MEMORY LOSS, HEALTH ISSUES AND END OF LIFE CARE:

Aging And Long-Term Care

Part II

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Abstract

In the United States the population is aging and, in the coming decades, this trend is anticipated to increase. Between 2010 and 2050, it is expected that there will be a rapid growth in the older age groups. By 2050, the total national population aged 65 and older is predicted to rise rapidly and to reach 88.5 million, which is more than two-fold its population in 2010. This growth in the elderly population will far exceed the growth in younger age groups. Aging And Long Term Care is a 3-part series discussing important topics related to aging factors, special disability populations, end-of-life care issues and trends in long-term care.
**Policy Statement**

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**Continuing Education Credit Designation**

This educational activity is credited for 3 hours. Nurses may only claim credit commensurate with the credit awarded for completion of this course activity.

**Statement of Learning Need**

Nursing professionals are increasingly caring for elderly and disabled individuals requiring placement or residing in long-term care facilities. Long-term care involves making complex decisions influencing care outcomes that require nurses to have specialized knowledge related to unique issues affecting quality of life as well as end-of-life issues.

**Course Purpose**

To provide nursing professionals with knowledge in the area of long-term care for the elderly and disabled individuals.
Target Audience
Advanced Practice Registered Nurses and Registered Nurses
(Interdisciplinary Health Team Members, including Vocational Nurses and Medical Assistants may obtain a Certificate of Completion)

Course Author & Planning Team Conflict of Interest Disclosures
Jassin M. Jouria, MD, William S. Cook, PhD, Douglas Lawrence, MA
Susan DePasquale, MSN, FPMHNP-BC – all have no disclosures

Acknowledgement of Commercial Support
There is no commercial support for this course.

Please take time to complete a self-assessment of knowledge, on page 4, sample questions before reading the article.

Opportunity to complete a self-assessment of knowledge learned will be provided at the end of the course.
1. The elderly population in the U.S. is expected to increase to more than ____ million by 2030.
   a. 35  
   b. 45  
   c. 60  
   d. 70

2. Adult Day care is designed for elderly:
   a. with at least late mild to moderate dementia.  
   b. to provide structured and safe daily activities.  
   c. to reduce caregiver distress.  
   d. All of the above

3. True or False: Compared to women, men are less susceptible to depression after the loss of a spouse and remain depressed for less time than women.
   a. True  
   b. False

4. Screening for geriatric depression can include:
   a. complete history and physical.  
   b. laboratory, EKG and radiology tests.  
   c. polysomnography for sleep disorders.  
   d. All of the above

5. Elder abuse is
   a. predominantly hidden.  
   b. committed outside the confines of the home.  
   c. generally reported by elders.  
   d. usually caused by strangers.
Introduction

Dementia may be defined as a progressive decline in more than one cognitive domain that interferes with activities of daily living. The most common causes of dementia include Alzheimer’s disease, frontotemporal dementia, and dementia with Lewy bodies. Another cause of memory loss is mild cognitive impairment (MCI), which includes people who do not have functional impairments that meet the criteria for dementia but whose cognitive function falls between the changes associated with normal aging and dementia.

Memory Disorders In The Elderly

Memory loss is the impaired ability to learn new information or to retrieve previously learned information. It is a common cognitive change in the elderly. An individual with memory loss in most cases will exhibit measurable delayed recall, for example, impairment in the ability to recall recently learned information. However, memory loss actually can indicate impairment in another cognitive domain that may present as memory loss. For instance, trouble finding the right word is indicative of a language impairment or inattention associated with depression, particularly if the patient themselves report the loss.

Prevalence Of Alzheimer’s Disease And Other Dementias

The elderly population in the U.S. is expected to increase from approximately 35 million today to more than 70 million by 2030, a two-fold increase. With this rapid growth in the population of elderly, long-term care of chronic diseases such as Alzheimer’s disease (AD)
will assume greater importance. AD is the fifth-leading cause of death for elderly.\(^1\) In 2012, approximately 5.4 million Americans had AD, and around 5.2 million people were elderly. One in eight elderly individuals, or approximately 13% have AD.

Almost half of those elderly who are age 85 and older have AD. Of those with AD, approximately 4% are under the age of 65, 6% are between 65 and 74, 44% are between 75 and 84, and 46% are 85 or older. Women are more susceptible to AD and other dementias than are men. Of the 5.2 million elderly with AD, 3.4 million are women. Women tend to live longer on average than men and this is believed to account for the increased risk of AD. Approximately 53 new cases per 1,000 people occur in those 65 to 74 years of age. This increases to 170 new cases per 1,000 people for those between the ages of 75 to 84. The incidence rises to 231 new cases per 1,000 people for those over the age of 85 years.\(^2\)

In the future, the elderly population is expected to increase due to advances in the medical field, as well as improvements in social and environmental conditions. Additionally, the baby boomer generation is reaching the age group with the greater susceptibility to AD and other dementias. On average, a person with AD will spend more years (40% of the total number of years with AD) in the most severe stage of the disease than in any other stage. Elderly patients with AD will spend much of this time in a nursing home.\(^3\)

Elderly patients with AD and other dementias require more and longer hospital stays or skilled nursing facility stays and home health care visits. These hospital or facility admissions are highlighted below.\(^4\,^5\)
• **Hospitals:**

In 2008, there were 780 hospital stays per 1,000 Medicare beneficiaries in the elderly with AD compared with only 234 hospital stays per 1,000 Medicare beneficiaries without these conditions.

• **Skilled nursing facility:**

In 2008, there were 349 skilled nursing facility stays per 1,000 beneficiaries with AD and other dementias compared with 39 stays per 1,000 beneficiaries for people without these conditions.

• **Home health care:**

In 2008, approximately 23% of Medicare beneficiaries who were elderly with AD and other dementias had at least one home health visit during the year, compared with only 10% of Medicare beneficiaries without these conditions.

Approximately 60-70% of elderly with AD and other dementias reside in the community compared with 98% of elderly without such conditions.\(^4,6\) Also, approximately two-thirds of elderly with dementia die in nursing homes, compared with only 20% of cancer patients and 28% of people dying from all other causes.\(^7\)

People with AD require long-term care for an extended period of time. This impact’s public health concerns. Of those elderly patients with AD and other dementias that live in the community, approximately 75% live with someone and the remaining 25% live alone.\(^4\) Many people
with AD and other memory deficits also receive paid services at home; in adult day centers, nursing homes, or in more than one of these healthcare settings.

**Use and Setting of Long-Term Care Services**

The majority of elderly persons with AD and related conditions who live at home receive unpaid help from friends and family, but some opt for paid home and community-based services, such as personal care and adult day care.

*Home Care*

It is estimated that approximately 37% of elderly persons who receive mainly nonmedical home care services have cognitive impairment consistent with dementia. In 2011, the average cost for a non-medical home health aide was $21 per hour.

*Adult Day Center Services*

Approximately 40% of elderly who go to adult day centers have dementia. In 2011, the average cost of adult day services was $70 per day.

*Nursing Home Care*

Approximately 64% of Medicare elderly beneficiaries residing in a nursing home have AD and related conditions. In 2011, approximately 47% of all nursing home residents had a diagnosis of dementia in their nursing home record.
Alzheimer’s Special Care Units

In June 2011, nursing homes had a total of 80,866 beds in Alzheimer’s special care units. While normal aging is generally associated with a decline in cognition and memory, this decline is not linked to memory disorders. Several factors such as genetics and neurodegenerative processes play an important role in causing memory disorders. While with aging, one may experience minor changes in memory and thinking, these changes do not significantly impact the activities of daily living. Some of the differences between normal age-related memory loss and AD include those listed below.

- Normal age-related memory loss where the individual may forget part of an experience; with AD the whole experience is forgotten.
- Normal age-related memory loss where the individual who forgets something will eventually remember the information; however, this is not the case with AD.
- Normal age-related memory loss where the individual can generally follow instructions, both verbal and written, without problems, but an individual with AD progressively loses this ability to follow instructions.
- Normal age-related memory loss where the use of notes and other types of reminders is beneficial; however, people with AD progressively become less able to benefit from memory aids.
- Normal age-related memory loss where people can still manage their activities of daily living, but those with AD become progressively dependent with their activities of daily living.
Several helpful tables are shown below that list common causes of symptoms and signs of age-related memory loss in elderly patients.

### Common Causes of Symptoms of Mild Memory Loss in Elderly Patients

<table>
<thead>
<tr>
<th>Cause</th>
<th>Typical Historical and Clinical Features</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer disease</td>
<td>Insidious onset of losses in memory, language, and visual, spatial and executive function with largely normal results on neurologic examination.</td>
<td>Patients may appear depressed because of social withdrawal. Extrapyramidal signs, such as rigidity, may be present, but are mild and do not antedate the cognitive symptoms.</td>
</tr>
<tr>
<td>Frontotemporal dementia</td>
<td>Two broad patterns of clinical manifestations: Pattern 1) profound changes in personality and social conduct; and, Pattern 2) changes in expressive language or in naming and comprehension.</td>
<td>The disease category includes Pick disease (pattern1) and progressive non-fluent aphasia and semantic dementia (pattern 2). Pattern 1 patients show executive function deficits; errors in memory, if any, are the result of inattention.</td>
</tr>
<tr>
<td>Lewy body dementia</td>
<td>Pattern of cognitive decline is similar to that of AD plus at least two of the following: visual hallucinations, fluctuating cognition, and parkinsonian signs (rigidity, falls, masked face).</td>
<td>Can be confused with Parkinson disease. Parkinsonian signs include poor responsiveness to L-dopa replacement therapy. Use of phenothiazine-based antipsychotic agents can precipitate marked worsening of parkinsonism.</td>
</tr>
<tr>
<td>Mild cognitive impairment</td>
<td>Memory or other cognitive problems in the setting of mild deficits on cognitive testing and relative preservation of</td>
<td>History will show no clinically meaningful functional impairment as a result of cognitive deficits.</td>
</tr>
</tbody>
</table>
**Depression (major depression, dysthyemia, or subsyndromal depression)**

<table>
<thead>
<tr>
<th>Depression</th>
<th>Other cognitive functions.</th>
<th>Patients may progress to dementia, especially Alzheimer disease.</th>
</tr>
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<tbody>
<tr>
<td>11</td>
<td></td>
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<tr>
<td>Referral to a neurologist is warranted for a patient who has cognitive impairment as well as neurologic signs such as focal muscle atrophy, fasciculations, dysarthria, other cognitive functions.</td>
<td>Impairments can be found in measures of cognition, but they are typically mild. These generally improve with successful treatment of the depression.</td>
<td>Patients will report memory loss, but testing of delayed recall will generally show mild if any impairment. Several symptoms of depression can overlap with dementia, such as diminished ability to concentrate, social withdrawal, and sleep disruption.</td>
</tr>
</tbody>
</table>

**Medications**

<table>
<thead>
<tr>
<th>Medications</th>
<th>Cognitive impairment following a medication change or addition.</th>
<th>Common causes include medications with sedative or anticholinergic effects.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cerebrovascular infarcts**

<table>
<thead>
<tr>
<th>Cerebrovascular infarcts</th>
<th>Cognitive impairment following the onset of a stroke.</th>
<th>With the exception of large strokes/major hemorrhages, the precise contribution to cognitive dysfunction of CT- or MRI-defined infarcts and T2 hyperintensities on MRI remains unclear.</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
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</table>

**Medical illnesses that impair brain metabolism**

<table>
<thead>
<tr>
<th>Medical illnesses that impair brain metabolism</th>
<th>Illnesses that cause hypoxia, hepatic and endocrine disease, such as hypothyroidism and hyperparathyroidism.</th>
<th>Thyroid testing is warranted as part of an initial work-up of a patient with documented memory loss.</th>
</tr>
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<tbody>
<tr>
<td>11</td>
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</table>

*Referral to a neurologist is warranted for a patient who has cognitive impairment as well as neurologic signs such as focal muscle atrophy, fasciculations, dysarthria,
abnormal voluntary eye movements, or limb weakness that cannot be explained by a stroke. CT= computed tomography; MRI= magnetic resonance imaging.

*These symptoms apply to major depression.

<table>
<thead>
<tr>
<th>Signs of Age Related Normal Memory Loss</th>
<th>Signs of Memory Loss Due to Other Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forgetting an appointment occasionally.</td>
<td>Memory loss that disrupts daily life. Memory loss, especially recently learned information, is often the most clinically important sign of a potential problem.</td>
</tr>
<tr>
<td>Not sure what day of the week it is while on vacation.</td>
<td>Not sure what day of the week it is during a routine schedule.</td>
</tr>
<tr>
<td>Getting lost occasionally while in new circumstances.</td>
<td>Getting lost in familiar places.</td>
</tr>
<tr>
<td>Trouble with vision or spatial issues that can be corrected with glasses or cataract surgery.</td>
<td>Difficulty judging distance, which may lead to falls or minor car accidents.</td>
</tr>
<tr>
<td>Inability to remember a word that’s on the tip of your tongue.</td>
<td>Routine inability to recall words. Or calling a person or animal by the wrong name regularly. Also includes finding ways to describe an object because the person can’t recall the object’s real name.</td>
</tr>
<tr>
<td>Losing things occasionally.</td>
<td>Routinely losing things – particularly losing the same thing over and over.</td>
</tr>
<tr>
<td>Temporary agitation or anxiety in normally stressful situations.</td>
<td>Regularly becoming easily agitated and anxious over small things.</td>
</tr>
<tr>
<td>Making a regretful decision every once in a while.</td>
<td>A marked change in judgment resulting in poor decisions or even being taken</td>
</tr>
</tbody>
</table>
Care Giving for Elderly

Caring for an elderly person with memory issues requires a multilevel approach. Patients should be kept active by focusing on their positive abilities and avoiding stress. Routines for dressing and bathing should be conducted in such a way that the patient feels a sense of independence. Simple techniques such as finding clothes with large buttons, Velcro straps, or elastic waistbands can make it easier for the patient to getting dressed. Finances must be properly managed preferably by involving a trusted family member or friend. Any activity should be done in a stepwise manner. Furthermore, visiting and talking to the patient with memory issues is very important.

The approach towards the elderly should always be respectful and simple. It is important to talk one-on-one to the patient, especially if the individual lives alone, in order to prevent or minimize social isolation and increase mental stimulation. When caring for an elderly individual with memory problems, it is important to provide them independence in a respectful way.

Memory Care

Memory care is a long-term care option for elderly patients who cannot properly accomplish at least two areas of daily living (ADLs) because of dementia, Alzheimer’s disease and other memory and cognitive disorders. Memory care is specifically meant and designed for individuals with a level of cognitive impairment making it unsafe for them to continue to stay at home, but who do not need the intensive care of a skilled nursing facility. It allows the elderly with memory loss
to maintain a degree of independence within the safe and secure environment of a residential facility with professional healthcare staff. Such long-term care units are usually incorporated as separate care units of assisted living communities. In such facilities, elderly are provided 24-hour support and programs that ensure a high quality of life coupled with increased safety. These elderly reside in private or semi-private units and have scheduled activities and programs that are designed to enhance memory under the supervision of trained staff members. In these facilities, common spaces are provided to increase activities and socialization.

**Adult Day Care**

Adult Day care is designed for elderly with at least late, mild to moderate dementia. The facility provides structured and safe daily activities that reduce a patient’s boredom and anxiety, as well as reduce the caregiver’s distress.

**Nursing Home Care**

Among all the other long term care facilities, nursing homes provide the most comprehensive service with highly skilled and professional staff members, but offer the least independence for the patients. They are also the most expensive long-term care option. Elderly should be preferably placed in the nursing home when there is greater risk of malnutrition, illness and fall-related and other injuries, especially for those individuals who live alone.

**Depression In The Elderly**
Depression is a mental disorder, which manifests as a state of low mood and aversion to activity that may negatively impact on individuals’ thought processes, behaviors, feelings, worldview and physical wellbeing. Individuals with depression may experience sadness, emptiness, hopelessness, anxiousness and irritability. Depressed people may experience anhedonia (a state of finding no pleasure in ordinary activities of enjoyment), an aversion to pleasure seeking activities such as sex, exercise or social activities. Depression is formally classified as a mood disorder, and not necessarily a psychotic disorder.

Depression in the elderly is common and widespread globally. It is generally undiagnosed, and often goes untreated. It is also the most treatable disorder, which affects approximately 15% of elderly, 20% of hospitalized elderly patients, and over 40% of elderly nursing home residents. Depression is common in elderly, but it is not a normal part of aging. The prevalence of depression in the elderly in the U.S. and globally is around 1-5%, with several research studies reporting prevalence rates at around 1%. There are over 35 million elderly Americans and approximately 7 million of them experiences some form of depression. Approximately 2 million elderly experience clinical depression and around 5 million experience milder forms of depression.

In the U.S., approximately one third of nursing home residents experience depression. The disorder may develop at any time during a patient’s placement in a nursing home. A study conducted on nursing home residents observed that 14% of patients had clinical depression, and only 20% of these patients were provided antidepressant
treatment. Depression in the elderly is severely under recognized and under treated.

Depression is a mood disorder that is the most prevalent mental health problem among the elderly; however, it should be remembered that the majority of elderly are not depressed. Depression may lead to significant suffering and distress among the elderly. It also can result in mild to severe impairments in physical, mental, and social functioning. The presence of depression in elderly usually adversely impacts the course and complicates the treatment of other comorbid and chronic diseases. Those elderly with depression visit their health provider and hospital more frequently, use more medication, and stay for longer periods of time in the hospital.

Finally, depression in the majority of cases is a treatable condition. It is estimated that major depression in elderly persons living in the community may range from less than 1% to about 5% but increases to 13.5% in those who need home healthcare and to 11.5% in hospital settings. Other studies have estimated that major depression for those in long-term care ranges from 6 - 24%, and minor depression and dysthymia (a state of chronic depression) may range from 30 – 50%. Depression among the elderly is usually under detected in long-term care facilities and, if detected, is often inadequately treated.

Depression in the elderly with a higher sociotropy score (indicating a higher or excessive need for interpersonal relationships) is closely associated with stressful life events related to loss or disruption, whereas depression in the elderly with a higher autonomy score is closely associated with negative events linked to achievement. It is
observed that depressed individuals behave in ways that tend to increase the risk of stressful events in the future. Rumination (a compulsive focused attention on negative feelings and experiences in the past), which has been associated with decreased social support, may play a key role in the development of depression. A stressful event, such as the loss of loved ones is known as bereavement. Depressive symptoms are a natural emotional reaction to loss, but symptoms that persist for more than two months may indicate depression.

Some researchers believe that depression associated with bereavement is actually complicated grief, which is manifested by symptoms of traumatic distress and separation distress. However, some argue that complicated grief and major depression have a lot in common with few differences. A recent study on depression in elderly observed that bereavement greatly increased (tripled) the risk of depression. However, the risk of depression due to bereavement is less for the elderly than for the middle aged.

It seems that the elderly are often better equipped to handle the loss of loved ones than younger adults because of better adaptation capabilities. Compared to females, males are more susceptible to depression after the loss of a spouse. Men also remain in depression for a longer period of time. For females, financial stress is the major mediator of depression or depressive symptoms, whereas for males, the major mediator is household chores or management. Providing adequate care for a loved one can also trigger stress, which becomes more common with advancing age. However, recent studies have
found no significant differences in depression between caregivers and non-caregivers.

It has been found that the risk of depression is higher among individuals caring for a person with dementia than among those caring for a person with a physical disability.\textsuperscript{13} Furthermore, rates of depression increase significantly in the caregiver if the care recipient has severe distress behavior problems.\textsuperscript{14} Some researchers believe that the rate of depression increases in these caregivers because of their restricted normal activities. Comorbidity of depression with other disorders is common and adversely impacts the course of the depression, increases disabilities, economic burdens, and use of health care services. Common medical illnesses that are associated with depression include cardiovascular disease, diabetes, stroke, hypertension, cancer, and osteoarthritis. In the nursing home setting, the predominant clinical entities include major depressive disorder, dysthymic disorder, minor depression and depression concurrent with Alzheimer’s disease. As indicated in the table below, depressive symptoms in nursing home patients must be considered in the differential.

**DIFFERENTIAL DIAGNOSIS OF DEPRESSIVE SYMPTOMS IN NURSING HOME PATIENTS**
Major Depressive Disorder:
Presence of at least 5 of 9 depressive symptoms for at least 2 weeks and impaired social functioning.

Minor Depression:
Not meeting above criteria but significant sub-threshold symptoms.

Dysthymia:
Low-grade depression symptoms that are chronic for more than two years.

Depression in Alzheimer’s disease:
Specific criteria proposed that require only 3 symptoms, with irritability as a qualifying symptom.

Signs and Symptoms of Depression Unique to Elderly
Depression in the elderly may have distinctive signs and symptoms as compared to those in younger adults. Compared to young adults, the elderly are less likely to exhibit cognitive-affective symptoms of depression such as worthlessness or dysphoria. The elderly also complain more frequently about sleep disturbances, insomnia, fatigue, loss of interest in living, and hopelessness. The elderly also complain about poor memory and loss of concentration. Common clinical findings include slower cognitive function and executive dysfunction. It has also been found that depressed elderly women experience more appetite disturbances than men, whereas elderly men experience more agitation.

Depression is difficult to diagnose when symptoms arise because of a medical condition. It is usually either over diagnosed or under diagnosed in the presence of another disease such as cancer that may cause weight loss and fatigue. Depression manifests itself with different signs and symptoms among patients with neurological syndromes. Depression that develops after a stroke is less likely to
include dysphoria and is more prominently characterized by vegetative symptoms.\textsuperscript{15} This is particularly seen in patients who have right hemisphere damage. Milder forms of depression are associated with Parkinson's disease; additionally, dysphoria and anhedonia are seldom seen when compared to depression in the elderly without neurological disease.

Depression seen in patients with Alzheimer disease is diagnosed only when three or more symptoms of major depression are present, excluding lack of concentration, but including non-somatic symptoms such as social withdrawal and irritability. Depression in patients with vascular dementia, compared to depression in patients with Alzheimer disease, is characterized predominantly by vegetative symptoms such as weight loss, fatigue, and myasthenia (muscular weakness).

The table below outlines the biopsychosocial risks and protective factors of depression in the elderly.

\begin{center}
\textbf{Biopsychosocial Risk Factors Throughout Life and In Elderly}
\end{center}

\begin{table}[h]
\begin{tabular}{|l|}
\hline
\textbf{Biological risks:} \\
\hline
\hspace{0.5cm} Hereditary/Genetics \\
\hspace{0.5cm} Females are at higher risk \\
\hspace{0.5cm} Low serotonin or high cortisol (neurotransmitters) \\
\hspace{0.5cm} Low testosterone (can affect females as well as males) \\
\hspace{0.5cm} High blood pressure or hypertension \\
\hspace{0.5cm} Stroke \\
\hspace{0.5cm} Medical illness and overall poor function (\textit{i.e.}, problems walking) \\
\hspace{0.5cm} Alcohol abuse and dependence \\
\hline
\end{tabular}
\end{table}
Social risks:

- Stressful life events and daily difficulties
- Bereavement (grief experienced by loss of a loved one due to death)
- Socio-economic disadvantage (being poor or having a low income)
- Impaired social support (lack of friends and family for fellowship and support)

Risk and Protective Factors Especially Important In Late Life

- Personality disorder
- Neuroticism (neurosis = poor ability to adapt, inability to change one's life patterns, and the inability to develop a richer, more complex, more satisfying personality)
- Learned helplessness
- Cognitive distortions (overreaction to life events; misinterpret life events; exaggerate their adverse outcomes; catastrophizing too much)
- Lack of emotional control and self-efficacy (low skills to control emotions and low belief in one's capacity to succeed at tasks)
The American Psychiatric Association (ASA) provides clinical direction in the assessment and diagnosis of psychiatric symptoms and treatment in the care of the elderly. These are referenced below.

**Biological risks:**
- Genetics
- Low DHEA (a pro-hormone)
- Poor blood flow in the brain (ischemia)
- Alzheimer’s Disease

**Protective factors:**
- Socio-emotional selectivity (focus on the positive for the remainder of life)
- Wisdom (applying life’s lessons in a positive way to deal with challenges)

Five or more of the following symptoms present for a minimum of 2 weeks:
- Depressed mood
- Loss of interest or pleasure in activities
- Changes in weight or appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Low energy
- Feelings of worthlessness
- Poor concentration
- Recurrent suicidal ideation or suicide attempt

**Atypical Presentation of the Depressed Older Adult**
- Deny sadness or depressed mood
- May exhibit other symptoms of depression
- Unexplained somatic complaints
- Hopelessness
- Helplessness
• Anxiety and worries
• Memory complaints (may/may not have objective signs of cognitive impairment)
• Anhedonia
• Slowed movement
• Irritability
• General lack of interest in personal care

Adult depression scales support clinical diagnosis and a treatment plan. Specifically the clinical guide or tool below supports care outcomes for the elderly person with symptoms.

**Workup of Depression in Nursing Home Patients**

| Screening: | Geriatric Depression Scale |
| Present illness History: | including assessment of suicidal ideation, current medications |
| Past History: | including antidepressant trials |
| Cognitive Screen: | Mini Mental Status Exam (MMSE) |
| Laboratory and EKG Tests: | Basic metabolic panel, complete blood count, TSH, free T4, serum B12 and folate levels, serum albumin in case of poor nutrition; EKG if a tricyclic antidepressant is being considered |
| Polysomnography: | if a sleep disorder is suspected |
| MRI: | to confirm diagnosis of vascular depression |

MMSE, mini-mental state exam; TSH, thyroid-stimulating hormone; EKG, electrocardiogram; MRI, magnetic resonance imaging.

**Geriatric Depression Scale**

Screening for depression in the elderly may require the Geriatric Depression scale or other screening tools, such as the ones listed below.
Geriatric Depression Scale – Short Form

Clinician to ask patient: *Think over the past week and answer the questions below as “yes” or “no.”*

<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1)</td>
<td>Are you basically satisfied with your life?</td>
<td>Yes *NO</td>
</tr>
<tr>
<td>2)</td>
<td>Have you dropped many of your activities and interests?</td>
<td>*YES No</td>
</tr>
<tr>
<td>3)</td>
<td>Do you feel that your life is empty?</td>
<td>*YES No</td>
</tr>
<tr>
<td>4)</td>
<td>Do you often get bored?</td>
<td>*YES No</td>
</tr>
<tr>
<td>5)</td>
<td>Are you in good spirits most of the time?</td>
<td>Yes *NO</td>
</tr>
<tr>
<td>6)</td>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>*YES No</td>
</tr>
<tr>
<td>7)</td>
<td>Do you feel happy most of the time?</td>
<td>Yes *NO</td>
</tr>
<tr>
<td>8)</td>
<td>Do you often feel helpless?</td>
<td>*YES No</td>
</tr>
<tr>
<td>9)</td>
<td>Do you prefer to stay at home, rather than going out and doing new things?</td>
<td>*YES No</td>
</tr>
<tr>
<td>10)</td>
<td>Do you feel you have more problems with memory than most people?</td>
<td>*YES No</td>
</tr>
<tr>
<td>11)</td>
<td>Do you think it is wonderful to be alive now?</td>
<td>Yes *NO</td>
</tr>
<tr>
<td>12)</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td>*YES No</td>
</tr>
<tr>
<td>13)</td>
<td>Do you feel full of energy?</td>
<td>Yes *NO</td>
</tr>
<tr>
<td>14)</td>
<td>Do you feel that your situation is hopeless?</td>
<td>*YES No</td>
</tr>
<tr>
<td>15)</td>
<td>Do you think that most people are better off than you are?</td>
<td>*YES No</td>
</tr>
</tbody>
</table>

**TOTAL * SCORE**

If the * score is 10 or greater, or if numbers 1, 5, 7, 11, and 13 are answered with a * [asterisk], then the individual may be depressed and they should consult with their doctor or other qualified health professional. Health professionals should proceed with a referral and/or treatment plan as necessary.

There are several treatment options that are available for depression, which includes pharmacotherapy with antidepressants, psychotherapy or counseling, or electroconvulsive therapy (ECT). Some patients may require a combination of these treatment options, as indicated in the table below.
### Treatment of Depression in Nursing Home Patients

<table>
<thead>
<tr>
<th>Major depressive disorder:</th>
<th>Citalopram, sertraline, or paroxetine. If no response at 6 weeks, then switch to venlafaxine (extended release), or bupropion (slow release), or mirtazapine. If no response, consider ECT. Add psychotherapy if appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic depression:</td>
<td>SSRI + antipsychotic medication, or ECT</td>
</tr>
<tr>
<td>Persistent minor depression or dysthymia:</td>
<td>Either SSRI or psychotherapy alone</td>
</tr>
<tr>
<td>Depression comorbid with Alzheimer’s disease:</td>
<td>SSRI and/or behavioral therapy</td>
</tr>
</tbody>
</table>

ECT, electroconvulsive therapy; SSRI, selective serotonin reuptake inhibitor

---

### Sexual Issues Associated With Elderly

The last few decades have witnessed an enormous increase in life expectancy globally. In the U.S., the aging of the “baby boomer” generation, and the openness regarding sexual behavior in the society, has resulted in an aging population that considers sexuality as being just as important as it has ever been.

### Gender Differences in Sexuality

There is no doubt that sexuality, and its expression, remains important to both elderly men and women. There are gender differences in the incidence of remaining sexually active into our older years. Several studies have observed that for both genders, male and female, there is a decline in sexual activity with age; however, sexual interest, sexual activity and the quality of sexual life seems to be consistently higher in elderly men compared to elderly women. With aging, these gender differences seem to increase.
In one research study conducted on the elderly in the 75–85 years age group, it was found that around 38.9% of men compared to 16.8% of women were sexually active. These men also reported a greater degree of interest in sex, approximately 41.2% elderly men compared to only 11.4% women. They also had a higher quality of sex life than women (70.8% expressing satisfaction compared to 50.9%). It is becoming increasingly acknowledged that the sexual behavior and function for women remains distinct from that of men. As women age, they experience a noticeable decrease in sexual activity and libido (interest in sex) compared to men, but women also experience comparatively less distress than men with the same symptoms.

This behavior in the females may well reflect different psychosocial factors, which include overall health status, and relationship, presence or absence of a partner and life satisfaction. With aging, both men and women show an overall reduction in sexual frequency when a partner loses interest in sex, but women lose interest more than men. For older women, life stressors, past sexuality and mental health problems, contextual factors, are more significant predictors of sustaining their sexual interest than physiological status alone. Although it is generally believed that sexual desires tend to decrease with age, several studies have observed that sexual patterns remain unchanged throughout the life span.

The elderly continue to enjoy sexual relationships throughout their lives. A recent study conducted on U.S. elderly individuals revealed that reported sexual activity was around 73% in the age group of 57-64 years, 53% in the age group of 65-74 years and 26% in the age
group 75-84 years. The expression of sexuality among the elderly leads to a higher quality of life achieved by fulfilling a natural urge.

The need to express sexuality persists among the elderly. However, they are more prone to many comorbid medical diseases or conditions. In addition, the normal aging process may hinder the expression of sexuality. Also, the medications and other therapies required for the management of comorbid disease may also lead to reduction in sexual response. Approximately 50% of elderly Americans reported at least one sexual problem. Women complained of low sexual desire (43%), vaginal lubrication difficulties (39%), and inability to climax (34%). Erectile dysfunction was the most common problem among elderly men. Some common barriers to sexual activity among the elderly are covered below.

**Common Barriers That Preclude Sexual Activity For Elderly Individuals**

- Physiological and biological changes
- Illness and/or decline of health (self or partner)
- Impotence
- Feelings of guilt (*i.e.*, cultural and/or generational attitudes about sex)
- Widow’s Syndrome
- Lack of freedom
- Lack of privacy
- Lack of a partner
- Fear of what others will think or say
- Inability to discuss issues and concerns with healthcare professionals
- Low self-esteem

**Physiological Changes Associated with Aging**
Aging leads to changes that influence the vascular, endocrine, and neurological systems. These changes impact sexual arousal and sexual performance.

**Men**

In elderly men, the most frequent sexual dysfunction reported is erectile dysfunction. This is considered to be partly due to hormonal changes and underlying conditions affecting the gonads as well as the neurological and vascular systems. The treatment of erectile dysfunction encompasses assessment of risk factors such as cardiovascular, lifestyle modifications and a trial of PDE-5 inhibitors, if not contraindicated. There is a strong association between erectile dysfunction and metabolic syndrome, which should be thoroughly evaluated in elderly men with erectile dysfunction.

With aging, free testosterone declines by 1–2% each year from the age of 45–50 years. Similar declines are witnessed in the levels of dehydroepiandrosterone (DHEA) with increased levels of follicle stimulating hormone/luteinizing hormone (FSH/LH) and sex hormone binding globulin (SHBG). Even if the serum testosterone levels are at normal or high levels, free testosterone (testosterone available to tissues) declines between the ages of 40–70 years. Furthermore, with aging DHEA and dehydroepiandrosterone sulphate (DHEA-S), precursors of testosterone also decline 2–3% per year. Marked falls in these hormones and precursors can cause mood changes, low energy levels, decreased strength, decreased libido and erectile dysfunction. Elderly men with symptoms of androgen deficiency may benefit from hormone replacement.

**Women**
In the aging woman, the most common sexual dysfunctions reported are lack of libido and lack of arousal. With the post-menopausal phase, there is a consistent decline in female hormones leading to atrophy of the vaginal and vulval membranes, increased urinary frequency and urinary incontinence, and urogenital prolapse. These changes also lead to vaginal dryness and dyspareunia, decreased libido, and inability to achieve climax or orgasm. Medical treatment includes hormone replacement therapy, which may be local or systemic.

The following tables list some of the common changes occurring in elderly individuals related to sexual function.

<table>
<thead>
<tr>
<th>Changes In Sexual Function in Elderly</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Normal changes in sexual function in Elderly Men</strong></td>
<td><strong>Normal changes in sexual function in Elderly Women</strong></td>
</tr>
<tr>
<td>• Erections may require more intense or prolonged physical stimulation</td>
<td>• Decreased clitoral engorgement</td>
</tr>
<tr>
<td>• There is a longer time for erectile response</td>
<td>• Decreased vaginal lubrication</td>
</tr>
<tr>
<td>• There may be a less rigid erection with some softening during sexual activity</td>
<td>• Decreased breast swelling</td>
</tr>
<tr>
<td>• Decreased intensity of ejaculation</td>
<td>• Decreased vasovaginal congestion</td>
</tr>
<tr>
<td>• Decreased ejaculatory volume</td>
<td>• Diminished pre-orgasmic sweating</td>
</tr>
<tr>
<td>• Delay in ejaculation</td>
<td>• Diminished orgasm intensity</td>
</tr>
<tr>
<td>• Increased refractory period</td>
<td></td>
</tr>
</tbody>
</table>
## Common Sexual Problems for Elderly

### A. Lack Of Interest / Decreased Desire
- Self or partner not interested in having sex
- Hormonal changes (i.e., menopause and post menopausal status, testosterone levels) may result in low sexual desire
- Fear of pain and/or discomfort
- Cognitive decline and/or impairment
- Change in relationship status- single, divorced, widow(er), etc.

### B. Female Sexual Dysfunction
- Decreased sexual function and responsiveness
- Dyspareunia - pain associated with intercourse
- Estrogen deficiency
- Difficulty with lubrication and reduced elasticity of vagina and vulva
- Delayed or absent orgasm
- Multiple medical ailments and chronic diseases which may affect sexuality
- Psychological factors
- Increased body sensitivity

### C. Male Sexual Dysfunction
- Delay of erection
- Decreased tension of scrotal sac
- Loss of testicular elevation
- Erectile Dysfunction (ED) - inability to achieve or maintain an erection adequate for sexual intercourse
- ED is commonly caused by (1) vascular disease and (2) neurologic disease
- Adverse medication side effects
- Endocrine problems
- Psychogenic issues- i.e., relationship conflicts, performance anxiety, childhood sexual abuse, etc.
Institutionalized Care

Several studies have reported that elderly residents wish to remain sexually active in long-term care settings. There are several barriers that prevent elderly patients from engaging in sexual activity in institutionalized care facilities. Sexuality in assisted living facilities or nursing homes is not commonly discussed; however, the focus is gradually shifting as several studies report that many elderly couples are sexually active. In today's society, many assisted living facilities allow overnight stays for spouses and family members of residents.

Barriers to Sexual Activity in Institutionalized Care

The list below summarizes some of the barriers to sexual activity for elderly who reside in an institution for their everyday care needs.

- Lack of privacy
- Attitude of family
- Attitude of staff
- Lack of an able sexual partner
- Physical limitations and poor health
- Cognitive impairment and dementia
- Lack of finances for education of staff or to institute changes

Other Medical Conditions

Continued good health of an elderly person is associated with a higher rate of sexual activity as well as sexual satisfaction. However, morbidity increases with aging and many comorbid diseases or conditions adversely impact sexuality and sexual dysfunction. The normal sexual response may change with impairment of central or peripheral physiology because of various diseases and conditions.22
Sexual dysfunctions can all be caused or worsened by medical conditions and the drugs or other treatment options used. Therefore, it is crucial to investigate elderly individuals and couples who complain of sexual difficulties for serious underlying medical conditions. The role of health care providers in long-term care facilities and the unique physical needs and syndromes of elderly are summarized below.

<table>
<thead>
<tr>
<th>Role Of Healthcare Providers in Long Term care Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Treat elderly with respectful and non-judgmental attitudes</td>
</tr>
<tr>
<td>• Conduct thorough sexual health assessments/histories</td>
</tr>
<tr>
<td>• Ask direct, straightforward questions about sexual activity and attitudes</td>
</tr>
<tr>
<td>• Educate patients and their caregivers about topics in sexuality and aging</td>
</tr>
<tr>
<td>• Provide appropriate treatment options</td>
</tr>
<tr>
<td>• Recommend treatments and adaptations for sexual problems</td>
</tr>
<tr>
<td>• Listen to patients’ sexual concerns</td>
</tr>
<tr>
<td>• Incorporate patients’ sexuality into counseling</td>
</tr>
<tr>
<td>• Provide appropriate referrals to specialists as needed</td>
</tr>
</tbody>
</table>

### Common Geriatric Syndromes in Older People

<table>
<thead>
<tr>
<th>Geriatric Syndrome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIFFICULTY SWALLOWING</strong></td>
<td>Age-related physical changes, medication side-effects, dementia and certain other illnesses can make swallowing difficult. This may lead to malnutrition and related problems. Other problems may be choking and aspiration (food or liquid &quot;going down the wrong pipe&quot;).</td>
</tr>
<tr>
<td><strong>MALNUTRITION</strong></td>
<td>Older adults usually need fewer <em>calories</em> than younger adults, but may need more of certain <em>nutrients</em>, such as calcium, vitamin D, and vitamin B12. Malnutrition can present as weight loss or weight gain. This can lead to other problems, such as weakness and increased falls, bone disorders, and diabetes.</td>
</tr>
<tr>
<td><strong>BLADDER CONTROL PROBLEMS</strong></td>
<td>Many things can cause bladder control problems, or “urinary incontinence,” including an overactive bladder muscle, urinary tract infections, constipation, delirium, heart disease, diabetes, dementia, medication side effects, and difficulty getting to the toilet in time. Urinary incontinence can lead to problems such as falls, depression, and isolation.</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>SLEEP PROBLEMS</strong></td>
<td>Sleep problems can affect quality of life and can contribute to falls, injuries and other health problems. Many factors can affect an elderly person’s sleep, including stress, anxiety, depression, delirium, dementia, certain drugs, alcohol, and medical problems such as pain, arthritis, nerve problems, breathing difficulty, heartburn, and frequent trips to the bathroom at night.</td>
</tr>
</tbody>
</table>
| **DELIRIUM** | Many older adults who go to the Emergency Room or are admitted to the hospital develop delirium. Delirium is a state of sudden confusion that can last days, weeks or even months. Drug side effects, dehydration, thyroid problems, pain, urinary tract and other infections, poor vision or hearing, strokes, bleeding, or heart or breathing problems can cause delirium. 

Older people can develop serious and life-threatening complications and loss of function, if delirium isn't recognized and treated quickly. |
| **DEMENTIA** | Alzheimer’s disease and "vascular dementia," (caused by a series of small strokes), are two common forms of dementia. While some healthy older people find it harder to remember things or carry out certain mental activities, this doesn’t necessarily mean they have dementia. Dementia gets worse over time and can severely limit functioning. |
| **FALLS** | Falls are a leading cause of serious injury in older people. Among other things, safety hazards in the home, medication side effects, walking and vision problems, dizziness, arthritis, weakness, and malnutrition can boost risks of falls. Like other geriatric syndromes, falls usually have more than one cause. |
| **OSTEOPOROSIS** | Osteoporosis, or “thinning bones,” is a condition that makes the bones of older adults more fragile and easy to break. A diet that doesn’t have enough calcium and vitamin D, too little exercise, smoking, too much alcohol, certain medications, and certain medical conditions such as thyroid problems, and a family history of osteoporosis can increase risk of having it. |
| **PRESSURE ULCERS** | Also known as “bed sores,” pressure ulcers are skin and tissue damage caused by constant pressure on skin and the “soft tissue” underneath it. These can be painful and lead to serious infections. Smoking, being underweight, poor diet, low blood pressure, diabetes, heart disease, kidney failure, and bladder problems can increase the risks of developing pressure ulcers. |
| **VISION PROBLEMS** | Common vision problems among older adults include nearsightedness, glaucoma, cataracts, diabetic eye disease, presbyopia, (age-related changes in the eye that make it hard to see close-up), and macular degeneration (damage to the eye’s center that can result in loss of central vision). |
| **HEARING PROBLEMS** | Hearing loss is the most common sensory problem among older adults. |
| **DIZZINESS** | The word “dizziness” is often used to describe feelings of spinning, almost fainting, falling, or lightheadedness. These feelings can make it harder to walk and can increase an elder’s risk of falls. Many things may cause dizziness, including low blood pressure, vision problems, inner ear problems, anxiety, and medication side effects. |
| **FAINTING** | Fainting, or briefly passing out, is increasingly common with age and leads to falls, and potentially significant injury. There are many possible causes, including low blood pressure, low blood sugar levels, and irregular heartbeat. In older people there is often more than one cause. |
| **DIFFICULTY WALKING OR “GAIT PROBLEMS”** | This is usually due to a combination of age-related health problems or diseases such as arthritis, bone and muscle problems, Parkinson’s disease, poor circulation, dizziness, changes after a stroke, vision problems, loss of strength, and even fear of falling. |
Elder Abuse

Elder abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. It is predominantly a hidden social problem as it is usually committed within the confines of the elderly person's home, mostly by the immediate family members. In addition, elder abuse victims usually do not report this crime for a number of reasons, which includes fear of loss of independence, fear of others' disbelief, fear of being institutionalized or losing their sole social support, and fear of being subject to future retaliation by the perpetrator(s). The central part of elder abuse is the expectation of trust by the elderly toward their abuser.\textsuperscript{23-25}

Cognitive decline in elder abuse victims' and ill health is also responsible for under reporting of their abuse. Lack of proper training of healthcare professionals regarding elder abuse can also lead to under reporting of their abuse.\textsuperscript{26} With the growth in the U.S. population, the problem of elder abuse has slowly come to the forefront. Each year, approximately 4 million elderly Americans are victims of different forms of abuse. However, these statistics are deceptive because for every reported case of elder abuse, it is estimated that around 23 cases of elder abuse go unreported. Those elderly persons who suffer abuse usually experience worsened financial and functional conditions and progressive dependency, feelings of helplessness and loneliness, poor self-rated health, and increased psychological agony.
Studies have also observed that the elderly who experience abuse have a tendency to die earlier than those who have not been abused, even in the absence of chronic or life-threatening conditions or disease. Elder abuse is a complex social problem, which is not confined to elderly with poor financial status. Elder abuse also happens in community settings, as well as institutional settings like nursing homes and other LTC facilities. In 2008, approximately 3.2 million Americans resided in nursing homes. In 2009, more than 900,000 American lived in assisted living settings.

In a recent study conducted on elderly people, it was observed that approximately 7.6% – 10% of the participants experienced elderly abuse in the prior year. This study did not include financial abuse. Another study estimated that only 1 in 14 cases of elder abuse is reported or comes to the attention of authorities.

In a recent survey, major financial abuse was reported by older people at a rate of 41 per 1,000 surveyed, which was even higher than self-reported rates of physical, emotional, and sexual abuse or neglect. Elderly abuse also exists in healthcare institutions such as nursing homes, hospitals, and other LTC facilities. A survey of nursing-home staff suggests the abuse rates may be high. The survey observed that approximately 36% of the staff witnessed at least one incident of physical abuse of an elderly patient in the previous year. At least 10% of the staff committed at least one act of physical abuse towards an elderly patient, and around 40% of nursing staff admitted to psychologically abusing patients.
Another study found that approximately 90% of abusers against elderly were immediate family members, usually adult children, spouses, partners, and others. There are several types of elder abuse, which includes the following those outlined below.\textsuperscript{33-35}

- **Physical Abuse**

  Physical abuse can range from slapping to severe beatings and restraining. It also includes false confinement, or providing excessive or improper medication.

- **Psychological or Emotional Abuse**

  Psychological or emotional abuse is any type of behavior (coercive or threatening) that causes fear, mental anguish, or emotional pain to the elder. It may take verbal forms such as name-calling, constantly criticizing, bullying, accusations, blaming, ridiculing, or non-verbal forms such as shunning, ignoring, \textit{etc.}

- **Financial Abuse**

  Financial abuse encompasses forceful, illegal or unauthorized use of an individual’s property, money, or other valuables. The financial abuse is usually accomplished by deception, misrepresentation, undue influence, coercion, \textit{etc.} Other forms of financial abuse include deprivation of money or property. It also includes scams by strangers via fraudulent investment schemes, predatory lending, and lottery scams.
• **Sexual Abuse**

Sexual abuse can range from inappropriate touching, sexual exhibition to rape. Sexual abuse is probably the least reported form of elder abuse.

• **Neglect as a Form of Abuse**

Neglect is a form of abuse that ranges from food deprivation to emotional deprivations. In such cases, caregivers intentionally deprive the physical, social, or emotional needs of the elderly. Neglect can include failure to provide adequate medications, clothing, and assistance with activities of daily living. Neglect can also include failure to pay the bills for the elderly or to manage the financial aspects of the older person. In rare cases, family caregivers can also neglect unintentionally, also known as passive neglect, because of their own lack of resources knowledge, or maturity.

Some U.S. state laws also recognize the following conditions and situations as a form of elder abuse.

• **Abandonment:**

Elder abuse also includes desertion of an elderly person by care providers or by an individual who has the physical custody of an elder that might endanger their health or welfare.

• **Rights Abuse:**

An important aspect of elder abuse is rights abuse, which is increasingly being recognized and encompasses forceful denial of
the rights (civil and constitutional) of an elderly individual who is not declared by court to be mentally incapacitated.

- **Self Neglect:**
  Elderly people neglect themselves by not caring about their own health or safety. Self-neglect is treated as conceptually different from elder abuse.

- **Institutional Abuse:**
  Institutional abuse refers to physical or psychological abuse, as well as rights violations in settings where care and assistance is provided to dependent elderly or others.

**Warning Signs of Elder Abuse**

The ability to detect the warning signs of elder abuse is the key to its prevention. Signs of elder abuse may vary according to the type of abuse the elderly person experiences. Each form or type of abuse has distinct signs and symptoms associated with it. Caregivers with past history of substance abuse or mental illness have a greater likelihood of committing elder abuse than other individuals.

Elder abuse can be difficult to detect if subtle in nature. Therefore, any suspicion must be taken seriously and concerns should be immediately and properly addressed. Warning signs of elder abuse are outlined in the table below.\(^{36}\)
<table>
<thead>
<tr>
<th>WARNING SIGNS OF ELDER ABUSE</th>
<th>Physical Abuse</th>
<th>Verbal, Emotional and Psychological Abuse</th>
<th>Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bruises or grip marks around the arms or neck</td>
<td>• Unresponsive and uncommunicative</td>
<td>• Unexplained vaginal or anal bleeding</td>
<td></td>
</tr>
<tr>
<td>• Repeated unexplained injuries</td>
<td>• Unreasonably frightened or suspicious</td>
<td>• Torn or bloody underwear</td>
<td></td>
</tr>
<tr>
<td>• Rope marks or welts on the wrists and/or ankles</td>
<td>• Lack of interest in social contacts</td>
<td>• Bruised breasts or buttocks</td>
<td></td>
</tr>
<tr>
<td>• Dismissive attitude or statements about injuries</td>
<td>• Evasive or isolated</td>
<td>• Venereal diseases or vaginal infections</td>
<td></td>
</tr>
<tr>
<td>• Refusal to go to same emergency department for repeated injuries</td>
<td>• Unexplained or uncharacteristic changes in behavior</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Financial Abuse or Exploitation

- Life circumstances don’t match what is known about the individual’s financial assets
- Large withdrawals from bank accounts, accounts that have been switched; unusual ATM activity
- Signatures on checks don’t match the older person’s signature

### Caregiver Neglect

- Lack of basic hygiene, adequate food and water, or clean and appropriate clothing
- Sunken eyes or loss of weight
- Person with dementia left unsupervised
- Untreated pressure bedsores
- Lack of medical aids (glasses, walker, teeth, hearing aids, medications)

### Risk Factors Contributing to Elder Abuse

Risk factors that contribute to elder abuse may be identified at the individual, relationship, community, and socio-cultural levels. These levels of risk are further delineated in the sections below.

**Individual**

Risks at the individual level include dementia of the elderly, alcohol and substance use and the presence of mental disorders in the perpetrator. Other individual-level factors include female gender and a shared living situation. Elderly women are particularly at higher risk of neglect through abandonment especially if they are widowed and with poor financial status. Women are also more frequent victims of persistent and severe forms of elder abuse and injury.
**Relationship**

A shared living arrangement is also a risk factor for elder abuse. The perpetrator’s dependency, particularly financial, on the elderly also increases the risk of elder abuse. Poor family relationships can lead to elder abuse because of increasing frustration and stress as elderly people become more dependent with aging. Family members have less spare time to provide adequate care for elderly which may become a burden, increasing the risk of elder abuse.

**Community**

Social isolation of elderly people as well as caregivers coupled with absence of social support is an important risk factor for elder abuse. The elderly may become prone to isolation because of poor physical and mental health or due to loss of family and friends.

**Socio-cultural**

Socio-cultural factors that may increase the risk of elder abuse include:

- Depiction of elderly as weak, frail and dependent.
- Erosion of the intimacy and bonds between generations of a family.
- Issues of inheritance and land rights that may adversely impact distribution of wealth and power within families.
- Migration of family members, particularly young couples, leaving elderly parents alone, in societies where elderly were traditionally cared for by their offspring.
- Poor financial ability to pay for care.
Within healthcare settings elder abuse is likely to occur when:

- There are poor standards for health care and health care facilities for elderly people.
- The staff is poorly trained, underpaid, and overworked.
- There is a poor physical environment.
- The policies are pro-institution rather than pro-residents.

The level at which victimization of elderly occurs and correlating risk factors for it are included in the table below.

<table>
<thead>
<tr>
<th>Level</th>
<th>Risk Factors</th>
</tr>
</thead>
</table>
| Individual (victim)    | Sex: women
Age: older than 74 years
Dependence: high levels of physical or intellectual disability
Dementia, including Alzheimer’s disease and other types of dementia
Mental disorders: depression
Aggression and challenging behavior by the victim |
| Individual (perpetrator) | Sex: men in cases of physical abuse and women in neglect cases
Mental disorders: depression
Substance abuse: alcohol and drug misuse
Hostility and aggression
Financial problems
Stress: caregiver burnout |
| Relationship           | Financial dependence of the perpetrator on the victim
Dependence of the perpetrator on the victim (emotional and accommodation)
Intergenerational transmission of violence
Long-term history of difficulty in the relationship
Kinship: children or partner
Living arrangement |
| Community              | Social isolation: victim lives alone with perpetrator and both have few social contacts
Lack of social support: absence of social support resources and systems |
| Societal               | Discrimination because of age: ageism
Other forms of discrimination: sexism and racism
Social and economic factors
Violent culture: normalization of violence |
Health Consequences of Abused Elders

Compared to elders who have not been abused, those who undergo abuse have been found to experience an increased (three-fold) risk of mortality. A recent study has shown that victims of elder abuse have had substantially greater levels of psychological distress and lower perceived self-efficacy than the elderly who have not been victimized. Furthermore, elderly who are victims of violence have additional health care problems than other older people, including osteoporosis, arthritis, depression, hypertension, and cardiovascular disease.

The impact of elder abuse also leads to a significant economic burden. The direct medical costs due to elder abuse were estimated to be $2.9 billion in 2009. The health consequences of elder abuse are varied and can be very serious. Elder abuse can clearly adversely affect an individual’s quality of life, as indicated in the following table.

<table>
<thead>
<tr>
<th>Health Consequences Of Elder Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Declining functional abilities</td>
</tr>
<tr>
<td>• Increased dependency</td>
</tr>
<tr>
<td>• Increased psychological stress</td>
</tr>
<tr>
<td>• Greater sense of helplessness</td>
</tr>
<tr>
<td>• Deteriorating psychological status</td>
</tr>
<tr>
<td>• Increased mortality and morbidity</td>
</tr>
<tr>
<td>• Depression and dementia</td>
</tr>
<tr>
<td>• Under nutrition or malnutrition</td>
</tr>
<tr>
<td>• Mortality or Death</td>
</tr>
</tbody>
</table>
Elder Abuse Prevention

The first and most important step toward preventing elder abuse is to recognize that no individual should be subjected to abusive, humiliating, neglectful, or violent behavior. The following action plans support providers and families in the prevention of elder abuse.

- Education is one of the principal means of preventing elder abuse. Concerted efforts should be made to educate the public about the needs and problems of elderly and the risk factors associated with elder abuse.

- Respite care for caregivers is necessary to meet their need for time alone, and free from the stresses associated with elder care. Respite care is particularly important for caregivers of the elderly with Alzheimer’s disease or other forms of dementia.

- Social contact and support can be very helpful to the elderly as well as to family members and caregivers. Elderly individuals with expanded social circle tend to have fewer stresses and tensions. The probability of abuse is higher with an increasing isolation of elders.

- Counseling can be beneficial for behavioral or personal problems of an elderly or the caregivers.

Reporting Elder Abuse

Any individual who suspects that elder abuse has occurred should report the incidence because the abuse can continue and may escalate if there is no intervention. All cases of elder abuse should be reported
to the Elder Abuse Provider Agency agencies in the area. If an individual is in doubt about elder abuse, it is always better to err on the side of caution and report the situation. If elder abuse occurs in a long-term care facility, such as a nursing home or residential care facility, one may call the local Long-Term Care Ombudsman, local law enforcement agency, etc. A complaint can be filed with the appropriate state regulatory agency.

For suspected abuse that occurs anywhere other than in a facility, reports should be made to the local law enforcement or local county Adult Protective Services Agency. Each county Adult Protective Services (APS) agency is responsible for providing assistance to the elderly who are abused or are functionally impaired, and who are unsuspecting victims of exploitation or neglect, including self-neglect. The agency investigates reports of abuse that occur in private homes, hospitals, clinics, social day care centers and adult day care centers. Some professionals (healthcare physicians, hospital staff, dentists, chiropractors, social workers, registered nurses and law enforcement officers) are mandated to report the suspicion of elder abuse or neglect of a resident in a licensed nursing facility.

**End-Of-Life Care**

End-of-life (EOL) care may be defined as health care for patients in the last few day or hours of their lives, and all individuals with a terminal condition or illness such as cancer that is progressive, advanced, and incurable will require end-of-life care. EOL care requires addressing a number of issues and decisions, including patients' right to self-determination (to live or die), medical experimentation, and the efficacy and ethics involved with medical interventions. EOL also
touches upon the burden associated with it such as rationing and the allocation of resources in hospitals and healthcare system. Such decisions also involve medical considerations, bioethics, and economic factors. Another prime consideration is the individual patient’s autonomy. Finally, it all depends upon the wishes of the patients and their families to decide whether to pursue further medical treatment or withdraw life support. It is estimated that approximately 27% of Medicare's annual $327 billion budget ($88 billion) is spent in end of life care.  

As the elderly confront the end of life issues, they and their families usually face tasks and decisions that encompass a number of choices ranging from simple to extremely complex. The issues can be medical, psychosocial, spiritual, legal, or existential in nature. For instance, dying elderly and their families are faced with choices and dilemmas about the type of caregiver help and whether to receive care at a healthcare institution or home. Dying people and their family may have to make decisions regarding the amount of family involvement in decision-making and care giving.

Ethical guidelines for physicians pertaining to EOL care depend upon several factors, which include beneficence, non-maleficence, patient autonomy and resources. In recent decades, society has recognized the important role of patient autonomy, a key issue in the EOL care. Patient autonomy is the right of patients to make decisions about their medical care without their health care provider trying to influence the decision. In some cases, a patient’s decision regarding end of life care may differ from that of family members and health care providers’
recommendations. In such a scenario, every physician should make sure that the patient is fully informed about his or her condition.

Patient's goals for care should be established as early as possible. In addition, when discussing patient preferences about life sustaining treatments, healthcare providers should accurately explain to the patient any possible benefits and burdens about life sustaining treatments. Another key ethical principle is the appropriate stewardship of resources. This is particularly important in end-of-life care when life-sustaining treatments can be a burden because of cost and time involved in the treatment. Effective communication is critical to meet the needs of elderly at the end of life, as is highlighted below.

**Effective Communication Tips at the End-of-life**

- Ensure a quiet location for communication
- Allow appropriate time for the interaction
- Involve the family in all communication
- Speak from a seated position
- Assess patient understanding
- Use open-ended questions to invite the patient perspective
- Accept and address emotions of patients and loved ones
- Educate patient and family on disease state(s)
- Inquire about and address cultural issues
- Demonstrate reflective listening
- Express empathy
- Disclose all benefits and risks to treatment as well as alternative therapy
- Speak objectively in an evidence-based manner
- Suggest all appropriate resources to patients and their families including psychiatric care, pastoral support, and social services
- Identify and discuss advance directives
- Establish patient goals and develop a plan
The Provider's Role

Health providers and other healthcare workers have to confront many challenges in the management of end-of-life care. The general approach of healthcare givers and physicians is to preserve life; however, patients have the right to choose the objectives and goals of their own medical care.

The main role of the healthcare providers near the end of life is to coordinate and administer optimal medical and psychosocial care for the patient. In addition, healthcare workers should educate and advise the elderly patient and family to help in the decision-making process. Physicians and healthcare providers must take on the appropriate level of involvement keeping in view the patient and family perspectives and wishes.

Ethical Issues

To enhance end-of-life (EOL) care physicians and other healthcare providers should demonstrate the following standards.

- Respect the dying patient's needs for care, comfort, and compassion.
- Communicate promptly and appropriately with patients and their families about EOL care choices, avoiding medical jargon.
• Elicit the patient's goals for care before initiating treatment, recognizing that EOL care includes a broad range of therapeutic and palliative options.

• Respect the wishes of dying patients including those expressed in advance directives. Assist surrogates to make EOL care choices for patients who lack decision-making capacity, based on the patient's own preferences, values, and goals.

• Encourage the presence of family and friends at the patient's bedside near the end-of-life, if desired by the patient.

• Protect the privacy of patients and families near the end of life.

• Promote liaisons with individuals and organizations in order to help patients and families honor EOL cultural and religious traditions.

• Develop skill at communicating sensitive information, including poor prognoses and the death of a loved one.

• Comply with institutional policies regarding recovery of organs for transplantation.

• Respect the dying patient's needs for care, comfort, and compassion.

• Communicate promptly and appropriately with patients and their families about EOL care choices, avoiding medical jargon.
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• Protect the privacy of patients and families near the end of life.

• Promote liaisons with individuals and organizations in order to help patients and families honor EOL cultural and religious traditions.

• Develop skill at communicating sensitive information, including poor prognoses and the death of a loved one.

• Comply with institutional policies regarding recovery of organs for transplantation.

• Obtain informed consent from surrogates for postmortem procedures.
Hospice and Palliative Care

Hospice and palliative care facilities provide several services associated with end of life care, which helps patients and loved ones in the transition towards death. These facilities provide care to preserve the quality of life and to provide pain relief. Hospice also provides support to cope with the psychological stresses involved at the end-of-life.

Hospice and palliative services are available at the patient's home, hospitals as well as acute and chronic care facilities. Hospice services have been covered under Medicare since 1983. Palliative care is gaining importance and is helpful in prolonging life and extending survival. Proper palliative care helps elderly patients to shift attention from their condition to their wishes for how they choose to spend the remaining time of life.

It is important to note that palliative care does not begin when life-prolonging care ends. Rather, these two approaches of care can be used concurrently. The role of the physicians and healthcare providers is to strike a balance between these two approaches to provide the most optimal, effective and individualized care for the elderly patients. Appropriate changes in palliative care may be made in order to improve end-of-life care.

A recent study stressed the need for appropriate use of a palliative care team for terminally ill patients. Many studies have reported that compared with Caucasian Americans, minority groups are less likely to benefit from hospice care. When compared with European Americans, elderly African Americans and Latinos have a greater likelihood of dying at home and have less likelihood of getting hospice care.
Pharmacologic management of symptoms at the end-of life is a complex and a well-debated issue. Sedatives can be effectively used for refractory symptoms, especially dyspnea and agitation, which cannot be managed with other forms of therapy. Some researchers and physicians argue that the use of pain medications may accelerate a patient's death. However, the majority of healthcare providers and people agree that if the provider's intent is to relieve suffering, an unintentional effect of influence on the time of death is legally, ethically, and morally acceptable.

**EOL Common Symptoms**

The common symptoms during the end of life are listed below.

- Pain
- Dyspnea
- Anxiety
- Depression
- Guilt
- Nausea
- Constipation
- Insomnia
- Weakness
- Fatigue
- Delirium

**Cultural and Spiritual Issues**

Cultural issues, especially pertaining to the end-of life, care are becoming increasingly significant as the U.S. has become more diverse. End-of life care and decision-making should reflect cultural
traditions and beliefs of the patient; however, it is important not to generalize that all members of a given culture have similar attributes. Culture may influence the type of end of life care a person desires. For example, patient autonomy is very close to people living in America and Europe; however, other cultures, especially Korean and Hispanic, believe that decision-making is the responsibility of the family.

Many Hispanics believe that they should not control life's processes and thus are less likely to be interested in advance care planning. Japanese people usually take a reserved approach and sometimes are reluctant to share personal information or feelings with healthcare givers or physicians. Indian people, on the contrary, tend to be more open and develop a deeper interaction with their treating physicians. They are more compliant to their provider's advice. These attitudes must be considered and taken into account when providing end of life care.

One area that significantly varies among different cultures is the communication of bad news. In the U.S., a provider usually fully discloses the patient's actual condition or prognosis irrespective of its severity. In Chinese and Hispanic cultures, this is considered to be inappropriate and family members tend to hide bad news or prognosis from the patient. It is important that providers and healthcare staff have an ethical, moral and legal obligation to fully inform a patient of their condition. In addition, providers should explain the rationale behind full disclosure, and that it equips the family member and the patients to make appropriate decisions regarding treatment and end of life care issues.
It is important to reiterate that cultural behaviors should not be generalized or stereotyped and should not be applied to all members of the culture. Providers need to understand that cultural variation does exist and should try to understand each of their patients' cultural values.

Spiritual issues and concerns play an important role in the end-of-life care for many patients. A recent review identified 11 dimensions for end-of-life spirituality, which includes:  
- meaning and purpose in life
- self-transcendence
- transcendence with a higher being
- feelings of communion and mutuality
- beliefs and faith
- hope
- attitude toward death
- appreciation of life
- reflection upon fundamental values
- developmental nature of spirituality
- conscious aspect of spirituality

Religious issues, particularly at the end of life, are important to each individual patient and should be addressed appropriately.

**Advance Directive Care Planning**

An advance directive is a legal document that allows patients to decide their treatment wishes to be carried out in case they are unable to make their preferences known. The *Do Not Resuscitate* (DNR) order written by a health provider, and a living will and durable power of
attorney for health care are the most common forms of advance directives.

A living will is a record declaring a patient's provisions for their care. A durable power of attorney for health care is when a patient proactively assigns a surrogate decision maker in case they are unable to make their medical decisions known. A patient’s spouse or other family member is usually the durable power of attorney, but a trusted friend can also fulfill the duty. It is important that elderly individuals openly discuss their end of life issues and preferences with their surrogate decision maker for optimal utilizing the purpose of this form of advance directive.

Advance directives fulfill several key purposes, especially the communication of elderly patient wishes regarding end-of-life care. Many elderly have their personal preferences with regards to cardiopulmonary resuscitation or CPR. These preferences vary broadly, and are dependent on several factors, including the patient’s age, state of health, and clinical setting. Recent studies have indicated that majority of patients do not desire full resuscitative efforts. Healthcare providers and families, in absence of advance directives, often misjudge the patient's end-of-life wishes. Medicare and Medicaid providers have to inform patients of their rights regarding advance directives.

However, there is still poor public awareness regarding patient care and rights at the end of life. Furthermore, it has been found that individuals who have advance directives do not properly understand their implications. All these elements associated end-of-life care issues
further complicate the role of the physician and outcomes for the patient; however, it is the provider's responsibility to communicate and inform elderly individuals of their rights as patients. In a recent study it was observed that only 10-30% of patients have completed advance directives. The ideal advance directive should facilitate a system to honor directives that encompasses the following factors.  

- It is comprehensive
- It preserves patient autonomy
- It is easily understood by everyone involved

**Communication with Elderly and Family Members**

Communication is a very important aspect of end-of-life care. It is of the utmost importance for patients and families nearing the end of life. Proper communication is a key component of end-of-life care throughout the entire disease course because of several factors. Healthcare staff and providers may use a number of communication techniques in order to effectively communicate with the patient and the family.

Open-ended questions help a great deal to assess baseline knowledge about a specific condition or particular situation. Some researchers also suggest use of frequent pauses in conversation, particularly after bad news is announced. This provides enough time for elderly patients to better assimilate and understand the information provided. Other communication techniques that are used by the physicians and healthcare staff include eye contact, empathy, and reflective listening.
Informed Consent and Decision-Making Capacity

Informed consent is a fundamental right of a patient that protects patient autonomy with regards to treatment options. Consent to medical treatment is not essential in certain extraordinary or emergency circumstances. However, in most clinical scenarios, informed consent must be obtained from the patient or from the family in case the patient is not capable. Informed consent requires three key components or elements: 1) decisional capacity, 2) delivery of information, and 3) voluntariness. Informed consent can be obtained only if the patient has adequate decision-making capacity.

Several factors are involved to determine the decision-making capacity of the patients, which includes the patient’s capacity to receive and process information, and effectively communicate their options. A patient’s decision-making capacity can be impacted by certain conditions such as pain, depression, anxiety, intoxication, side effects of certain drugs, medication and several others. A validated systematic process should be followed to minimize provider bias and standardize the measurement of capacity in each individual situation. Following a validated systematic process minimizes provider bias and standardizes the measurement of capacity in each individual situation.

Hospice Care

English physician Dr. Dame Cicely Saunders first initiated the concept of hospice in 1967. In the U.S., the concept of hospice care emerged in the mid-1970s. In 1982, hospice care was included in the Medicare program. Hospice services include professional nursing care, personal assistance with ADLs (activities of daily living), rehabilitation therapy,
dietary, psychosocial and spiritual counseling for elderly patients and families, respite care, volunteer services, availability of medical drugs and devices essential for palliative care, and family bereavement services after the patient’s death.

Hospice care is provided by a team which includes nurses, social workers, nursing assistants, other health professionals, and pastoral services, under the guidance and management of the patient’s own primary care provider or hospice program. In the U.S., the majority of elderly patients can avail Medicare Hospice Benefits (MHB). For an elderly to avail hospice care, a provider must certify that the elderly has a greater probability of dying within 6 months if the terminal disease such as incurable cancer, chronic disease, etc. follows its anticipated course. The patient is reassessed periodically, in the beginning after each of the first two 90-day periods, and then 60 days after that to document continued determination in the patient’s condition and to assess if the hospice care continues to be appropriate.

Despite Medicare Hospice Benefits, there is a tendency to provide Intensive Care Unit (ICU) hospitalization for end-of-life care, which is both expensive as well as often futile. Nursing homes are usually reluctant to have patients die on their premises and under their care. Hence, when an elderly comes close to death, the patient is usually shifted to the nearest hospital and admitted to the ICU. The following table outlines the key health team members of hospice care and their duties.
### Key Members of Hospice Care

<table>
<thead>
<tr>
<th>Members</th>
<th>Duty</th>
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<tbody>
<tr>
<td><strong>Primary Care Provider</strong></td>
<td>• Provides the hospice team with medical history.</td>
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<td>• Oversees medical care through regular communication with the hospice team.</td>
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<td>• Provides orders for medications and tests, signs death certificate, etc.</td>
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<td>• Determines his or her level of involvement on a case-by-case basis with the hospice medical director.</td>
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<td><strong>Hospice Physician</strong></td>
<td>• Provides expertise in pain and symptom control at the end of life.</td>
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<td></td>
<td>• Works closely with the hospice team and primary physician to determine appropriate medical interventions.</td>
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<td>• Makes home visits on an as needed basis.</td>
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<td></td>
<td>• May oversee the plan of care, write orders, and consult with patient and family regarding disease progression and appropriate medical interventions on a case-by-case basis.</td>
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<tr>
<td><strong>Nurse</strong></td>
<td>• Visits patient and family in the home or nursing home on regular basis (biweekly to 3-4 times per week, depending on the specific needs of the patient).</td>
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<td>• May provide on-call services (24 hours a day, 7 days a week for emergencies).</td>
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<td>• Assesses pain, symptoms, nutritional status, bowel functions, safety, and psychosocial-spiritual concerns.</td>
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<td></td>
<td>• Educates patient and family about disease progression, use of medications, daily care needs, and other aspects of the overall plan of care.</td>
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<tr>
<td></td>
<td>• Educates and supervises nursing assistants.</td>
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<tr>
<td></td>
<td>• Provides emotional and spiritual support to patient and family to cope with functional limitations, caregiver stress, and grief.</td>
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| **Home Health Aide** | • Assists patient with activities of daily living such as bathing and dressing.  
• Provides a variety of other services depending on assessment of need. |
| **Social Worker** | • Attends to both practical needs and counseling needs of patient and family based on initial and ongoing assessment.  
• Arranges for durable medical equipment, discharge planning (from hospital to home), funeral/burial arrangements.  
• Serves as liaison with community agencies (such as Department of Human Services, Department of Aging, Public Aid office).  
• Assist family in finding services to address financial needs and legal matters (Power of Attorney, Wills).  
• Provides counseling related to family communication.  
• Assesses patient and family anxiety, depression, role changes, caregiver stress.  
• Provides general grief counseling. |
| **Chaplain** | • Provides patient/family with spiritual counseling for questions on hope, meaning, despair, fear of death, relationship with divine, need for forgiveness, loss of life purpose.  
• Assists patient and family in sustaining their religious practice and in drawing upon religious/spiritual beliefs to cope with illness, dying, and grief.  
• Ensures the patient’s and family’s religious or spiritual beliefs and practices are respected by the hospice team (i.e., dietary restrictions, rituals to be observed at the time of death, disposition of the body).  
• Serves as liaison with the patient/family faith community.  
• May conduct funeral and memorial services for patients and families as requested.  
• Provides hospice staff with spiritual care and counseling. |
| Volunteer                                      | • Provides respite care to family members  
|                                               | • May assist with light housekeeping or grocery shopping  
|                                               | • Helps patients stay connected with community groups and activities  
|                                               | • Facilitates special projects such as memoirs/legacy work, letters to family, and massage therapy  
|                                               | • May provide community education and outreach  
|                                               | • May assist with office work |

**Services Offered by Hospice**

Services offered by hospice are provided for the patient and for their families and caregivers. These are covered below.

For the Patient:

- Hospice works with the patient’s family or nursing home staff in order to provide optimal care to the dying patient.
- Goals of care (realistic and achievable) are established and a care plan developed to help achieve these goals.
- The hospice team is geared to relieve patient’s pain and other symptoms because of end stage disease and other conditions.
- Medications are prescribed by the hospice or primary physician, and are usually bought by family members from the designated pharmacy.
- The hospice program provides laboratory services that are essential for the symptom control and are necessary for treatment.
- Ambulance services are also made available when the condition is related to the terminal diagnosis, and comes within the ambit of care plan.
• Family may provide friends, paid caregivers and/or nursing home staff assistance in activities of daily living with hospice staff providing only an educational and supervisory role.
• The majority of hospices provide 1-2 hours of care by a home health assistant or aide for particular needs such as bath service.
• Essential durable medical equipment such as a hospital bed, oxygen, walker, etc. is provided by hospice.
• Counseling is provided by the hospice to help patients cope with their end of life issues. Hospice staff may also help the patient regarding legal or financial business issues and in making funeral arrangements.
• Religious care is provided either directly by the hospice chaplain or through community church.

For Caregivers or Family Members:
• Counseling services for caregivers and family members to better cope with stress, depression, anxiety, role changes, family conflict, grief, as well as religious and spiritual concerns.
• Respite care may be made available to family either by volunteers or, by paid staff either in the hospital or at home.
• Education to family to provide hands on care to patients, for optimal use of prescribed medications, for knowledge about the disease, its progression, signs and symptoms of the dying process, normal grief response, coping mechanism of dealing stress, etc.
• Practical assistance pertaining to legal issues, Powers of Attorney, Living Will, and accessing community services.
• Assistance related to cremation/burial arrangements and with funeral/memorial services.
• Bereavement care can also be made available.
Benefits of Hospice Care

Several research studies have observed that family members are more satisfied with hospice or palliative care when compared with hospitalization. Compared to hospitalization, hospice provides better care with greater consumer satisfaction. A research study conducted on chronic heart failure (CHF) patients found that such patients lived longer, an average of 29 days, under hospice care. Furthermore, hospice care is generally associated with a decreased financial burden. There are barriers to hospice care that exist and pose challenges to best care outcomes, and these are covered in the section below.

Barriers to Hospice Use

Death of an elderly individual with end-stage disease cannot be predicted with accuracy. It has been observed that a mandated assignment of a 6-month time period according to Medicare has itself become a barrier to end-of-life care. Providers and other healthcare professionals are reluctant to refer a patient to hospice as they may consider it a medical failure because they are trained to prolong life.

The National Hospice Foundation has reported that approximately three-fourth of U.S. citizens do not have adequate information regarding hospice care. They do not know that hospice care can be provided in the home and around 90% do not know that hospice care is fully covered through Medicare.

Euthanasia and Physician-Assisted Suicide

Euthanasia and physician-assisted suicide are highly emotional and complex issues in American medicine. Euthanasia is the intentional
ending of the life of an individual who has an incurable or terminal illness.\textsuperscript{48} Physician-assisted suicide can be described as a practice in which the physician provides a patient with a lethal dose of a drug/medication, upon the patient's request, which the patient intends to use to end his or her own life. In a physician-assisted suicide, the physician offers the necessary means or information and the patient performs the act, whereas in euthanasia only the physician performs the intervention. Currently, physician-assisted suicide is legal in the states of Oregon and Washington, whereas euthanasia is illegal in every other state. Euthanasia is, however, legal in the Netherlands and Switzerland. Interestingly, many individuals as well as social groups support legalization of both euthanasia and physician-assisted suicide.\textsuperscript{49} Despite this support, physicians must follow the laws of the state.

Health providers must explain their legal obligations in case the patient expresses wishes regarding euthanasia or physician-assisted suicide. When treating such patients, providers should try to understand the root cause of their feelings. Many patients may consider euthanasia or physician-assisted suicide due to fears that may be allayed with proper education about their condition and disease as well as with effective palliative treatment.

**Summary**

Memory disorders are the most common cognitive change in the elderly which are generally caused by Alzheimer disease, frontotemporal dementia, and dementia with Lewy bodies. The majority of the elderly with AD and related conditions who live at home receive unpaid help from friends and family, but some opt for
paid home and community-based services, such as personal care and adult day center care. Caring for the elderly with memory issues also requires a multi-pronged approach. Depression is very common in older patients. Depression is a mood disorder, but not essentially a psychiatric disorder. Depression in elderly is common and widespread globally. It is also the most treatable disorder, which affects approximately 15% of elderly, 20% of hospitalized elderly patients, and over 40% of elderly nursing home residents.

Elder abuse is a single, or repeated act, or lack of appropriate action that happens any relationship where there is an expectation of trust, and which causes harm or distress to an elderly person. Elder abuse is predominantly a socially hidden problem as it is usually committed within confines of the elderly person’s home, mostly by the immediate family members. Any individual who suspects that elder abuse has occurred should report the incidence because the abuse can continue and may escalate if there is no intervention. All cases of elder abuse should be reported to the Elder Abuse Provider Agency agencies in the area where it has occurred.

End-of-life care may be defined as health care for patients in the last few days or hours of their lives, and for all individuals with a terminal condition or illness such as cancer that is progressive, advanced, and incurable. EOL care issues can be medical, psychosocial, spiritual, legal, or existential in nature. The general approach of healthcare providers and caregivers is to preserve life; however, patients have the right to choose the objectives and goals of their own medical care. The main role of healthcare providers as patients near the end of life is to coordinate and administer optimal medical and psychosocial care for
the patient. The patient may wish to have an advance directive. An advance directive is a legal document that allows patients to decide that their treatment, or absence of treatment wishes be carried out in case they are unable to make their preferences known. Do not resuscitate (DNR) orders, living wills and durable power of attorney for health care are the most common forms of advance directives.

Euthanasia and physician-assisted suicide are highly emotive and complex issues in American medicine. Euthanasia is the intentional ending of the life of an individual who has an incurable or terminal illness. Physician-assisted suicide can be described as a practice in which the physician provides a patient with a lethal dose of a drug or medication, upon the patient’s request, which the patient then intends to use to end his or her own life. Whatever the patient’s decisions at the end of their life, communication is a very important aspect of care; it is of utmost importance for patients and their families throughout an entire disease course and while making EOL decisions.

Please take time to help NurseCe4Less.com course planners evaluate the nursing knowledge needs met by completing the self-assessment of Knowledge Questions after reading the article, and providing feedback in the online course evaluation.

Completing the study questions is optional and is NOT a course requirement.
1. The elderly population in the U.S., is expected to increase to more than ____ million by 2030.
   a. 35
   b. 45
   c. 60
   d. 70

2. Adult Day care is designed for elderly:
   a. with at least late mild to moderate dementia.
   b. to provide structured and safe daily activities.
   c. to reduce caregiver distress.
   d. All of the above

3. True or False: Compared to women, men are less susceptible to depression after the loss of a spouse and remain depressed for less time than women.
   a. True
   b. False

4. Screening for geriatric depression can include:
   a. complete history and physical.
   b. laboratory, EKG and radiology tests.
   c. polysomnography for sleep disorders.
   d. All of the above

5. Elder abuse is
   a. predominantly hidden.
   b. committed outside the confines of the home.
   c. generally reported by elders.
   d. usually caused by strangers.

6. Within healthcare settings elder abuse is likely to occur:
   a. due to poor staff training, compensation, and workload.
   b. when there is a poor physical environment.
   c. when policies are pro-institution rather than pro-residents.
   d. All of the above
7. True or False: Palliative care begins when life-prolonging care ends.
   a. True
   b. False

8. The main role of health providers near the end of life is:
   a. to coordinate and administer optimal patient care.
   b. to educate the elderly patient/family during decision making.
   c. to support a patient’s wishes.
   d. All of the above

9. True or False: Research studies showed that family members are more satisfied with hospitalization when compared with hospice or palliative care.
   a. True
   b. False

10. Barriers to hospice use include(s):
    a. difficulty diagnosing end stage disease.
    b. Medicare does not pay for hospice.
    c. providers may prefer to prolong life and are reluctant to refer.
    d. patients prefer palliative care.

11. Which of the following is/are characteristic of a person with Alzheimer’s disease?
    a. The person might forget part of an experience
    b. The person can only follow written instructions
    c. The person loses the ability to follow instructions
    d. All of the above

12. A patient exhibiting cognitive decline plus visual hallucinations, and fluctuating cognition or parkinsonian signs (rigidity, falls, masked face) have symptoms of
    b. Lewy body dementia.
    c. frontotemporal dementia.
    d. cerebrovascular infarcts.

13. A patient with Pick’s disease has
a. frontotemporal dementia.
b. mild cognitive impairment.
c. Alzheimer’s disease.
d. suffered a stroke.

14. True or False: Several symptoms of depression can overlap with dementia, such as diminished ability to concentrate, social withdrawal, and sleep disruption.

a. True
b. False

15. One in eight elderly individuals, or approximately 13% have

a. Pick’s disease.
b. frontotemporal dementia.
c. mild cognitive impairment.
d. Alzheimer’s disease.

16. Which of the following signs is/are indicative of normal, age-related memory loss?

a. Memory loss that disrupts daily life
b. Routine inability to recall words
c. Getting lost occasionally while in new circumstances
d. All of the above

17. Caring for an elderly person with memory issues requires

a. an abrupt, firm daily routine.
b. regular visits and talks with the patient.
c. practicing stressful situations.
d. controlling the patient’s daily activities.

18. Among all the other long-term care facilities, nursing homes provide

a. highly skilled and professional staff members.
b. greater independence for the patients.
c. temporary care in most cases.
d. the least expensive long-term care option.

19. An individual experiencing anhedonia will
a. seek activities such as sex, exercise or social activities.
b. have greater self-confidence and independence.
c. experience visual hallucinations.
d. find no pleasure in ordinary, pleasurable activities.

20. Depression in the elderly is

a. generally undiagnosed and often goes untreated.
b. the least treatable disorder among the elderly.
c. a normal part of aging.
d. uncommon.

21. True or False: Women are more susceptible to Alzheimer’s disease and other dementias then are men.

a. True
b. False

22. Elderly patients with depression

a. visit their health provider and hospital more frequently.
b. use more medication.
c. stay for longer periods of time in the hospital.
d. All of the above

23. ______________ is defined as a compulsive, focused attention on negative feelings and experiences from the past.

a. Sociotropy
b. Rumination
c. Anhedonia
d. Bereavement

24. Neglect is a form of elder abuse involving a caregiver depriving a patient of

a. emotional support.
b. adequate medication.
c. assistance with activities of daily living.
d. All of the above
25. Which of the following signs and symptoms of depression is found more often in elderly individuals when compared to younger adults?
   a. Worthlessness
   b. Dysphoria
   c. Loss of interest in living
   d. Dissatisfaction

26. Depression that develops after a stroke is more prominently characterized by
   a. vegetative symptoms.
   b. worthlessness.
   c. dysphoria.
   d. anhedonia.

27. A recent study conducted on U.S. elderly revealed that reported sexual activity was around ___ in the age group of 57 to 64.
   a. 53%
   b. 10%
   c. 26%
   d. 73%

28. True or False: Individuals caring for persons with a physical disability have a higher risk of depression when compared to those who care for persons with dementia.
   a. True
   b. False

29. Elder abuse is defined as __________________ occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.
   a. a single act
   b. a repeated act
   c. a failure to take appropriate action
   d. All of the above
30. Malnutrition can present itself in the elderly patient because of
   a. weight loss, not weight gain.
   b. their need for more calories than younger adults.
   c. a lack of certain nutrients, e.g., calcium, vitamins D or B12.
   d. osteoporosis.

31. With respect to end-of-life care, patient autonomy is the right of __________ to make decisions about the patient’s medical care.
   a. a patient
   b. a caregiver
   c. a physician
   d. a family member

32. __________, or “thinning bones,” is a condition that makes the bones of older adults more fragile and easy to break.
   a. Osteoporosis
   b. Dysphoria.
   c. Anhedonia
   d. Dysphagia

33. True or False: Women tend to live longer on average than men and this is believed to account for the increased risk of Alzheimer’s disease in women.
   a. True
   b. False

34. __________ is the intentional ending of the life of an individual who has an incurable or terminal illness.
   a. Euthanasia
   b. Sociotropy
   c. Dysphoria
   d. Anhedonia
35. Many patients may consider euthanasia or physician-assisted suicide due to fears that may be allayed with

   a. proper education about their condition.
   b. proper education about their disease
   c. proper education about effective palliative care.
   d. All of the above

Correct Answers:

1. The elderly population in the U.S., is expected to increase to more than ____ million by 2030.
   d. 70

2. Adult Day care is designed for elderly:
   d. All of the above

3. True or False: Compared to women, men are less susceptible to depression after the loss of a spouse and remain depressed for less time than women.
   b. False

4. Screening for geriatric depression can include:
   d. All of the above

5. Elder abuse is
   a. predominantly hidden.

6. Within healthcare settings elder abuse is likely to occur:
   d. All of the above

7. True or False: Palliative care begins when life-prolonging care ends.
   b. False
8. **The main role of health providers near the end of life is:**
   
d. All of the above

9. **True or False: Research studies showed that family members are more satisfied with hospitalization when compared with hospice or palliative care.**
   
b. False

10. **Barriers to hospice use include(s):**
    
c. providers may prefer to prolong life and are reluctant to refer.

11. **Which of the following is/are characteristic of a person with Alzheimer’s disease?**
    
c. The person loses the ability to follow instructions

12. **A patient exhibiting cognitive decline plus visual hallucinations, and fluctuating cognition or parkinsonian signs (rigidity, falls, masked face) have symptoms of**
    
b. Lewy body dementia.

13. **A patient with Pick’s disease has**
    
a. frontotemporal dementia.

14. **True or False: Several symptoms of depression can overlap with dementia, such as diminished ability to concentrate, social withdrawal, and sleep disruption.**
    
a. True

15. **One in eight elderly individuals, or approximately 13% have**
    
d. Alzheimer’s disease.
16. Which of the following signs is/are indicative of normal, age-related memory loss?
   c. Getting lost occasionally while in new circumstances

17. Caring for an elderly person with memory issues requires
   b. regular visits and talks with the patient.

18. Among all the other long-term care facilities, nursing homes provide
   a. highly skilled and professional staff members.

19. An individual experiencing anhedonia will
   d. find no pleasure in ordinary, pleasurable activities.

20. Depression in the elderly is
   a. generally undiagnosed and often goes untreated.

21. True or False: Women are more susceptible to Alzheimer’s disease and other dementias then are men.
   a. True

22. Elderly patients with depression
   d. All of the above

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References Section

The reference section of in-text citations include published works intended as helpful material for further reading. Unpublished works and personal communications are not included in this section, although they may appear within the study text.


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