementia may become confused, frustrated, and easily agitated as they become unable to perform formerly routine tasks. When agitation is frequent or excessive, pharmacotherapy may be necessary. It is also important to take steps to protect the individual from harming him/herself and others. This may consist of creating a calm environment (e.g., quiet, reduced clutter) and providing continuing care, support, and reassurance.

PARANOIA

Paranoia is a form of delusion in which an individual is fearful, jealous and/or suspicious of others. When a person with dementia displays paranoia, it is best not to directly react. Instead, the individual should be reassured that s/he is safe and protected. It can be helpful to redirect the individual to a different task or activity to interrupt paranoid thinking patterns.

SPIRITUALITY

All individuals, including those with dementia, have spiritual needs, and spiritual health is part of holistic care. As much as possible, individuals should remain part of their faith community. Spirituality and religion should be incorporated into discussions and daily activities as much as is desired. In some cases, spiritual music may be comforting. Members from the individual's faith community may be encouraged to remain connected.

DRIVING

The risk of driving-related accidents is increased among the older population, and impaired mental status due to cognitive impairment and/or the effects of certain medications can increase risk further. Restricting an individual's driving causes a considerable loss of independence and can be a highly sensitive issue, and the decision should be collaborative, if possible. A dementia diagnosis alone is not considered grounds to revoke driving privileges. Other factors must be present, including cognitive decline and comorbidities [12]. Many states require physicians to report impaired drivers, especially if there is a history of a closed head injury. However, laws vary regarding reporting by other service providers. Professionals are encouraged to study their own state's laws. There are driving schools and classes in many communities specifically designed to assist older adults in maintaining their driving skills and license, which may be an option for some individuals.

It is also important to assess if alcohol or drugs are playing a role in an older driver's abilities. Efforts to intercede to stop drinking/substance abuse or to keep an impaired patient from driving may be necessary.

INFORMED CONSENT

Informed consent requires awareness of relevant information and the demonstrated competency to understand the nature of an issue under consideration and its implications and consequences. Agreement from patients who lack the capacity to give consent actually results in no consent at all. In such cases, the patient requires a healthcare surrogate to be designated through the process of a conservatorship, a will and an advance directive for health care, and/or the appointment of a power of attorney. These surrogates are sometimes referred to as the responsible party (RP). Failing a provision for consent to be granted by some preauthorized RP, healthcare and/or financial decisions require court intervention.

If a patient has a preapproved healthcare surrogate, as outlined by law or an advance directive, all treating professionals and facilities should have a copy of the document on file. This is an area of frequent abuse and boundary violations, even by well-meaning family members. The provider of service must be careful to assure that informed consent or permission of the RP has been granted before proceeding, even when the intended service seems necessary and/or obviously desired. Consent to proceed with any treatment or financial dealing must be with the consent of the RP, and all communication regarding the patient is with and through the RP.

PRESCRIBED MEDICATIONS

Medication management and polypharmacy are major concerns for older adults. An estimated 30% of individuals older than 65 years of age take five or more prescription medications [13]. This number does not take into account over-the-counter medications, vitamins, minerals, and dietary supplements. Taking multiple medications and supplements significantly increases the risk of interaction with foods, other medications, and alcohol.

Common medication problems include incorrect dosage, erratic drug use, misuse of over-the-counter medications, drug interactions, mixing medications and alcohol, use of drugs at the wrong time of the day, using medications prescribed for another person, using two or more medications with synergistic effects, and using several medications with profound side effects or that might be contraindicated due to comorbid conditions.

Aging itself can contribute to unforeseen medication problems. Older individuals tend to absorb, metabolize, and excrete medications at a slower rate. Many older people also have major complicating medical problems, such as Parkinson disease, cardiovascular difficulties, neurologic disorders, infections, and vertigo, that may be impacted by various medications. In general, older persons are at a greater risk for side effects. If present, cognitive deficits may lead to greater confusion regarding timed doses and medication use.

SKILLED CARE FACILITIES AND ASSISTED LIVING

The move to a higher level of care is not an easy decision for any impaired person, family members, or healthcare providers. Each patient has different circumstances that must be taken into account. The decision usually involves consideration of a variety of psychologic, medical, financial, practical, and family issues. Often, it is based on the inability of the family to fully provide the needed level of care. If the family has been the sole care provider, burnout and exhaustion may be factors. It may even depend on the ability to adapt the home to accommodate the new needs of the patient. When selecting a facility, the focus should be on location and the competency and personability of the staff.

Generally, a patient will need to be hospitalized for three days to qualify for referral to a skilled nursing facility under the Medicare guidelines. Admission to an assisted living program, on the other hand, is not covered by Medicare or most health insurance plans. Long-term care insurance may be a financial help to offset medical costs and the costs of alternative nursing care, including home care.

Selecting a skilled nursing or assisted living facility is difficult for many families. The following may be offered to families to assist in making the best possible decision:

- Is the facility within a reasonable distance to supportive family members?
- Is the facility able to provide the appropriate level of care and needed services anticipated?
- Is the facility stable, with a low staff turnover rate? Has the facility changed ownership several times?
- Is the facility nonprofit for for-profit?
- Does the facility have a positive record with the state (e.g., facility infractions, wrongful staff actions)?
- Is the food reasonably prepared and served in a manner consistent with the patient's culture and eating history?

LONGEVITY CONCERNS

The number of individuals 85 years of age and older is growing steadily in the United States. In 2020, there were 6.7 million individuals in this age-group; this number is expected to grow to 19 million by 2060 [14]. Many people who live past 85 years of age fear they will outlive their resources. Providing education about healthcare savings programs throughout life may be helpful, even into the aging years. Preparation for long-term assisted living is essential, such as having long-term healthcare insurance, having a healthcare reserve fund, and being compliant with healthcare treatment plans (if possible). Regular exercise, rest, social support, and a good attitude are among the essential factors needed for healthy longevity [15].

CAREGIVER BURNOUT

Care providers tend to experience burnout within a few years of constant care of a loved one. In general, male caregivers experience burnout sooner than women. Care providers should try to take respite breaks at least one day per week. Taking mini-vacations can be helpful. Respite care coverage for even a few hours a day can also be helpful. The underlying lesson is for caretakers to take care of themselves physically and mentally, so they are able to continue to provide care for the loved one.

CONCLUSION

The aging process can become a very challenging time in a person's life. It is often difficult for the aging person to understand and accept the changes that are taking place, to maintain a positive level of functioning for as long as possible, and to compensate for ongoing losses. It is vital for nurses to support these patients to best protect their health, safety, and well-being.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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