

NRS 353

Gerontology and Gerontic Nursing Practice

Assignment 2: Assignment Questions

Questions and Answers about Elderly People and Patients

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Introduction

Health of older people has some issues which nurses should know. Older people tend to suffer some health problems, however, some people do not know about problems of older people and may treat them wrongly. These are some questions and answers below whose topics may be well-known but misunderstood. Nurses need to know scientific truth about health and health problems of older people and should reject myths of them which may be widely known.

Q 1: Discuss reasons for why the elderly suicide

Hughes (2006, p. 549) noted risk factors of suicide for older people: Majority of older people who commit suicide generally has depressive disorder when they are dead. Also, the elderly who have physical illness and complain pain are more likely to suicide. Luggen (2004, p. 636) added spousal loss are clearly relates to elderly suicide. Negative experiences such as loss of spouse or declining physical health are precipitating factors for depression (Hughes, 2006, p. 536). Also, these experiences might be more common for older adults. Thus, depressive disorder is one of common factors which cause the elderly people suicide and depressive events are more likely to occur for the older people because of loss of things they valued.

Q 2: Define the word dementia

Davies, Aveyard and Norman (2006, p. 491) define the term of dementia as “a range of brain disorders that have in common loss of brain function that is usually progressive, irreversible and eventually fatal. Collectively, these conditions represent the most common serious mental illnesses affecting older people.” “Dementia can be a symptom of a number of conditions, including Alzheimer’s disease, vascular dementia, Korsakoff’s syndrome and Huntington’s chorea” (Eastley & Wilcock, 2000, as cited in Mott & Kingsley, 2004, p. 191).

Q 3: Is the use of restraints a justifiable approach for managing patients with dementia? Discuss

Some older people who have dementia tend to wander. Luggen and Hill (2004) described “wandering is one of the most difficult management problems encountered in institutional settings. Each year some residents wander away from a facility and are later found injured or dead.” Thus, it is necessary to protect the elderly people from the injury or death. Restraints have been protections for the older adults and also meant security of the elderly and the staff (Luggen & Hill, 2004, p. 401). Moreover, Davies et al. (2006, p. 516) mentioned there are insufficient human resources in the most care environment so that they cannot follow wandering of each older adult who have dementia and make sure of individual’s safety. However, restraints cause the elderly people to have negative emotions such as anger, fear and humiliation (Strumpf & Evans, 1988, as cited in Luggen & Hill, 2004, p. 402). In addition, physical restraints cause not only negative feelings of the older adults but also physical problems; for example, pressure ulcer formation, hypostatic pneumonia or constipation (Pisani, Partridge, Taylor & Porter, 2009, p. 860). Hence, usage of restraint should be minimised as much as possible both from ethical and physical viewpoints. Restraints could take other risks of harm to the elderly people.

Q 4: Discuss the alternatives to physical restraint in the care of patients with dementia

As mentioned above, physical restraints cause health problems. So, it is important to minimise to use physical restraints or take alternative ways to the restraints for older people having dementia. Reasons why patients who have dementia wander are unique to individual and have particular meaning in their context or situation. Thus, care which they need can be differ in each person (Algase et al., 2003, cited in Davies et al, 2006, p. 516). Koch (2004, p. 249) cited instances of some alternative ways of restraints; hip-protectors, safety helmets and surveillance equipment such as monitoring tags. These ways could protect the patients from injuries if they tried to wander. She also described adapting design of the facilities for the older patients, for example, using subdued colour in order to calm down

the older patients who are agitated and wander. Replacing linear corridor with connected passages that encourage the patient wander around on their own pace in the facility.

These ways could reduce the patients who are wandering or cases of injury from wandering. The important thing to remember is the alternatives to physical restraints are not one. The alternative ways of the restraints can be mixed for fitting the individual's behaviour of wandering. The alternative approaches to reduce the risk of wander may not be known as wide as a means of physical restraint. So, it would be important to extend knowledge of the alternatives in the workplace.

Q 5: Define the term delirium

Delirium is defined as “a transient disturbance in cognitive and attentional function, characterised by a fluctuating course and an alteration in the conscious state” (Street, 2004, p. 140). According to Luggen (2004, pp. 573-574), delirium is a common clinical condition for older patients and it often caused by emergency surgery and chemotherapy. The symptoms of delirium are reducing abilities to maintain and process attention both internal and external stimuli. They are difficult to respond appropriately, to follow commands and to talk coherently.

Q 6: Describe three specific depressive behaviours which can be very convincingly mimic, or masquerade as dementia in order people so that it is hard to distinguish between two

Treatment of depression is issues for aged care. However, “some mental illnesses and dementia need radically different approaches to care” (Mott & Kingsley, 2004, p. 195), delirium and depression are often mistaken for dementia (Hunt, 2009, p. 235). So, older people with depression may not be receiving appropriate care. Three features appear in depression resemble these in dementia.

Firstly, cognitive impairment can be seen both in depression and dementia, but the impairment of depression is reversible (Mott & Kingsley, 2004, p. 195). There is also a difference. The symptom of depression is typically worse in the morning and improves late of the day, in contrast, the symptom of

dementia is relatively stable (Luggen, 2004, p.574). Nevertheless, some older people with dementia become depressed. They might have both of the diseases (Hughes, 2006, p. 541).

The second features of these illnesses are cerebral dysfunction. Both of the illnesses affect the person's intelligence. People with depression can have memory and decision-making problem (Hughes, 2006, p. 531), and so do people with dementia (Davies et al., 2006, pp. 493,494). However, depression may cause psychomotor retardation, their ability of thinking is intact. On the other hand, people with dementia are impoverished of thinking. They often have difficulty with abstract thinking, judgment or finding words (Luggen, 2004, p. 574).

Thirdly, people with dementia or depression may have problems with activity. They often have limitation of activities, for example, some of people with depression or dementia cannot do some basic activities such as cooking or cleaning. These problems are caused by different reasons, even though they have the limitations of activities. People with depression are reduced energy and it diminishes their activity (Hughes, 2006, p. 531). On the other hand, dementia causes apraxia. People who have dementia may be difficult to purposeful movement (Davies et al. 2006, p.494), so some of them are unable to do effective activities for their life.

Q 7: Discuss and analyse the barriers to effective pain management in the older person

According to Hess (2004, p. 281), a number of older people who is living in community with pain is twice as many as younger people. Moreover, it is considered that a significant number of older people who is in long-term care setting have pain because of chronic health conditions that cause chronic pain such as musculoskeletal disorders and cancer. However, pain in the elderly people may not be treated effectively because of some barriers.

Seers (2006, p. 463) mentioned "the nurse and the patient may have different perspectives on pain and its management". These differences can cause barriers for pain management. From the perspectives of older people on their pain management, some of them hesitate to ask caregivers to relieve pain and

also to use the equipment like a patient-controlled analgesia pump. Furthermore, some older people have cognitive impairment such as dementia which impedes them to tell caregivers about their pain (Pasero & McCaffery, 1996, cited in Seers, 2006, p. 464). These pains might be relieved if nurses/caregivers observe the older people carefully. However, some people believe myths of pain in the older people which tell that pain is expected with aging and pain sensitivity of older people are less than younger people (Hess, 2004, p. 283). So, pain in the elderly might be underestimated, consequently, the pain management could not be done effectively.

Moreover, insufficient knowledge of pain relief can be barrier for pain management. Opioids are used for pain relief, but some people may associate opioides as addictive substances. In result, the older people, their family or perhaps the health care team are reluctant to use opioids (Pasero & McCaffery, 1996, cited in Seers, 2006, p. 464), and then the pain will not be treated efficiently.

In summary, lack of knowledge of pain management often cause barriers to control pain in the older people. It may be thought some myth of pain with aging, relationship which the older people hesitate to tell their pain or fear of using the drugs can be obstruct active approach toward the pain.

Q 8: Analyse the relationship between medication and falls in the elderly

Street (2004, p. 142) mentioned falls are not caused by single and identifiable reason and are usually happened with several risk factors. He noted the several risk factors includes medications, especially tranquilisers and longer-acting sedatives. Tranquilisers are used as antipsychotics and sedatives are used as anxiolytics and hypnotics. These medications affect brains, and have adverse effects which increase risk of fall in older people. For instance, Benzodiappines are one of sedative substances which are used for sleeping disorders and anxieties. They might cause amnesia, diplopia and blurred vision as side effects (Galbraith, Bullock & Manias, 2004, p.328). Amnesia may increase the risk of fall of older adults, because people with amnesia are not aware what he/she is doing. This means people with amnesia has poor skills of attention, when they is walking. They are easier to stumble,

then may fall. Diplopia and blurred vision significantly affect people walking. Vertigo and impaired vision are risk factors of fall (Brians et al., 1991, cited in Pisani et al. 2009, p. 850).

Furthermore, aging brings physiological change including pharmacokinetics and pharmacodynamics. Metabolism of the older people is decreased, and medications need more time to be resolved in body of older people (Baker, Tiziani, 2004, p.229). It results medication can be stored in their body.

Consequently, the elderly people are easier to be overdosed and adverse effect can appear more frequent.

Older people potentially have higher risk of fall because of weaken muscle and sense of balance. In addition, they often have one or more chronic diseases and need to take medications. Some medications increase the risk of fall because of their adverse effect. These side effect may rise the cases of fall in the older people.

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