IMPLEMENTING THE GET PROGRAM: A TOOLKIT FOR EDUCATORS
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GET Program DAY 1

Foundations in Nursing Care of Older Adults in Acute Care
Geriatric Education & Training Program  
Course Schedule

Day 1: Foundations in Nursing Care of Older Adults in Acute Care  
September 18, 2013

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
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<tbody>
<tr>
<td>0830</td>
<td>Survey #1</td>
</tr>
<tr>
<td>0900</td>
<td>Welcome &amp; Introductions</td>
</tr>
<tr>
<td>0930</td>
<td>Patients &amp; Families as Partners in Care</td>
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<td></td>
<td>• Personhood</td>
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<td>• Patient &amp; Family Centered Care</td>
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<tr>
<td>1000</td>
<td>Break</td>
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<td>1015</td>
<td>The Nursing Process: Bringing Patient Centered Care to the Point of Care</td>
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<tr>
<td>1115</td>
<td>Quality Improvement: Thinking about Patient &amp; Family Centered Care at the Unit and Systems Level</td>
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<td>Lunch</td>
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<td>• Lunch &amp; Learn: Library Services</td>
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<tr>
<td>1300</td>
<td>3Ds: Delirium, Dementia, Depression</td>
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<td>1615</td>
<td>Evaluation/Feedback on the day</td>
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Please indicate your level of agreement with the statements below:

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<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>The content was organized and easy to follow</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
<td></td>
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<tr>
<td>The objectives were clearly identified</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td></td>
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<tr>
<td>Participation and interaction were encouraged</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Questions and exchanges were encouraged</td>
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<tr>
<td>The material covered was relevant</td>
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<tr>
<td>The amount of time allowed to cover the material was sufficient</td>
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<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>The training session met my expectations</td>
<td>○</td>
<td>○</td>
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<td>○</td>
<td></td>
</tr>
<tr>
<td>Would you recommend this session to someone else?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>

See reverse
What did you find was the most helpful?

Any suggestions on what should be changed to improve the program.

Please use the area below for any additional comments:

Thank you for your feedbacks
The Nursing Process: Bringing Patient-Centered Care to the Point of Care

GET Program
September 18, 2013
OBJECTIVES

• Review the nurse’s role in the identification and management of nursing problems

• Discuss the process by which nurses come to a clinical judgment about a patient or a situation

• Apply the nursing process to common geriatric syndromes and clinical situations
THE NURSING PROCESS

• “is a problem-solving approach to identifying, diagnosing, and treating the health issues of clients. It is fundamental to how nurses practice. ...it is continuous, and in practice, you will learn to move back and forth between the various steps.”

• The nursing process allows the nurse to
  – Organize and systematize nursing practice
  – Make inferences about the meaning of a client’s response to a health problem or generalize about functional ability
  – Clearly define the client’s issue or problem as the basis for planning and implementing nursing interventions and evaluating the outcomes of care

Potter and Perry 2010, p. 159
NURSING CARE INVOLVES...

- Recognizing an issue/concern/client problem exists
- Collecting all significant cues and other relevant information
- Analyzing information (clinical data) about the issue/concern/client problem
- Verifying & validating the data and drawing conclusions
- Identifying nursing interventions and priorities
- Evaluating nursing actions/interventions impact on client
- Communicating with the patient, their family and other health care team members
THE NURSING PROCESS

ASSESSING

GATHER DATA.

I.D. PROBLEM. FORMULATE NURSING DIAGNOSIS.

WRITE CARE PLAN TO MEET GOALS.

ANALYZING

CARRY OUT PLAN.

PLANNING

COLLECT OBJECTIVE DATA TO DETERMINE THE EXTENT TO WHICH GOALS WERE ACHIEVED. REVISE PLAN AS NEEDED.

IMPLEMENTING

EVALUATING

©1997 Nursing Education Consultanta
NURSING ASSESSMENT

Medical Perspective is disease focused where the focus of care is to provide a differential diagnosis and prescribe treatment of the disease.

Nursing Perspective is focused on the client’s response to the changes and impact on everyday functioning and coping abilities.
Assessing is a continuous process carried out during all phases of nursing process. All phases of the nursing process depend on the accurate and complete collection of data.

Assessing is the systematic and continuous collection, organization, validation and documentation of data.

Potter and Perry (2006)
ASSESSMENT APPROACHES

- **Comprehensive**
  Holistic, incorporating physical assessment, health perceptions, social aspects etc.; generalized assessment creates a profile of the client (e.g. Nursing History)

- **Focused**
  Limited to a specific need; to further evaluate a specific problem or to validate initial findings or inferences (e.g. respiratory assessment for client with pneumonia)

- **Screening**
  Monitor specific problems; ongoing observation and validation related to baseline data (e.g. elevated temperature)
**OBJECTIVE DATA VS. SUBJECTIVE DATA**

- **Objective data**
  - Observable and measurable data that can be seen, heard, or felt by someone other than the person experiencing them
  - E.g., elevated temperature, skin moisture, vomiting

- **Subjective data**
  - Information perceived only by the affected person
  - E.g., pain experience, feeling dizzy, feeling anxious
VALIDATING & VERIFYING

• Validation is an ongoing process during data collection and afterwards when the data are reviewed and compared.

• It is important to
  • avoid making assumptions
  • jumping to conclusions or focusing in the wrong direction
  • Missing pertinent information
  • Misunderstanding situations
VERIFY WITH...

• The client
• Further assessment
• Other nurses
• Secondary sources i.e. the client’s chart

• Grossly abnormal findings are re-checked, objective and subjective data are compared for congruence or inconsistencies
GENERAL GUIDELINES FOR SETTING PRIORITIES

• Take care of immediate life-threatening issues
  • *ABCDs
• Attend to safety issues
• Patient identified priority issues
• Nurse identified priorities based on the client’s medical diagnosis &/or nursing care plan
NURSING DIAGNOSIS/NEED IDENTIFICATION

• Begins the process of nursing care planning
  • Identify the nursing problem
  • Identify the desired goals or outcomes
  • Select appropriate nursing interventions
  • Set priorities

• Sources to guide developing the care plan
  • Nursing knowledge
  • Evidence Informed Clinical Pathways
  • Practice Standards and Guidelines
NURSING DIAGNOSIS/NEED IDENTIFICATION

• May be an actual problem or risk (potential problem)

• The suspected cause or reason for the problem is related to part of the Nursing Diagnosis

• The signs and symptoms, clinical manifestations (cues) or risk factors are the as evidenced by part of the Nursing Diagnosis

• Identifying appropriate patient-centered Nursing Care Plan
• Abdominal Pain related to appendectomy as evidenced by score of 8/10 on pain scale, facial grimacing, and increased BP.

• Deficient knowledge related to appendectomy as evidenced by lack of knowledge of post op care.

• Difficulty breathing related to acute asthma exacerbation as evidenced by increased respiratory rate and effort.

• At risk for falling related to alteration in coordination and mobility as evidenced by left sided weakness.
• Establish the goals, interventions and outcomes
IMPLEMENTATION

• Carry out the plan
• Continue to assess and collect data
• Document care
EVALUATION

• Determine if goals were met
• Decide if care should continue OR
• Modify plan if necessary
In Conclusion Nursing Care Plans:

• Ensure consistent, effective, individualized nursing care

• Articulate unique contribution of nursing practice for older adults
REFERENCES

### NURSING CARE PLAN

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Objectives</th>
<th>Nursing Interventions</th>
<th>Rationale</th>
<th>Evaluation</th>
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</table>
ASSESSMENT DATA
NURSING CARE OF HOSPITALIZED OLDER ADULTS:

DEMENTIA, DELIRIUM & DEPRESSION
Objectives

Dementia, Delirium & Depression (3Ds)

1. To identify the risk factors and/or symptoms associated with delirium, dementia & depression.
2. To distinguish 4 key differences between dementia, delirium & depression.
3. To describe 3 evidence-based tools for assessments.
4. Discuss 6 evidence-based interventions for nursing care.
CLINICAL PRESENTATION

My patient is confused & irritable:

1. Is this *delirium*? (acute onset, fluctuating course, disorganized thoughts, variable LOC)
   
   or

   *Depression or dementia or drug effect?*

2. If this is dementia, why should it matter in acute care?

   • Isn’t this an issue that the community should deal with?

Adapted from: Dr. A. M. Chung, February 2013
DEMENTIA IN ACUTE CARE

Why Admit?
• Safety
• Failure to thrive
• Neglect/abuse
• Falls/fall risks
• Medication adherence
• Behavioral issues
• Caregiver stress

Implications?
• Difficulty with care
• Competency
• Long length of stay
• Delirium (again)
• Transition challenges
• Discharge planning
• Readmission risk
DEMENTIA IN ACUTE CARE

Implications for Discharge Planning

– Need for ADL support
– Safety issues****
– Medication adherence
– Ability to complete follow up
– Lack of judgment, insight
– Caregiver burnout
– Risk for readmission
AGING & COGNITION

- Functions that may decline
  - Recall of names
  - Speed of learning
  - Speed of performing complex tasks

- Functions that do not decline
  - Vocabulary
  - Store of information
SETTING THE STAGE: THE AGING BRAIN

1. ↓ in weight & volume
2. Increased size of ventricles
3. ↓ size/number of neurons
4. Decreased number/size/transmission of neurotransmitters
   • Serotonin, dopamine, acetylcholine
FRAGILE BLOOD BRAIN BARRIER

Implications
- Sensitive to medications, hypoxia, environment
- High risk for delirium, ↑ cognitive impairment
WHAT IS DEMENTIA?

Myth or Reality

1. Dementia is a normal part of aging.
2. Alzheimer’s Disease only affects older people.
3. Any type of memory loss means Alzheimer’s Disease is not far behind.
4. If I’m diagnosed with Alzheimer’s, my life would be over.

Adapted from: Alzheimer’s Society 2011
WHAT IS DEMENTIA?

A brain syndrome* that leads to a progressive decline in intellectual ability & interferes with social and occupational roles

* A cluster of symptoms that, taken together, form an illness or disorder
WHAT ARE THE SYMPTOMS?

- Decline in cognition: Abstract thinking, problem solving, judgement, insight
  - Short term memory loss (hallmark of dementia)
- Change in personality/mood/behavior
  - Apathy, empathy
- Impairment in complex tasks:
  - Speech, language
  - Recognition: people, objects, animals, places
  - IADL/ADL
- Decline must impact daily life

Dalziel, 2008
DEMENTIA: AN UMBRELLA

Most Common: Alzheimer’s

Types of dementia: vascular, Lewy body, Parkinson’s, ETOH

Source: Alzheimer’s Society
TYPES/PREVALENCE OF DEMENTIA

1. Alzheimer’s (50%)
2. Lewy Body (15%)
3. Vascular (10%)
4. Mixed (10-15%)
5. Other (10%):
   • Parkinson’s
   • Huntington’s
   • Frontotemporal (Pick’s)
   • Hydrocephalus
   • Post-infection
   • Toxic-metabolic
   • ETOH
FACTS ON ALZHEIMER’S

1. BC: 70,000 people with dementia
   2038: > 177,000

   ➢ # 5 women; # 7 men; 4th > 85 years

4. LTC Prevalence: 47-78% (64%)

Sources: Alzheimer’s Society; Stats Canada; DeVane & Mintzer, 2003
WHAT IS ALZHEIMER’S DISEASE?

https://www.youtube.com/watch?v=9Wv9jrk-gXc
COURSE OF ALZHEIMER’S DISEASE

Average life after diagnosis: 10 years
- Range: 2-20 years

Poorer Prognosis
- Psychiatric features (ie, BPSD)
- Chronic illness(es)
- Alcohol use
- Weight loss

NB: Vascular disease ↑ symptoms

Adapted from: Dr. A. M. Chung, February 2013
BIOLOGICAL RESPONSES & AGING

DECREASED ABILITY TO TOLERATE:

- Temperature change (heat, cold)
- Sleep disturbance*
- Fatigue
- Relocation
- Loneliness
- Losses
- Stress
SCREENING TOOLS

• Mini Mental State Exam (MMSE)

• Montreal Cognitive Assessment (MoCA)
CLOCK DRAWING (ABNORMAL)
The brain and behaviour

Frontal Lobe
The frontal lobe is responsible for higher cognitive functions involving planning, problem solving, starting and stopping actions and regulating social behaviour.

Damage to this region causes
- Inability to initiate activity
- Repetitive behaviour
- Inability to regulate mood or emotional state
- Rude and socially inappropriate behaviour

Parietal Lobe
The parietal lobe processes and integrates tactile information (touch, pressure, temperature and pain) along with information from the occipital lobe, to create an understanding of ourselves and the world around us.

Damage to this region causes
- Inability to locate and recognize objects
- Lack of coordination
- Disorientation

Temporal Lobe
The temporal lobe plays a vital function in learning & memory, understanding language, perception and recognition.

Damage to this region causes
- Difficulties in understanding speech, recognizing faces and objects
- Long and short term memory loss
- Increased aggression
- Changes to interest in sexual behaviour
- Persistent talking

Occipital Lobe
The occipital lobe separately encodes visual information received by the retina in the eyes into colour, orientation and movement and passes this information to the temporal and parietal lobes.

Damage to this region causes
- Hallucinations
- Blindness
- Inability to see colour or motion
- Synesthesia (e.g. hearing colours, tasting sounds)

Limbic System
The limbic system has a primary role in processing and regulating emotions, memory and sexual arousal.

Damage to this region causes
- Increased agitation
- Uncontrolled emotions
- Disturbed day/night cycle
- Changes to sexual arousal

As Dementia Progresses....

<table>
<thead>
<tr>
<th>Social</th>
<th>Communication</th>
<th>ADLs</th>
<th>Orientation (Spatial)</th>
<th>Health</th>
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<tbody>
<tr>
<td>Process visual, hearing cues</td>
<td>Word finding difficulty (anomia)</td>
<td>Sequencing</td>
<td>Sense of direction</td>
<td>• Pain</td>
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<tr>
<td></td>
<td></td>
<td>Touch</td>
<td></td>
<td>• Symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Nutrition</td>
</tr>
<tr>
<td>Process social cues</td>
<td>Verbal language:</td>
<td>Time</td>
<td>Judging distances</td>
<td>• Constipation</td>
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<tr>
<td></td>
<td>• Expressive</td>
<td></td>
<td></td>
<td>• Infection</td>
</tr>
<tr>
<td></td>
<td>• Receptive (aphasia)</td>
<td></td>
<td></td>
<td>• Dehydration</td>
</tr>
<tr>
<td>Recognize current self, family, others</td>
<td>Agraphia</td>
<td>Body parts (R/L)</td>
<td>Following visual maps</td>
<td>Circadian rhythm</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Day/night</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Sundown</td>
</tr>
<tr>
<td></td>
<td>Following social conversation</td>
<td>Grasp reflex</td>
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# Behavioral & Psychological Symptoms of Dementia (BPSD)

<table>
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<tr>
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<tbody>
<tr>
<td>Aggression, agitation</td>
<td>Hallucinations, delusions</td>
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<tr>
<td>Screaming, swearing</td>
<td>Suspicious</td>
</tr>
<tr>
<td>Wandering*, shadowing*</td>
<td>Depression, anxiety</td>
</tr>
<tr>
<td>Hoarding*</td>
<td>Irritable</td>
</tr>
<tr>
<td>Disinhibition</td>
<td>Night time disturbance</td>
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# TYPES OF AGITATION

<table>
<thead>
<tr>
<th>Definition</th>
<th>Physical</th>
<th>Verbal</th>
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</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Physically striking self or others</td>
<td>Verbally striking out at others</td>
</tr>
</tbody>
</table>
| **Examples** | • Hitting, pushing  
• Scratching, biting  
• Kicking  
• Grabbing objects, people  
• Throwing, tearing  
• Physical sexual advances | • Screaming, yelling  
• Swearing  
• Temper outbursts  
• Strange loud noises  
• Repetition  
• Verbal sexual advances |
<table>
<thead>
<tr>
<th>RISK FACTORS FOR AGITATION</th>
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<tbody>
<tr>
<td>• Impaired social interaction</td>
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<tr>
<td>• Impaired communication</td>
</tr>
<tr>
<td>• Complex instructions</td>
</tr>
<tr>
<td>• ADL dependence</td>
</tr>
<tr>
<td>• Cool air/water temperature</td>
</tr>
<tr>
<td>• Medications</td>
</tr>
<tr>
<td>• Pain, health issues</td>
</tr>
<tr>
<td>• Caregiver behaviors &amp; banter</td>
</tr>
<tr>
<td>• Male gender</td>
</tr>
<tr>
<td>• Mood disturbance</td>
</tr>
<tr>
<td>• Irritability</td>
</tr>
<tr>
<td>• Stress responses</td>
</tr>
<tr>
<td>• Personal space</td>
</tr>
<tr>
<td>• Fatigue</td>
</tr>
<tr>
<td>• Sleep disturbance</td>
</tr>
</tbody>
</table>

University of Iowa Gerontology Research Centre, 2005-R; Shaw, 2011-R
RISK FACTORS BY TIME OF DAY

- During personal care
- At night
- During staff breaks
**TREATMENT**

- **Donepezil**: Oldest (10 mg)
- **Rivastigmine**: Cholinesterase inhibitor. Available as a patch
- **Galantamine**: Inhibits cholinesterase & alters acetylcholine release
- **Memantine**: NMDA receptor antagonist
  - Used in combination therapy
- **Side-effects**:
  - Syncope, brady-arrhythmia, nightmares, GI upset (↑ with rivastigmine), anorexia, headaches, bronchospasm
The most important care provided to patients with dementia is to:

a) Keep them showered & toileted regularly even when agitated.
b) Meet their family members expectations.
c) Provide caring care and meaningful relationships.
d) Have them leave hospital as quickly as possible.
DELIRIUM IS THE

GERIATRIC EMERGENCY
WHAT IS DELIRIUM?

True or False?

Can patients with delirium:

• Become restless and easily upset?
• Be forgetful?
• Drift between sleep and wakefulness?
• Become more alert than normal?
• See or hear imaginary objects, people, animals?
WHAT IS DELIRIUM?

- MULTIFACTORIAL BRAIN SYNDROME
- *TRANSIENT & ABNORMAL* DISTURBANCE OF COGNITIVE FUNCTION
- OFTEN “CONFUSED” WITH DEMENTIA
Risk Factors for Delirium

- Dementia
- Age >75 years
- Polypharmacy
- History of delirium
- Chronic illnesses
- Post surgery/procedure
WHAT CAUSES DELIRIUM?

DRUGS, BUGS & DISEASE
## DELIRIUM: KEY SYMPTOMS

<table>
<thead>
<tr>
<th>KEY</th>
<th>OTHER</th>
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</thead>
<tbody>
<tr>
<td><strong>1. RAPID ONSET</strong></td>
<td>BEHAVIORAL CHANGES</td>
</tr>
<tr>
<td>• Hours to days</td>
<td>• Agitation, aggression, anxiety, restlessness</td>
</tr>
<tr>
<td>• Abrupt change from baseline</td>
<td></td>
</tr>
<tr>
<td><strong>2. REDUCED ATTENTION SPAN</strong></td>
<td>EMOTIONAL CHANGES</td>
</tr>
<tr>
<td>• Easily distractible</td>
<td>• Irritability, labile mood</td>
</tr>
<tr>
<td><strong>3. DISORGANIZED THINKING</strong></td>
<td>PSYCHOSIS</td>
</tr>
<tr>
<td>• Rambling, incoherent thought</td>
<td>• Hallucinations</td>
</tr>
<tr>
<td><strong>4. VARIABLE Level Of Consciousness</strong></td>
<td></td>
</tr>
<tr>
<td>Vigilant</td>
<td>• Delusions</td>
</tr>
<tr>
<td>Comatose</td>
<td>• Suspiciousness</td>
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<td>SLEEP DISTURBANCE</td>
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<td>• Day-night reversal</td>
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CLINICAL PRESENTATION

“THE LOOK”
## WHAT ARE THE SUBTYPES?

<table>
<thead>
<tr>
<th>DELIRIUM SUBTYPE</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| **1. Hyperalert, Hyperactive**  
Over stimulated mental state with aggressive, agitated behaviors | - Each patient presents with a unique cluster of symptoms (aka features)  
- Features include: disturbance in attention span, thought processing, LOC, memory, perception, speech, orientation, sleep patterns, affect & psychomotor activity |
| **2. Hypoalert, Hypoactive**  
Apathetic, lethargic mental state that can be mistaken for sleep or depression | - Symptoms vary & fluctuate in intensity over 24 hours  
- LOC almost always fluctuates: Vigilant ➔ Alert ➔ Lethargic ➔ Stupor ➔ Coma |
| **3. Mixed, Variable**  
Combination of hyper- and hypoactive features that can fluctuates between agitation and apathy | |

*LOC*: Levels of Consciousness
DELIRIUM SCREENING with CAM: Confusion Assessment Method

In the past 24 hours, has the patient had any of the following features:

1. ACUTE/RAPID ONSET & FLUCTUATING COURSE
2. INATTENTION
3. DISORGANIZED THINKING
4. ALTERED LOC

Key: To have delirium, the patient must have features 1 and 2 plus either 3 or 4
## ASSESSMENT: PRISM-E

| P  | Pain  
|    | Psychosocial |
|---|---
| R  | Retention  
|    | Risk factors (Agitation; Safety-falls, elopement) |
| I  | Incontinence  
|    | Impaction  
|    | Intake-oral |
|    | Infection  
|    | Impaired cognition |
| S  | Sensory losses  
|    | Sleep deprivation |
|    | Social isolation |
| M  | Medications |
|    | Metabolic |
| E  | Environment |

Vancouver Coastal Health, 2007; 2013
COMPLICATIONS

IATROGENESIS (Adverse Effects of Hospitalization)

- Sensory deprivation
- Social isolation
- Cognitive/functional decline
- Depression
- Facility placement
- Early death
## IS IT DELIRIUM OR DEMENTIA OR BOTH?
### 2D COMPARISON

<table>
<thead>
<tr>
<th></th>
<th>DELIRIUM</th>
<th>DEMENTIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td><strong>Acute</strong> &amp; usually reversible loss of cognitive function due to health, functional, social &amp;/or environmental changes</td>
<td><strong>Chronic</strong> &amp; progressive loss of brain cells resulting in decreased day-to-day cognition and function</td>
</tr>
<tr>
<td><strong>Onset</strong></td>
<td>Sudden, abrupt, hours to days</td>
<td>Slow, often unrecognized in early stages</td>
</tr>
<tr>
<td><strong>Course</strong></td>
<td>Fluctuates over 24 hours; may be worse at twilight or at night</td>
<td><strong>Chronic</strong> &amp; progressive; stress may produce more rapid change</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Hours, weeks or months</td>
<td>Months to years (8-20)</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
<td>Impaired, fluctuates</td>
<td>Generally normal</td>
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<tr>
<td><strong>Alertness</strong></td>
<td>Increased, decreased, or variable</td>
<td>Generally normal</td>
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<tr>
<td><strong>Thinking</strong></td>
<td>Disorganized, distorted, fragmented, incoherent, slowed or accelerated</td>
<td>Decreased thought content; difficulty with abstract ideas, word-finding difficulty</td>
</tr>
<tr>
<td><strong>LOC</strong></td>
<td>Increased, decreased and/or fluctuates</td>
<td>Generally clear</td>
</tr>
</tbody>
</table>
DELIRIOUS and at RISK

Which patient is most at risk with delirium?

1. Sleep / wake cycle disrupted, combative, hearing someone call their name

2. Quiet, smiling, rarely asking for anything, seems “pleasantly confused?”
Developmental Tasks of Aging: Loss, Change & Becoming the Older Generation

- Role changes: retirement, loss/disability of partner/spouse
- Normal biological changes, functioning, appearance
- Loss related to health, death of family members, friends, finances
- Challenging time and mortality
- Intergenerational changes in relationships
- Modulating dependence & independence

Buckwalter & Piven, 1999; RNAO, 2003
What is Depression?

• Significant mental health problem in older adults
• Depression +/- dementia often unrecognized/untreated
• Major Depressive Disorder (DSM IV)
• Must have depressed mood +/- anhedonia plus 1 of:
  • Weight loss
  • Sleep disturbance
  • Psychomotor agitation/retardation
  • Fatigue
  • Feelings of worthlessness
  • Inability to concentrate/indecisiveness
  • Thoughts of death; suicide ideation/attempt

Brown et al., 2007
WHY SCREEN FOR DEPRESSION?

• May progress, especially when untreated
• Does not resolve with time (unlike bereavement, SAD)
• May lead to severe symptoms
  • Excessive somatic complaints, suicidal gestures/ideation, psychosis (hallucinations, delusions), aggression, cognitive decline, death
• Major risk for suicide, especially men
  – 1.3 suicides daily in Canada
• NBC Segment on Depression

Brown et al., 2007; Smith et al., 2011
Estimated Prevalence

– Canada: 14%
– Community: 14 – 30%
– Hospital: 12 – 45%
– LTC: > 40%

CIHI, 2011; Smith et al., 2011
## ESTIMATED PREVALENCE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence (%)</th>
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<td>Hemodialysis</td>
<td>6-34</td>
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<tr>
<td>Coronary Artery Disease</td>
<td>17-23</td>
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<tr>
<td>Cancer</td>
<td>20-50</td>
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<tr>
<td>Stroke</td>
<td>19-23</td>
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<tr>
<td>Parkinson’s Disease</td>
<td>27-51</td>
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<tr>
<td>Alzheimer’s Disease (mild)</td>
<td>28-53</td>
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<tr>
<td>Alzheimer’s Disease (moderate – advanced)</td>
<td>36-68</td>
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<tr>
<td>Hypothyroidism</td>
<td>56-80</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>9-27</td>
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</tbody>
</table>

Adapted from: Piven, 2005; Smith et al. 2011
Risk Factors for Depression

- Female
- Widowed/divorced/estranged
- History of depression
- Major disease/illness
- Physical disability
- Polypharmacy
- Social isolation
- Previous attempts at self harm
- Chronic pain
- Chronic use of alcohol, drugs
- Adverse life events
- Caregiver for another
- Loss of independence
- Sleep disturbance

Brown et al, 2007; Smith et al., 2011
Implications of Depression: Acute Care

Why Depression?
- Additive effect of health problems, hospitalization
- Co-exist with illness
- Leads to more pain, illness symptoms & ↓ physical, social & role functioning
- Functional decline

Implications?
- ↓ participation in ADLs, D/C plans
- Competency
- ↑ length of stay
- Delirium risk
- Transition challenges
- Readmission risk
# TRIAD of DEPRESSIVE SYMPTOMS

<table>
<thead>
<tr>
<th>Mood</th>
<th>Perception</th>
<th>Somatic</th>
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<tbody>
<tr>
<td>Anxiety, panic</td>
<td>Social withdrawal</td>
<td>Functional decline</td>
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<tr>
<td>Crying</td>
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<td>Sleep disturbance</td>
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<tr>
<td>Inattention</td>
<td></td>
<td>Fatigue</td>
</tr>
<tr>
<td>Irritability</td>
<td>Hopelessness</td>
<td>Appetite changes (+/-)</td>
</tr>
<tr>
<td></td>
<td>Fearfulness</td>
<td>Constipation, tachycardia</td>
</tr>
<tr>
<td>Paranoia</td>
<td>Hallucinations</td>
<td>Speech changes: slowed, paused</td>
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<tr>
<td>Sadness, guilt</td>
<td>Delusions (poverty)</td>
<td>monotone</td>
</tr>
<tr>
<td>Low mood</td>
<td></td>
<td>Suicide: thoughts, attempts</td>
</tr>
</tbody>
</table>

Adapted from: Buckwalter & Piven, 1999; RNAO, 2003
Anxiety

• Combination of apprehensive expectations & worried that are unrealistic/excessive
  • Restlessness, feeling “keyed up/on edge”
  • Fatigue
  • Inability to concentrate
  • Irritability
  • Muscle tension
  • Sleep disturbance

Smith et al., 2008
Assessment Tools

1. **Geriatric Depression Scale**
   - GDS-4 Short Form (Isella et al., 2001)
   - Questionnaire used to validate risk factors & symptoms with patient

2. **Sig: E Caps** (Rivard, 1999)
   - Observational screen based on DSM-IV
### ASSESSMENT TOOLS:
### SIG: E CAPS

<table>
<thead>
<tr>
<th>S</th>
<th>Sleep disturbance</th>
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</thead>
<tbody>
<tr>
<td>I</td>
<td>Loss of interest</td>
</tr>
<tr>
<td>G</td>
<td>Feelings of guilt</td>
</tr>
<tr>
<td>E</td>
<td>Low energy &amp; excessive fatigue</td>
</tr>
<tr>
<td>C</td>
<td>Concentration &amp; cognitive difficulties</td>
</tr>
<tr>
<td>A</td>
<td>Appetite disturbance</td>
</tr>
<tr>
<td>P</td>
<td>Psychomotor changes</td>
</tr>
<tr>
<td>S</td>
<td>Suicidal ideation</td>
</tr>
</tbody>
</table>

**Positive Screen:** Daily presence of 5+ symptoms for 2 weeks

Rivard, 1999
Depression & Memory

Related to memory, which one of the following reflects depression?

Does the patient with depression have:
1. Impaired recent and immediate memory.
2. Impaired recent and remote memory.
3. Generally intact memory, but may be selective. Highlights negativity.
Depression & Cognition

Which of the following is characteristic of depression, related to \textit{thinking}?

a. The patient has a change in mood, expresses indecisive thinking and has less ability to problem solve.

b. The patient thinks he/she is depressed, but family think he/she is “more confused than usual.”

c. The patient does not hallucinate.
Rather than viewing behaviors from the caregiver’s perspective as disruptive or agitated, they are assessed from the patient’s point of view as expressions of:

UNMET NEEDS &/OR UNMET GOALS
NEED-DRIVEN
DEMENTIA COMPROMISED (NDDCB) BEHAVIOR
Patient’s Perspective

- My behavior is meaningful communication. I am trying to reach out to tell you what I need.
- Understanding my behavior is key to helping me meet my needs & goals.
- Your caring response will help reduce my feelings of danger & anxiety.
NEED-DRIVEN
DEMENTIA COMPROMISED (NDDC)
BEHAVIOR

Myth or Reality

1. Most patients with dementia become agitated and aggressive.

3. Patients with dementia frequently behave in ways that are challenging just to get attention.

Adapted from: Alzheimer’s Society 2011
ASSESSMENT: 4 LENSES

- Physical/emotional
- Environment
- Task-related
- Communication
ASSESSING BEHAVIOR

1. ASSESS THE BEHAVIOR(S)

- What is the behavior?
  
  **Examples:** pushing away, calling out, throwing objects, hitting staff, spitting, striking out

- Is the current behavior a change from usual?

- Check collateral: Physician, community, team members (SW, discharge planner)

- Be specific!
AVOIDING
OPINIONS, LABELS & JARGON

What Not to Use?

- REALLY CONFUSED
- SPACE CADET
- WILD
- OVER THE TOP
- CRAZY
- WORKED UP

WHY?
ASSESSING BEHAVIOR

2. When does the behavior occur?

- **Examples:** evening/at night, family arriving/leaving, prior to pain medications

- **What activates the behavior?**
  
  Examples: personal care, invasion of personal space, speed of care giving, toileting needs
ASSESSING BEHAVIOR

3. WHAT HAPPENS BEFORE/ AFTERWARDS?

4. WHAT MAKES THE BEHAVIOR BETTER? WORSE? DOES THE PATIENT HAVE AN AGENDA?

5. WHAT ARE THE PATIENT’S GOALS & UNMET NEEDS?
ASSESSMENT TOOLS

- BEHAVIOR LOG
- SLEEP & AGITATION LOG
- COHEN-MANSFIELD AGITATION INVENTORY (CMAI)
CARE PLAN GOALS

To meet the patient’s needs & goals as much as possible

- To enhance the patient’s safety, dignity
- To provide physical and emotional comfort
- To reduce symptoms due to dementia, delirium &/or depression
INTERVENTIONS

1. Understand the patient’s views, values, beliefs
2. Discuss assessment findings with patient, family, caregivers, staff
3. Determine the intimate zone & respect personal boundaries
4. Provide structure/distraction at high risk times
5. Provide patient/family accurate information, education
INTerventions

Modify Physical Environment

1. Reduce stimulation: noise, lights, people
2. Reduce shadows & glare
3. Place equipment out of sight
4. Provide safe wandering, hoarding
5. Assess +/- interactions
6. Assess bed safety
INTERVENTIONS

With Each Interaction:

1. Comfort
2. Attention
3. Orientation
PLANNED INTERVENTION

➢ CONSTANT OBSERVATION
  • Identify & prevent triggers
  • Watch for escalation
  • Intervene early

➢ ASSESS OVERALL HEALTH
  • Pain/discomfort, PRISM-E

➢ MEDICATIONS
  • Regular & PRNs

➢ COMMUNICATION
NEED DRIVEN DEMENTIA CARE

True or False?

1. It’s ok to leave the patient out of the conversation because she/he cannot understand what is going on anyway.

3. Patient should be orientated to reality to keep their brain healthy.

3. Which cue should you give to an aggressive patient before talking with them?
   a) Visual    c) Verbal
   b) Touch    d) It depends on what I do best

Alzheimer’s Society 2011
Communication: 
The Essentials of Understanding Goals & Needs

- Use visual cues to gain attention
- Use the patient’s preferred name
- Use statements to get your message across
- Use positive phrases
- Give one message at a time
- Respond to the emotional tone
Communication: The Essentials of Understanding Goals & Needs

- Repeat important information
- Show/demonstrate & talk
- Simplify what you say & take your time
- *Always* explain what is going to happen
- Check *your* approach
  - Watch *your* body language
Communication: What Not To Say: Top 5

✔ Don’t argue, scold, or treat like a child

✔ Don’t tell the patient what he/she can’t do

✔ Don’t ask a lot of questions that rely on memory

✔ Don’t talk about the patient in front of them

✔ Don’t try to convince the patient that their experience (see, hear, smell or believe) is not real
NURSING APPROACHES

1. Provide structure: Minimize changes in routine, caregivers, rooms
2. Distraction
3. Environmental modification
4. 1:1 socialization
5. Modified, individualized routines
6. Music, aromatherapy, meaningful activities
7. Caregiver education
CHALLENGES

“Caring For Self While Caring For Others”

- Stress, pace, turnover
- Emphasis on tasks, meds, procedures, discharges
- Crisis vs preventative approach
- Culture of safety
STAFF SUPPORT: NEED-DRIVEN DEMENTIA CARE

“Caring For Self While Caring For Others”

- Never, ever enter high risk activities alone
  1. History of/new onset aggression
  2. New patient with risk factors
  3. Patient with unpredictable behavior

- Always enter with an exit plan
- Always delay activities until help arrives
- Avoid catch up with medications
STAFF SUPPORT: NEED-DRIVEN DEMENTIA CARE

“Caring For Self While Caring For Others”

- Know your personal triggers
- Acknowledge situation when approach, skills, knowledge have little effect
- Have realistic expectations for yourself
- Give yourself patience, flexibility & hope
Four Steps towards Better Communication with Patients with Dementia

1. **Start the interaction in a conversational manner**
   - Approach from the front, calmly and slowly
   - Make eye contact
   - Call the patient by their preferred name
   - State who you are and why you are there
   - Allow time for a response
   - Begin in a conversational manner—not task focused

2. **Simplify what you say**
   - Use questions that can be answered “yes” or “no”
   - Use simple, short sentences
   - Provide choices when possible
   - Rephrase your sentences

3. **Check your approach**
   - Modify your verbal message, tone of voice, rate of speech, volume
   - Suggest or invite, don’t tell, as an approach to begin a task
   - Check your non-verbal message, body language, facial expression, use of touch
   - Always ask permission before touching

4. **Be supportive**
   - Provide the words that the patient is looking for
   - Listen for the patient’s emotional message in his/her:
     - Tone of voice
     - Body language
     - Facial expression
   - Validate the emotional message with empathy and acceptance

Adapted from: GeroPsychiatric Education Program (2008), Vancouver Coastal Health
I would like to ask you about certain specific behaviours sometimes seen in older persons. Some are verbal. Some are physical. Some are quiet behaviours and others are disruptive. I do not expect that all of these behaviours apply to your relative (client).

<table>
<thead>
<tr>
<th>Physical, Aggressive Agitation physique agressive</th>
<th>Never</th>
<th>&lt; 1 time/wk</th>
<th>1-2 times/wk</th>
<th>few times/wk</th>
<th>1-2 times/day</th>
<th>few times/day</th>
<th>few times/hr</th>
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</thead>
<tbody>
<tr>
<td>Hitting self/others Frapper les autres/se frapper</td>
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<tr>
<td>Kicking Donner des coups de pied</td>
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<td>Grabbing onto people S’agripper aux autres</td>
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<td>Pushing Bousculer</td>
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<td>Throwing things Lancer des objets</td>
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<td>Spitting Cracher</td>
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<td>Tearing things/destroying property</td>
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Total
<table>
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<tr>
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<td>Pace, aimless wandering</td>
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<td>Inappropriate dress/desrobing</td>
<td>S'habiller de façon inappropriée/se déshabiller</td>
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<td>Trying to get to a different place</td>
<td>Essayer d'aller ailleurs</td>
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<td>Intentional falling</td>
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<td>Eating/drinking inappropriate substances</td>
<td>Manger/boire des produits non comestibles</td>
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<td>Cacher des objets</td>
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<td>Hoarding things</td>
<td>Amasser des objets</td>
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<td>Performing repetitive mannerisms</td>
<td>Avoir des tics</td>
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<th>1-2 times/wk</th>
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<th>1-2 times/day</th>
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<td>Making verbal sexual advances</td>
<td>Faire des avances sexuelles verbales</td>
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<td>Cursing or verbal aggression</td>
<td>Proférer des jurons et agresser verbalement</td>
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<th>few times/hr</th>
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<tbody>
<tr>
<td>Agitation verbale non agressive</td>
<td>Jamais</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repetitive sentences or questions</td>
<td>Répéter des phrases ou des questions</td>
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<tr>
<td>Strange noises (weird laughter/crying)</td>
<td>Émettre des bruits bizarres (pleurs/tires étranges)</td>
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GERIATRIC DEPRESSION SCALE - GDS-4: Short Form with SIGECAPS

Ask the following 4 questions:

1. Are you basically satisfied with your life? □ Yes □ NO

2. Do you feel that your life is empty? □ YES □ No

3. Are you afraid that something bad is going to happen to you? □ YES □ No

4. Do you feel happy most of the time? □ Yes □ NO

Answers in capitals score 1. Score of 1 or more indicates possible depression.

SIG E CAPS

Depressive Symptoms:

At least 5 of the following symptoms* have been present nearly every day, for most of the day, during the same 2-week period and represent a change from previous functioning.

S - Sleep is disturbed.
I - Interest is decreased.
G - Guilt (feelings of guilt are common, having regrets, etc.).
E - Energy is lower than usual.
C - Concentration is poor and memory problems may be exacerbated.
A - Appetite is disturbed, usually a loss of appetite accompanied (or not) by weight loss.
P - Psychomotor retardation or agitation
S - Suicidal ideation, at least a passive wish to die, is frequently present.
Standardised Mini-Mental State Examination (SMMSE)

Please see accompanying guide for directions for administration

Say: I am going to ask you some questions and give you some problems to solve. Please try to answer as best you can.

1. (Allow 10 seconds for each reply). Say:
   a) What year is this? (Accept exact answer only) ......................................................... / 1
   b) What season is this? (During the last week of the old season or first week of a new season, accept either) ........................................................................ / 1
   c) What month is this? (On the first day of a new month or the last day of the previous month, accept either) .............................................................................. / 1
   d) What is today's date? (Accept previous or next date) .................................................. / 1
   e) What day of the week is this? (Accept exact answer only) ........................................... / 1

2. (Allow 10 seconds for each reply). Say:
   a) What country are we in? (Accept exact answer only) ................................................ / 1
   b) What county/town are we in? (Accept exact answer only) .......................................... / 1
   c) What city/town are we in? (Accept exact answer only) ............................................... / 1
   d) (At home) What is the street address of this house? (Accept street name and house number or equivalent in rural areas) ................................................................. / 1
   e) (In facility) What is the name of this building? (Accept exact name of institution only) ......................................................................................................................... / 1

3. Say: I am going to name three objects. When I am finished, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes (Say slowly at approximately one-second intervals).

   Ball    Car    Man

   For repeated use: Bell, jar, fan; bill, tar, can; bull, bar, pan

   Say: Please repeat the three items for me. (Score one point for each correct reply on the first attempt) .............................................................. / 3

   Allow 20 seconds for reply; if the person did not repeat all three, repeat until they are learned or up to a maximum of five times. (But only score first attempt).

4. Spell the word WORLD. (You may help the person to spell the word correctly) Say: Now spell it backwards please (Allow 30 seconds; if the subject cannot spell World even with assistance, score 0) Refer to accompanying guide for scoring instructions (Score on reverse of this sheet) ....................................................... / 5

5. Say: Now what were the three objects I asked you to remember? ................................ / 3

   (Score one point for each correct answer regardless of order; allow 10 seconds)

6. Show wristwatch. Ask: What is this called? ................................................................ / 1

   (Score one point for correct response; accept "wristwatch" or "watch"; do not accept "clock" or "time", etc.; allow 10 seconds)

7. Show pencil. Ask: What is this called? ........................................................................ / 1

   (Score one point for correct response; accept "pencil" only; score 0 for pen; allow 10 seconds for reply)

8. Say: I would like you to repeat a phrase after me. No ifs, ands, or buts. ....... / 1

   (Allow 10 seconds for response. Score one point for a correct repetition. Must be exact, e.g. no ifs or buts, score 0)

9. Say: Read the words on this page and then do what it says........................................ / 1

   Then, hand the person the sheet with CLOSE YOUR EYES (score on reverse of this sheet) on it. If the subject just reads and does not close eyes, you may repeat: Read the words on this page and then do what it says, (a maximum of three times. See point No. 3 in Directions for Administration section of accompanying guide). Allow 10 seconds, score one point only if the subject closes eyes. The subject does not have to read aloud.

10. Hand the person a pencil and paper. Say: Write any complete sentence on that piece of paper. (Allow 30 seconds. Score one point.

    The sentence must make sense. Ignore spelling errors).................................................. / 1

11. Place design (see reverse of this sheet), pencil, eraser and paper in front of the person. Say: Copy this design please. Allow multiple tries.

    Wait until the person is finished and hands it back. Score one point for a correctly copied diagram. The person must have drawn a four-sided figure between two five-sided figures. Maximum time: One minute. .............................................................. / 1

12. Ask the person if he is right or left handed. Take a piece of paper, hold it up in front of the person and say the following:

    Take this paper in your right/left hand (whichever is non-dominant), fold the paper in half once with both hands and put the paper down on the floor.

    Takes paper in correct hand................. / 1
    Folds it in half............................... / 1
    Puts it on the floor....................... / 1

TOTAL TEST SCORE: ......................................................................................................................... / 30

ADJUSTED SCORE : .......................................................................................................................... / 


The Standardised Mini-Mental State Examination (SMMSE) is the copyright of Dr D.W. Molloy and may not be reproduced without the written consent of the author.

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CLOSE YOUR EYES
VISUOSPATIAL / EXECUTIVE

1. Begin
2. A
3. B
4. C
5. D
End

Copy cube

Draw CLOCK (Ten past eleven) (3 points)

Contour Numbers Hands __/5

NAMING

Lion
Rhino
Camel

MEMORY
Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

FACE VELVET CHURCH DAISY RED
1st trial
2nd trial

ATTENTION
Read list of digits (1 digit/sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt __/3

LANGUAGE
Repeat: I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ]

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] ______ (N ≥ 11 words) __/1

ABSTRACTION
Similarity between e.g. banana - orange = fruit [ ] train - bicycle [ ] watch - ruler __/2

DELAYED RECALL
Has to recall words WITH NO CUE Points for UNCUED recall only __/5

Optional
Category cue
Multiple choice cue

ORIENTATION
[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

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NAME:
Education:
Sex:
Date of birth:

DATE:

POINTS

Normal ≥ 26 / 30

Add 1 point if ≤ 12 yr edu

TOTAL __/30
References: 3Ds

**Dementia, Delirium, Depression**


Fick, D. (2007). Assessing and managing delirium in older adults with dementia, Try This: Best practices in nursing care to older adults, *D8*. Available at: [Geriatric Nursing Resources for Care of Older Adults](https://www.agingcare.gov/guidelines.html).


In M. G. Titler (Series Ed.), Series on evidence-based practice guidelines for older adults. Iowa City, IA: University of Iowa College of Nursing Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core. Available at: Evidence-Based Practice Guidelines.


Quality Improvement: Patient & Family Centered Care at the Unit and Systems Level

Fall 2013
Learning Objectives

- Describe quality improvement and characteristics of a QI process
- Identify a local quality improvement issue in your workplace
- Consider how to address local quality improvement issues by a) identifying the problem/issue, b) articulating the standard that should be met, and c) exploring potential avenues for meeting the standard
What is Quality Improvement?

...the combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.

This definition arises from our conviction that healthcare will not realize its full potential unless change making becomes an intrinsic part of everyone’s job, every day, in all parts of the system.

Linked aims of improvement.

Better patient (and population) outcomes

Everyone

Better system performance

Better professional development

Batalden P B, and Davidoff F Qual Saf Health Care 2007;16:2-3
Where to start?

• Problem identification
  – Understanding current practice, identifying potential gaps

• Identify the desired outcome of the improvement
  – Defining the standard of practice
  – Determine measures of success

• Brainstorming
  – What options may solve the problem?

• Planning the change
  – Implementing PDCA cycle
Plan, Do, Check, Act

• Plan
  – Determine goals and targets
  – Determine methods of reaching goals
• Do
  – Determine methods of education and training
  – Implement your plan
• Check
  – Check the effects of implementation (e.g. audit tools)
• Act
  – Take appropriate action (e.g. adapt plan if necessary)
Ingredients for Success

• Local champions at the point of care
• Mentoring & support from managers and clinical leaders
• Sharing experiences of local quality improvement activities
References


Working in teams and at the unit or program level, bring to the October GET Workshop the first 2 steps in the QI process:

1) Identify a problem or area for improvement
2) Identify the desired outcome
GET Program DAY 2

Consequences of Hospitalization
# Day 2: Consequences of Hospitalization

**October 16, 2013**

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<thead>
<tr>
<th>Time</th>
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<tr>
<td>0830</td>
<td>Introduction</td>
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<tr>
<td>0900</td>
<td>Iatrogenesis: Going Downhill in Hospital</td>
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<td>0930</td>
<td>Break</td>
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<td>0945</td>
<td>Iatrogenesis Going Downhill in Hospital (cont’d)</td>
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<td>1115</td>
<td>Clinical Case Presentations</td>
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<td>1300</td>
<td>Clinical Case Presentations (cont’d)</td>
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<td>1345</td>
<td>Quality Improvement Project: Team work time</td>
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<td>1500</td>
<td>Break</td>
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<td>1515</td>
<td>Challenges in Medications &amp; Older Adults in Acute Care</td>
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<td>1615</td>
<td>Evaluation/Feedback on the day</td>
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Day 2: Consequences of Hospitalization  
October 16, 2013

Please indicate your level of agreement with the statements below:

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See reverse
What did you find was the most helpful?

Any suggestions on what should be changed to improve the program.

Please use the area below for any additional comments:

Thank you for your feedbacks
GET Program Case Studies

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Case Presentation: ED & Falls

Mr. Brown is an 86 years old, widowed father and grandfather who lives independently. He has no community services in place and manages his own personal care and finances independently. Although he needs a cane outdoors and takes Handiart for appointments, Mr. B is active with a senior's centre. His only daughter lives in another province. Mr. B has Parkinson’s disease, osteoarthritis and CHF and takes over 10 medications including antiarrhythmics, analgesics and antihypertensives. Past medical history includes CABG X3, pacemaker and Type II Diabetes.

After Mr. B slipped and fell in his bathroom at home, his daughter, who was visiting at the time, called for an ambulance. Mr. B was then brought to the emergency department (ED) with a possible fractured right wrist.

Due to high demand upon his arrival, Mr. B was triaged (CTAS 5) and instructed to sit in the waiting room where he sat with his daughter for two hours. During this time, Mr. B was instructed not to eat or drink; however, he became increasingly restless and disoriented. Once in the ED, the admitting doctor completed an examination, requesting an X-ray and blood work. An IV was started as Mr B had developed dehydration with acute kidney injury (AKI). He was told to remain in bed until test results became available.

Soon after, Mr B’s daughter informed one of the nurses that her father had appeared more confused than usual in recent days, and was quite unsteady on his feet. The nurse made sure that the side rails were up and told Mr B not to get up by himself, but the information was not noted in the nursing notes or reported to the physician. Fall risk and mental status assessments were not performed. Since it was late in the evening and there was an unexpected delay in getting Mr B’s wrist casted, it was suggested to the daughter that she go home and call the ED first thing in the morning. Overnight, Mr B became even more confused, pulled out the IV and climbed off the stretcher. He fell and sustained bruising to his head, requiring a CT scan, and lacerations to his face, requiring sutures.

Mr B’s daughter returned the next day. She was distressed to find that her father did not recognize her. She was even more upset that measures had not been taken to manage her father’s risk of falls, particularly as she had specifically informed the nurse of his confusion and unsteadiness. Mr B has now been in ED for 14 hours and remained in bed during the entire period.

Questions:
1. Identify name the conditions (ie, acute/chronic, functional, family, psychosocial, environment) which affected how Mr B was able to adapt to the ED?
2. How did these factors affect the outcome for Mr B (ie, length of stay, dependency on others, iatrogenic complications, comfort etc.)?
3. How would you assess and manage his falls risk and “confusion”?
4. Select and evaluate at least two interventions that you would apply in your care for Mr B? Why?
5. Consider the situation with Mr B’s daughter.
   a. What stressors is the daughter experiencing?
   b. How would you address her views and needs?
Case Presentation: Delirium

Mr Schwartz is an 82-year-old man, who wears glasses and has some hearing loss. Mr Schwartz had a fall at home while changing a light bulb and his neighbour, who heard his calls for help after a few hours, found him on the floor and called an ambulance. He was taken to hospital, where an X-ray revealed that he had a fractured neck of femur.

Prior to his presentation at the emergency department (ED), Mr Schwartz was living alone at home independently. Past medical history includes a recent diagnosis of Atrial Fibrillation for which he receives Metoprolol and Coumadin, and mild memory changes noticed by his daughter.

In the ED, the admitting doctor completed a head to toe medical examination and prescribed morphine 2.5 -5mg PO or 1-2 mg subcut Q4 h PRN for Mr Schwartz’s pain. Labs were drawn including CBC, electrolytes, BUN, Creatinine, Albumin, Glucose, INR and PTT. His results were as follows – HBG 119, lytes normal, BUN & Creatinine slightly elevated, Glucose 6.8, Albumin slightly low, INR 2.3 and PTT normal. Mr Schwartz is given 5mg morphine PO for pain, and an indwelling foley catheter is inserted.

Mr Schwartz is admitted to the Orthopaedic unit at 2200 hours that evening and is ordered NPO at 2400 hours at which time an IV of D5NS at 75cc / hr is started. He is also given a couple of units of FFP to reverse his INR in preparation for surgery with a repeated INR drawn in the AM. At 1700 hours the next day his surgery is postponed and he receives a dinner tray of which he eats 50%. His urinary output remains within normal limits. He is made NPO at 2400 hours again for OR in the morning.

At 0800 the next morning after receiving his INR result (1.4) Mr Schwartz if transferred to the OR to undergo a hemiarthroplasty of his R hip.

Following surgery, Mr Schwartz returns to the orthopaedic ward where his vital signs are monitored his temp is 37.5, P 88 and slightly irregular, BP 130 /80. His U/O remains approx 26 cc/hr, his pain is scored at 4-5/10. He is given morphine 1.5 mg s/c Q4h and 650 mg of Tylenol pain Q6H while awake.

The next morning his urinary catheter is removed at 0600. He is orientated to person, place and time. After breakfast he is seen by Physio and assisted to take a few steps using a walker and is assisted to the chair. His post op labs show his HBG is 89, Na 135, K+ 4.2, BUN Creatinine normal,

When Mr Schwartz’s daughter visited later that day, she found that he had not eaten any of his evening meal. He seemed confused, agitated and unable to keep track of their conversation. She was very concerned about her father’s deterioration and mentioned it to the nurse who was looking after him. The nurse, who had only met Mr Schwartz that afternoon, told his daughter that it was not uncommon for older people to be a ‘bit confused’ for a couple of days after having an anaesthetic.

The next afternoon when Mr Schwartz’s daughter visited, he was less responsive than the day before. He was in bed and seemed unaware of her presence; staring into space. She spoke to the nurse, who took a set of vital signs (temperature 37.5, pulse 98, respirations 12, blood pressure 120/65 and oxygen saturation 92%) and tested Mr Schwartz’s urine, which showed signs of infection ( positive for nitrites and WBC) with frequency and urgency.
Questions:
1. In this scenario, name the conditions (ie, acute/chronic, functional, family, psychosocial, environment) which contributed to Mr Schwartz delirium
2. What could have been done in order to reduce the risk of developing delirium?
3. Select and evaluate at least two interventions that you would apply to your care for Mrs Schwartz? Why?
4. How will delirium influence the course of Mr Schwartz hospitalization?

Case Presentation: Dementia

Mr. Wong is an 80 year old man who lives with his wife. He speaks minimal English and needs help with ADLs and dressing. He uses a 2W walker at home. He had increased fatigue, SOB, orthopnea and cough x 2 weeks pre admission. He was sometimes dizzy when up and then collapsed one day en route to the BR at home. He was admitted with CHF exacerbation. Medical history: CHF - NYHA Stage III, A fib, CAD, HTN, renal insufficiency, gout, GERD, Chronic Kidney disease and from his previous admission in April, he had a ? dx of dementia vs protracted delirium (MMSE 23/28)

He had recently visited his cardiologist who discontinued his Metoprolol and started him on Diltiazem. His meds at home included Lasix, Spironalactone, Nitropatch, Ranitidine, Warfarin, Diltiazam, Candesartan, Tamsulosin, Allopurinol

Diet 2 GM Na+, 1.5 L Fluid restriction.

On admission to the unit:
TPR: 36.7 – 70 IR - 20, BP 109/70  O2 sats 98 % on 2 L O2/NP
Labs – Troponins negative, CBC within normal limits, Na+ 116, K+ 6, Cr 140
CXR showed a large left pleural effusion and basal atelectasis

He was given IV Lasix and PO Kayexalate. He was ordered Nitropatch, Ranitidine, sc heparin, Allopurinol and Tamsulosin. Other cardiac meds were held till a Cardiology consult and Echo were done. Orthostatic BPs were ordered. (Standing BP was 40 mm Hg lower than lying.) He had a Foley catheter inserted, and Oxygen applied via NP. He kept trying to remove his oxygen, Foley and Saline lock. He had a pigtail chest tube inserted for pleural effusion. Caring for him was challenging as he kept trying to remove his tubes and calling out for his wife. Eventually his electrolytes and SOB improved and he no longer needed Oxygen, his chest drainage decreased and the chest tube was removed. However he still had bilateral +3 pitting edema of his lower legs and feet, - and couldn’t wear socks or shoes. Both his lower legs were weeping. He developed a blister on his R foot.

He was a slow eater and his intake remained poor - he only took about 30 % of his meals. He kept asking for his wife, and wouldn’t let staff wash him.

This am he did not let the nurse take his BP in his Right arm. The PCA noticed he winced when she touched his right elbow and it looked red and swollen. When she tried to get him up for breakfast, he hit her in the arm.

The Aggressive Alert was initiated and loxapine was prescribed and given liberally that day and night.

The next day he was drowsy, slept through his breakfast and choked on his lunch. He became SOB in the evening. His O2 sats dropped to 90%. Oxygen was given, and an Xray done, which confirmed Aspiration pneumonia. IV antibiotics were prescribed.

Until then, no one had addressed advanced directives with Mr. Wong.

Questions:
1. Identify the conditions (ie, acute/chronic, functional, family, psychosocial, environment) influencing the course of hospitalization.
2. How did those factors affect the outcomes for Mr. W (ie, length of stay, dependency on others, iatrogenesis, comfort)?
3. How would you address Mr Wong’s behaviour and function?
4. Select and justify at least two interventions that you would apply in your care for Mr. W. How will your intervention influence his trajectory?
5. How would you address Mr. W advanced directives?
Case Presentation: Dysphagia

Mrs Myer is an 82-year-old widow. She lives independently but has a large family with six children, who check in on her regularly. She has been relatively healthy. Med hx includes mild osteoporosis and GERD. She takes Pantaloc OD and Tums PRN (and avoids spicy foods). She has slowed down somewhat since last winter when she had pneumonia. Since the pneumonia she finds she gets out of breath if she walks too far or tries to clean her whole apartment without a break. Her GP told her it is just her body telling her to take it easy. Mrs Myer presented to the ED after falling down the concrete stairs outside church. She had pain and severe bruising on her right arm and shoulder, which restricts the use of her arm. She is very weak and is admitted with soft tissue injuries of her right arm and shoulder and right-sided # 7 and 8 rib fractures. As she was in the ER x 24 hours with little to eat or drink, she was noted to be dry and was given 1 L of IV fluid. She is prescribed Tylenol # 3 Q4H prn.

On the unit, Mrs Myer needs help with her meals and ADLs. She gets breathless easily and her shoulder and ribs hurt if she sits up for too long. She doesn’t eat or drink much as she states she has no appetite and is too tired to eat. Her last BM was 4 days ago and she hasn’t slept well since her fall, so is prescribed a bowel protocol and Zopiclone at hs.

The next day Mrs Myer is drowsy, weak, has trouble swallowing and has a raspy voice after breakfast. She develops a fever and slight cough, with crackles in her right lung. She is made NPO pending swallowing assessment. Xray confirms aspiration pneumonia and she is treated with IV PipTazo. Mrs. Myer’s family is very concerned and want to bring in her favourite foods to improve her appetite.

Questions:

1. Identify the different factors (ie, acute/chronic, functional, family, psychosocial, environment) that contributed to her aspiration pneumonia? How could this have been prevented?
2. Describe how the aspiration pneumonia will affect the outcomes for Mr W (ie, length of stay, dependency on others, iatrogenesis, comfort)?
3. How would you address Mrs. Myer’s dysphagia, pain and function?
4. Using your nursing process, select and evaluate at least two interventions that you would apply in your care for Mrs. Myers. Why?

Case Presentation: Mental Health

Mrs. Han is a 74-year-old woman living independently in a social housing complex. She has a schizoaffective disorder, hypertension, COPD and IDDM. She is also currently on analgesics for a wrist injury she sustained a few days ago. She smokes and although she doesn’t drink regularly, in her chart, there is report of occasional binge drinking. A community agency assists her with her finances and monthly homemaking. When going outside, Mrs. Han uses a cane as she has experienced episodes of dizziness. A community health nurse sees her every month for an ulcer on her left heel. Otherwise, she has very little support. Her daughter, with whom she is estranged, lives 200km away.

Four days ago, Mrs. Han was brought to the Emergency Department (ED) after attempting suicide. This was her third known attempt. This time, she took what was left of her Tylenol 3 prescription, together with a large quantity of alcohol. She was found unconscious for an unknown period of time by her landlord. Her apartment was in such disorder that, once found by her landlord, 911 was called and Mrs. Han was brought to hospital by EMS/VPD.

Two days later, after being certified under the mental health act and medically cleared, she was admitted to a mental health unit for treatment of psychosis and depression with persistent suicidal ideations. Since then, Mrs. Han has had a flat affect and is very quiet, refusing to go to the dining room and to interact with other patients. She eats only small amounts of food, even when served in her room. She has been refusing personal care and most glucometer checks, but, when persuaded, cooperates and takes her antipsychotics and anti-hypertensive. Mrs. Han refused her inhaler although she was wheezing and SOB when walking.

Around 1000, when you walk in the room, Mrs. Han is unsteadily coming out of the bathroom, talking to you about her oven and mistaking you for her landlord. While having a loud conversation with herself, she tries to remove her clothes. In your assessment, you find Mrs. Han irritable, unable to concentrate, and feeling guilty about her daughter. Her thoughts appear disorganized and rambling and she is unpredictably jumping from topic to topic.

It is your first day caring for Mrs. Han. From the nursing notes, you were expecting to find her withdrawn and quiet. At lunch time, she yells at the staff, “go away with your stupid food and leave me alone”. As the staff walks out, she rolls over and goes back to sleep. When you walk into her room, she is disoriented.

Questions:
1. How would you assess Mrs. Han’s mood and cognition?
2. What are your hypotheses to explain her disorientation?
3. And what would be your nursing interventions related to your main hypothesis (nursing process)?
4. What acute health condition is this person experiencing?
5. Identify which different conditions (ie, acute/chronic, functional, family, psychosocial, environment) affected how Mrs. Han was able to adapt to hospitalization?
6. Select and evaluate at least two interventions that you would apply to your care for Mrs. H? Why?
7. What geriatric & mental health interventions are most important in prevention of functional decline? Why?
Case Presentation: Transition & Failure to Thrive (FTT)

Mrs. Phillips is a 77-year-old retired VGH nurse. She was living at home independently until her admission to hospital with Failure to Thrive which included weakness, fatigue, weight loss and “confusion.” No abnormalities were noted on her brain imaging but her haemoglobin and albumin are low.

Mrs. P has osteoarthritis and CHF and takes at least 3 medications daily including a diuretic, antihypertensive, plus Tylenol 3 and ibuprofen (OTC) PRN. Past medical history includes falls and Type II Diabetes. More recently, Mrs. P has had poor balance, anxiety and weight loss. Her husband died 15 months ago and she has become isolated at home and dependent upon her daughter for shopping and banking. For the past 3 months, Mrs. P has been forgetting the date and lunch meetings with friends.

Information from her GP is limited as Mrs. P’s last visit was two years ago. Her daughter, who calls her twice a week, has noted that their conversations have become one-sided and effortful. She feels that her mother is unmotivated and that she should be able to “take care of herself.”

In the first six days of admission, Mrs. P does not initiate self-care activities such as showering and toileting and is physically/verbally very slow. She remains anxious, in bed and sleeping throughout the day. A normally quiet person, Mrs. P has become tearful, rarely speaking to staff. She refuses to participate in physiotherapy. Her balance has not improved and she has made minimal progress in her mobility. Mrs. P has now developed a stage 2 pressure ulcer on her heel.

Morning rehabilitation with PT is provided. However, during the first week, she accepts physiotherapy twice but participates minimally. For the next two weeks, she does not participate despite encouragement from therapists. It is noted that she is not sleeping well at night and wakes early. After a three-week admission, Mrs. P has not improved and has experienced further functional decline in ADLs and mobility. As a result, a discharge plan to residential care is proposed and discussed with her.

Three days later it is noted that Mrs. P has not eaten since the discussion about discharge. Referrals to the dietician and occupational therapist are made. Their assessments indicate poor nutritional status with a low body mass index (BMI) but no swallowing difficulties. A social worker calls Mrs. P’s daughter and discusses her condition. Her daughter suggests that her mother may be depressed. Mrs. P is screened for depression and a psychiatrist is consulted. Mrs. P has a major mood disorder and medication is commenced. Food intake is encouraged by all staff and, after four days, Mrs P starts eating a small amount. She begins to get up with PT, although reluctantly.

Questions:
1. Identify how many different conditions (ie, acute/chronic, functional, family, psychosocial, environment) affected how Mrs. P was able to adapt to hospitalization?
2. How did these factors affect the outcome for Mrs P (ie, length of stay, dependency on others, iatrogenesis, comfort)?
3. Select and evaluate at least two interventions that you would apply in your care for Mrs. P? Why?
4. How would you address Mrs. Ps mood and functional decline?
5. What factors have contributed to Mrs. P need for relocation (red flags)? And which factors may contribute to her need for re-admission?

6. What are the considerations for discharge/transition for Mrs. P.?

Consider:
- Red flag symptoms/warnings (ie potential for readmission)
- Communication (who and what should be included)
  - Medication management
  - Primary care/specialist follow up

### Nursing Interventions for Older Adults/Families

<table>
<thead>
<tr>
<th>Type of Needs</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| **Psychosocial**       | • Anxiety reduction  
                         | • Coping enhancement  
                         | • Decision-making support  
                         | • Emotional support  
                         | • Touch |
| **Comfort Needs**      | • Pain management  
                         | • Positioning |
| **Health Promotion Needs** | • Fall prevention  
                         | • Risk identification  
                         | • Environmental management/safety  
                         | • Medication management  
                         | • Nutrition/hydration management  
                         | • Self-care/knowledge of chronic disease process(es)  
                         | • Sleep enhancement  
                         | • Anticipatory guidance  
                         | • Skin surveillance  
                         | • Education  
                         | • Disease monitoring  
                         | • Mental health promotion |
| **Spiritual**          | • Active listening  
                         | • Instilling hope |
| **Quality of Life**    | • Enhancing experiences of aging/hospitalization  
                         | • Plans for care - Advance Care Planning |


## NURSING CARE PLAN FRAMEWORK

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Objectives</th>
<th>Nursing Interventions</th>
<th>Rationale</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

### ASSESSMENT DATA
Teaching strategies for case studies

Below is a short list of ideas on how the above case studies might be used. When considering which strategy will best suit your audience, the choice of strategies will vary according to the needs of the participants and their level of expertise as well as the resources available (e.g., time, facilitators). The GET cases presented above were developed to meet the various backgrounds and level of expertise of our participants.

Case studies are a useful teaching method for developing participants’ critical thinking. Some of the goals of using case studies in your teaching could be to gain a better understanding of a complex situation, to recognize abnormal or changing situation, to identify appropriate actions and interventions and improve problem solving skills. Case studies focus on knowledge application and they promote reflection, instructor-participants dialogues as well as group discussions (Rowles & Russo, 2009).

This teaching method requires support and feedback to ensure learning objectives are being met. Case studies are more likely to lead to changes in practice than traditional teaching methods. You can refer to the table below for ideas on how to structure and facilitate learning using case studies.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Process</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Instructor led case study | Class process/discussion        | • Allows instructor to demonstrate the nursing process that needs to take place.  
• Serves as an exemplar/guiding process for subsequent case studies.  
• Allows to draw emphasis on most important points/concepts | • May be less challenging for more experienced nurses |
| Small groups       |                                | • Depending on the group size, ensures a more active participation from all participants  
• Allow participants to discuss and debate ideas in smaller group, which might be less intimidating | • Requires more resources:  
  — Time: participant-led process could be more time consuming  
  — Facilitator: depending on the number of participants, may require |
more than one facilitator to guide groups as needed.

<table>
<thead>
<tr>
<th>Groups work on same cases</th>
<th>Review via whole class discussion</th>
<th>Everyone is exposed to same new knowledge</th>
<th>Allow rich exchange among participants</th>
<th>Allows learning from other participants</th>
<th>Allows to cover more cases in less time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups work on different cases</td>
<td>With group presentations</td>
<td>Provides an opportunity for feedback and exchanges</td>
<td>Allows all participants to hear the feedbacks and nursing process for all cases without them working on all cases</td>
<td>Serves the purpose of having participants organizing and verbalizing their nursing process</td>
<td>More time consuming</td>
</tr>
</tbody>
</table>

Without presentations

- Less time consuming

- May not allow proper feedback period
- All participants are not exposed to same learning process and knowledge

References

GOING DOWNHILL IN HOSPITAL:
PREVENTION OF IATROGENESIS

Maureen Shaw, CNS Gerontology
Vancouver Coastal Health
Esther’s Voice

Esther's Story - Vancouver Sun

Esther's Voice - Coroner's Judgement of Inquiry
Objectives

• To define iatrogenesis

• To examine 6 concepts that lead to iatrogenesis:
  – Functional decline
  – Hospital acquired infection
  – Transient/functional incontinence
  – Skin integrity
  – Malnutrition
  – Adverse effects of diagnostic & therapeutic procedures

• To describe nursing interventions that avoid and/or limit the effect of iatrogenic complications
IATROGENESIS

True or False?

1. Older patients should receive the same medications & treatments as younger adults.
2. Older patients can retain their functional abilities while in hospital.
3. Hospital is a safe environment for older patients.
IATROGENESIS DEFINED

Iatrogenesis is:

• An unintended adverse outcome due to therapeutic, diagnostic & prophylactic interventions not considered part of the disease process.

• An unintended & untoward outcomes of well intended healthcare interventions.

Beyea, retrieved May 2013; Volpato et al, 2007
IATROGENESIS DEFINED

• Cascade iatrogenesis
  – A trigger event initiates the serial development of adverse outcomes followed by functional decline

• Complications *unrelated* to the presenting diagnoses that result in:
  – Longer hospitalizations
  – Unanticipated medical and/or surgical interventions
  – Death

Francis, 2008; adapted from NICHE Core Curriculum
CASCADE IATROGENESIS

- Prevalence:
  - 35-58% of older adults experience iatrogenic events
- May be irreversible
- Referred to as:
  - Hazards of hospitalization
  - Dysfunctional/geriatric/immobility syndrome

Beyea, retrieved May 2013; Fernandez et al., 2008; Palmer et al., 2003
Iatrogenesis & Surgical Repair of Hernia

Post-op Delirium
Medicated for agitation

Aspirates due to sedation

Outcomes
• ADL dependency
• ↑ LOS
• Facility placement
• Death

• Pneumonia
• Dehydration
• C. diff diarrhea
• Ongoing delirium

• Prolonged bedrest
• Functional decline
• Fall with hip #

Adapted from NICHE Core Curriculum
## WHO IS AT RISK FOR IATROGENESIS?

Older Adults with Advancing Age & Declining ADLs (Frailty Syndrome)

<table>
<thead>
<tr>
<th>AGE</th>
<th>% With Frailty/ADL Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>70-74</td>
<td>23%</td>
</tr>
<tr>
<td>75-79</td>
<td>28%</td>
</tr>
<tr>
<td>80-84</td>
<td>38%</td>
</tr>
<tr>
<td>85-90</td>
<td>50%</td>
</tr>
<tr>
<td>90+</td>
<td>63%</td>
</tr>
</tbody>
</table>

Ettinger, 2011; Permpongkosol, 2011; Stone & Steinbach, 1999; Volpato et al., 2007
WHAT ARE THE RISK FACTORS?
(Frailty & Hospitalization)

1. Frailty Syndrome
   - Advanced age
   - Functional decline PTA (ADL/IADL)
   - Cognitive impairment
   - History of falls in past year
   - ↑ comorbidity
   - Body composition (lean vs adipose)
   - Higher acuity on admission

Ettinger, 2011; Permpongkosol, 2011; Stone & Steinbach, 1999; Volpato et al., 2007
WHAT ARE THE RISK FACTORS?
(Frailty & Hospitalization)

2. Hospitalization

- Environmental hazards
- Reduced caloric intake
- Low physical activity, bed rest
- Social isolation
- Medications, treatments, procedures
- Lack of professional education in geriatrics
- Professional values & beliefs

Permpongkosol, 2011; Stone & Steinbach, 1999; Volpato et al., 2007
<table>
<thead>
<tr>
<th>Consequence</th>
<th>AGE- and HOSPITAL-RELATED CONSIDERATIONS</th>
</tr>
</thead>
</table>
| Impaired Mobility    | • Age-related: ↓ ability to maintain gait, balance, walking speed  
                      • Hospital related: Deconditioning due to bed rest, bed rails/restraints, lack of gait aides/opportunities for mobilizing                                                                                                                                 |
| Infection            | • Age-related: ↓ immune competence; atypical presentation  
                      • Hospital related: UTI due to catheters; aspiration pneumonia; MRSA/VRE/C DIFF; sepsis                                                                                                                                               |
| Incontinence         | • Age-related: Urinary stasis, thinning of bladder wall, ↓ capacity  
                      • Hospital related: Environment-shared toilet, no privacy/call bell; staff beliefs re dependence; medications, procedures, restraints, tubing                                                                                                                                 |
| Medications          | • Age-related: Exaggerated effects of medicines  
                      • Hospital related: Polypharmacy; drug interactions, medication errors, insufficient monitoring                                                                                                                                                                                                 |
| Malnutrition         | • Age-related: Blunted thirst mechanism; ↓ muscle mass/metabolism  
                      • Illness-related: Dysphagia, anorexia, pain, dietary restrictions, constipation, diarrhea, dehydration  
                      • Hospital related: Packaging, restraints, IV fluids, NPO, timing of meals                                                                                                                                                                |
| Accidents & Injuries | • Age-related: ↓ safety awareness, deconditioning  
                      • Hospital related: Environment, equipment, lines/tubes/tethers, hazards (gown, slippers); lack of signage                                                                                                                                 |

HAZARDS OF HOSPITALIZATION
IATROGENESIS

True or False?

• Bedrest does not cause physiologic changes in older patients.

• Cascade iatrogenesis contributes to poor health outcomes.

• Hospitalization can cause functional decline in older patients.
COMMON IATROGENIC ISSUES

1. Impaired mobility, & deconditioning & falls
2. Hospital acquired infections (HAIs)
3. Functional incontinence
4. Skin integrity
5. Malnutrition
6. Adverse effects of diagnostic & therapeutic procedures
IMPAIRED MOBILITY & DECONDITIONING: Bedrest

1. Negative effects on heart
   - Redistributions 500 mL to thoracic circulation
     • ↑ HR & cardiac output
     • Underlying cardiac disease now evident
     • In 5 days, cardiac output ↓ but HR remains elevated
     • Stasis gradually reestablished by atrial baroreceptors

3. ↓ elasticity of lungs/aerobic capacity

4. Daily loss of 5-10% of muscle mass for every week of bedrest

Adapted: Francis, 2005; NICHE Core Curriculum; Holohan-Bell & Brummel-Smith, 1999
INCIDENCE of IMPAIRED MOBILITY & DECONDITIONING

- Defined:
  - Hospitalization-associated disability involves a new loss, by D/C, to perform at least 1 ADL
  - Geriatric syndrome

- Prevalence:
  - 30-58% of patients > 70 years

- Consequences:
  - Home Care, LTC placement
  - Repeat hospitalizations*
  - Death

Covinsky et al., 2003; Volpato et al., 2006
Predisposing/Precipitating Factors

Medical/Health
- Arthritis/fractures/deformities
- Neurological
- Cardiovascular, pulmonary
- Anemia

Psychological
- Depression
- Dementia
- Bereavement
- Fear of falling

Social
- Isolation
- Meaningful contact
- Family discord

Environment
- Equipment, barriers
- Procedures, medicines
- Lack of knowledge

Deconditioning/Functional Decline

Adapted from Francis, 2008; Holohan-Bell & Brummel-Smith, 1999
BACKGROUND: COST OF FALLS

• Seniors with fall-related injuries stay in hospital 2X longer than seniors hospitalized for all other reasons.


• Costs 2005/06-2009/10:
  – Fall-related hip # accounted for 47% of annual hospital-related costs.
Fall-Related Hospital Cases and Rates Among Seniors, B.C., 2000/01 to 2009/10

*Standardized to the B.C. 1991 population.*

Source: Acute/rehab. separations from the 2000/01 to 2009/10 Canadian Institute of Health Information Discharge Abstract Dataset. Prepared by: Population Health Surveillance and Epidemiology, Ministry of Health Services, February 2011.
WHY ARE FALLS & FALL PREVENTION IMPORTANT TO ACUTE CARE?
FALLS IN ACUTE CARE
Multifactorial Risk Factors Impacting Injury (1/2)

1. Patient:
   - ↓ sensory, neurological, musculoskeletal responses
   - Delirium superimposed on cognitive impairment
   - New medications (ie antihypertensives, diuretics)
   - Toileting needs
   - Trauma risk factors (ie height of fall, number/frequency of falls, protective response of faller)

RNA O, 2007; Stone & Wyman, 1999
2. Hazards/barriers that ↑ the risk of falling:
   – Environment, entrapment hazards (ie, side rails, bed/mattress, tubes/lines, catheters)
   – Restraints
   – Culture, communication of fall risk: shift report, call bells, notifying interdisciplinary team
Key Symptoms Associated with Falls

- Delirium
- Arrhythmia
- Orthostatic hypotension
- Syncope
- Vertigo
- Generalized weakness (infection, sepsis)
- Ataxia
- Hypoglycemia
- TIA/CVA

Gray-Miceli, 2008
### FALL ASSESSMENT: CAMP-V SCREEN

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
<th>Score: 0-5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognition Impaired?</strong>&lt;br&gt;Is the patient agitated, confused, or disorientated?&lt;br&gt;eg Consider history of dementia delirium, lack of insight &amp; judgment</td>
<td>No=0&lt;br&gt;Yes=1</td>
<td></td>
</tr>
<tr>
<td><strong>Elimination?</strong>&lt;br&gt;Does the patient require frequent toileting?&lt;br&gt;eg. urgency, frequency, incontinence</td>
<td>No=0&lt;br&gt;Yes=1</td>
<td></td>
</tr>
<tr>
<td><strong>Mobility Impaired?</strong>&lt;br&gt;Does the patient ambulate or transfer with an assistive device or assist? Or does the patient ambulate with an unsteady gait and no assistance?</td>
<td>No=0&lt;br&gt;Yes=1</td>
<td></td>
</tr>
<tr>
<td><strong>Previous Fall?</strong>&lt;br&gt;Did the patient fall in the last 90 days?</td>
<td>No=0&lt;br&gt;Yes=1</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Impaired?</strong>&lt;br&gt;Is the patient visually impaired to the extent that everyday function is affected? eg. blurred vision, impaired peripheral vision.</td>
<td>No=0&lt;br&gt;Yes=1</td>
<td></td>
</tr>
<tr>
<td><strong>Scoring</strong>&lt;br&gt;Low/moderate Risk = 1-2&lt;br&gt;High Risk = 2+</td>
<td></td>
<td>Score: 0-5</td>
</tr>
</tbody>
</table>

Oliver et al., 1997
FALL ASSESSMENT: CAMP-V SCORING

*** Medications can affect each of the above factors and should be considered when completing the fall risk screen

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low / Moderate Risk</td>
<td>0 - 1</td>
<td>Universal / Standard Fall Precautions</td>
</tr>
<tr>
<td>High Risk</td>
<td>2 or more</td>
<td>Complete Multifactorial Risk Assessment &amp; develop individualized fall prevention care plan</td>
</tr>
</tbody>
</table>

Oliver et al., 1997
What can nurses do to prevent falls in older patients?

- Patient
- Environment
- Nursing
- Organization

SFU Video Analysis
KEY MESSAGES

• Functional decline is a leading consequence of iatrogenesis in older patients.

• Prevention is the best intervention.

• Focus on mobility and safety for the best outcomes.
HOSPITAL ACQUIRED INFECTIONS (HAIs)

True or False?

• UTIs are normal with aging especially with women.
• NPO is the best approach for patients with dysphagia.
• If an older patient does not have a temperature, he/she does not have an infection.
HOSPITAL ACQUIRED INFECTIONS (HAIs)

Risk Factors
- Advancing age
- Higher acuity
- Immune compromised
- Invasive procedures
- Intravascular devices

Consequences
- ↑ LOS
- Adverse complications
- ↑ mortality

Beyea, retrieved May 2013
BACKGROUND ON HAIs

Annually, in Canada, HAIs

• Infection: 250,000
• Mortality: 8,000 – 12,000

• Overall, one of the leading causes of death

# INFECTION: PREDISPOSING FACTORS

<table>
<thead>
<tr>
<th>Age-Related Change</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immune Response</td>
<td>• ↓ resistance, reactivation of latent infections</td>
</tr>
<tr>
<td></td>
<td>• Absence of classic response to infection</td>
</tr>
<tr>
<td></td>
<td>• Non-specific presentation (low grade fever)</td>
</tr>
<tr>
<td>Skin/Mucosa</td>
<td>• ↓ barriers to bacterial/viral organisms</td>
</tr>
<tr>
<td></td>
<td>• Thinning of epidermis (delayed healing, vulnerability to trauma)</td>
</tr>
<tr>
<td>Respiratory System</td>
<td>• ↓ ciliary action/cough reflex</td>
</tr>
<tr>
<td>GI Tract</td>
<td>• ↓ acid/motility; ↓ immunoglobulin, antibody in mucosal cells</td>
</tr>
<tr>
<td>Nutrition</td>
<td>• Vitamin deficiencies (folate, zinc). ↓ formation of RBC.</td>
</tr>
<tr>
<td></td>
<td>• Malnutrition—low albumin</td>
</tr>
</tbody>
</table>
MOST COMMON HAIs

• UTIs
  – Most common HAI
  – Account for 30-40% of all HAIs
  – Related to use/duration of bladder catheters

• Bloodstream
  – ~ 50% related to invasive device
  – 8th leading cause of death (ie, sepsis)
  – ICU: 3--7% with central line develop sepsis

Beyea, retrieved May 2013; Francis 2008
### MOST COMMON HAIs
**UTI & UROSEPSIS**

<table>
<thead>
<tr>
<th>Factors</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-Related</td>
<td>• Urinary stasis, bacterial growth</td>
</tr>
<tr>
<td></td>
<td>• ↓ immune function</td>
</tr>
<tr>
<td></td>
<td>• Thinning of bladder wall</td>
</tr>
<tr>
<td>Social/Cognitive</td>
<td>• Poor hygiene/motivation</td>
</tr>
<tr>
<td></td>
<td>• Lack of awareness</td>
</tr>
<tr>
<td>Hospital-Acquired</td>
<td>• Dehydration, dependence,</td>
</tr>
<tr>
<td></td>
<td>• Catheters, bedpans</td>
</tr>
<tr>
<td></td>
<td>• Functional incontinence</td>
</tr>
<tr>
<td></td>
<td>• Access to commodes/ toilets/ hand washing</td>
</tr>
</tbody>
</table>

*(Francis, 2008)*
MOST COMMON HAIs

• Pneumonia
  – 2nd most common HAI; 24-36% mortality rate
  – May present as delirium (ie silent aspiration)
  – Cause: Aspiration of GI or oropharyngeal secretions
  – With dysphagia, risk increases 7 fold

• Surgical Site Infections
  – 2.7%
  – Admitted from ICU? Risk rises to 60%

Beyea, retrieved May 2013; Francis, 2008
MOST COMMON HAIs

• Additional:
  – Skin (MRSA)
  – GI Tract (C. diff colitis; VRE)
  – Oropharyngeal cavity (Candida Albicans)

• Note:
  – Risk with transfer/transition
    • Unit ⇝ unit; residential ⇝ acute ⇝ residential care

APIC, 2013; Beyea, retrieved May 2013; Francis 2008
C. DIFFICILE DIARRHEA PRECIPITATED BY

High risk antibiotic treatment such as:

1. Clindamycin (Dalacin C)
2. Beta-lactams:
   - Penicillins (Ampicillin/Amoxicillin)
   - Cephalosporins:
     • Cefazolin (Ancef/Kefzol)
     • Cefotaxime (Claforan)
     • Ceftriaxone (Rocephin)

KEY MESSAGES

• 1/3 of HAIs are preventable.
• Continuously assess the need for indwelling lines and tubes and remove as soon as possible.
• Collaborate with MD/NP/pharmacist on use of antibiotics known to cause adverse drug events (ADE).
FUNCTIONAL INCONTINENCE

Which of the following statements is true?

1. Incontinence is a normal part of aging.
2. Transient incontinence is a potentially reversible condition.
3. Absorbent pads are the best way to manage incontinence.
FUNCTIONAL INCONTINENCE

Incontinence caused by:

1. Cognitive impairment (delirium, Alzheimer’s, Parkinson’s) that results in *dependence* in toileting and/or

2. Physical design, practices/procedures of hospital
   — No signs; inaccessible toilets; lack of privacy
   — Restraints; bedrest
   — Medications

Dowling-Castronova & Bradway, 2008; Stone & Steinbach, 1999
RISK FACTORS FOR TRANSIENT INCONTINENCE

Incontinence caused by potentially reversible symptoms:

– Delirium, depression
– Infection
– Restricted mobility
– Dehydration
– Constipation
– Diuresis

Dowling-Castronova & Bradway, 2008
PREVENTING FUNCTIONAL INCONTINENCE

1. Provide individualized, scheduled toileting or prompted voiding
2. Provide adequate fluid intake
3. Modify environment to maximize independence
4. Use absorbent products to meet patient/family needs if toileting plan is unsuccessful
5. Educate patient/family
6. Refer to PT/OT
KEY MESSAGES

• Transient incontinence is due to conditions outside of, or affecting, the urinary system such as delirium, infection or impaction.

• Functional incontinence is almost always associated with environmental barriers.

• Incontinent patients usually respond to an individualized plan of care.
SKIN INTEGRITY

• Aging Changes:
  – Loss of elastic, subcutaneous, connective tissue
  – ↓ sweat/sebaceous gland activity
  – ↓ capillary blood supply/skin turgor

• Appearance?
  – Thin, fragile, loose
  – Dry, flaky, rough

Adapted from Balas, Casey & Happ, 2008
SKIN INTEGRITY: Consequences of Aging

Why are older patients at risk for ↓ skin integrity?
SKIN TEARS

• Definition:
  – Dermis becomes separated from the epidermis
  – Usual cause?
  – Common areas effected?
    • Shins
    • Face
    • Dorsal aspect of hands
    • Plantar aspect of feet
    • Areas of purpura

Balas, Casey & Happ, 2008
# RISKS FOR SKIN TEARS

<table>
<thead>
<tr>
<th>• History of unhealed skin tear in last 90 days</th>
<th>• Unsteady gait</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bruising present/easily bruises</td>
<td>• Confined to bed or chair</td>
</tr>
<tr>
<td>• Decision-making capacity impaired or slightly impaired</td>
<td>• Resistive to personal care</td>
</tr>
<tr>
<td>• Extensive assist or dependent in ADLs</td>
<td>• Aggressive</td>
</tr>
<tr>
<td>• Loss of balance</td>
<td>• Presence of restraints</td>
</tr>
</tbody>
</table>

Adapted from Balas, Casey & Happ, 2008
KEY MESSAGES

• Maintaining skin integrity is important because:
  – Pressure areas are associated with:
    • Iatrogenesis
    • Pain
    • Reduced mobility
    • ↑ length of stay
    • Infection
MALNUTRITION

True or False?

• Malnutrition contributes to poor health outcomes.
• Hydration status does not precipitate delirium in older adults.
• Adverse effects of medications are linked to poor nutrition in older adults.
• My unit routine does not impact the older patient’s nutrition.
MALNUTRITION

• Defined:
  – Imbalance of nutrition or
  – Inadequate macro nutrition (protein, energy malnutrition) and inadequate micro nutrition (vitamin deficiency).

• In acute care:
  – Combination of cachexia (disease-related) and malnutrition (inadequate intake of nutrients)

• Prevalence: up to 40% in acute care

Australian Health, 2004; Barker et al., 2011
## MALNUTRITION

### Predisposing Patient-Related Factors

- Compromised nutrition upon admission
  - Low albumin (reflects status 3 months ago)
- Changes in taste, smell; GI peristalsis
- ↓ sensation of thirst
- Multiple chronic illnesses
  - COPD, Parkinson’s, hypertension, cancer
- ADL decline
- Social issues: loneliness, poverty
## MALNUTRITION

<table>
<thead>
<tr>
<th>Precipitating Patient-Related Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Treatment of health conditions</td>
</tr>
<tr>
<td>➢ N &amp; V, dry mouth, polypharmacy</td>
</tr>
<tr>
<td>• Constipation, diarrhea</td>
</tr>
<tr>
<td>• Decreased appetite, anorexia</td>
</tr>
<tr>
<td>• Dehydration</td>
</tr>
<tr>
<td>➢ ↑ risk for UTI, postural hypotension</td>
</tr>
<tr>
<td>• NPO +/- saline/glucose IV</td>
</tr>
<tr>
<td>• Dysphagia</td>
</tr>
</tbody>
</table>
## MALNUTRITION

### Precipitating System-Related Factors

- Lack of recognition of ↑ metabolic needs
- Restricted diets: ↑ risk ADE, dehydration
- Lack of meal time support
  - Staff breaks, lack of adaptive equipment/mealtime assistance, timing of tests/procedures
STRATEGIES FOR PREVENTION

• Screening for malnutrition
  – Mini Nutritional Assessment (MNA)
  – Height, weight, food/fluid intake
  – Identifying ↑ metabolic needs

• Referral to dietitian, pharmacist

• Supplements

• Planning for meal times
  – Monitoring schedule for diagnostic tests
  – Providing meal time assistance

DiMara-Ghalili, 2008; Stone, & Wyman, 1999
KEY MESSAGES

1. Poor nutrition & hydration contribute to morbidity & mortality in older adults.
2. New onset delirium may be related to dehydration.
3. Be aware of factors (ie NPO, over-use of IV fluids) that contribute to under nutrition.
4. Provide nutritional screening & food/fluid interventions to avoid unnecessary weight loss.
Dysphagia: Why is Swallowing Important?

Ben, age 74, was admitted to hospital for hip surgery due to arthritis and chronic pain. He has a 14-year history of Parkinson’s, taking Sinemet 4 times daily. Ben was NPO post-op & was also nauseated. This worsened his Parkinson’s & he had a new-onset difficulty in swallowing. You find him drowsy but rousable, coughing, drooling & speaking in a whisper. Upon auscultation, you hear crackles in the bases of both lungs.

What is happening to Ben?
Dysphagia: Why is Swallowing Important?

- Aging changes: ↓ swallowing rate/gag reflex
- Aspiration Pneumonia
  - Atypical presentation in older adults
  - Signs & symptoms:
    - Delirium
    - Behavior/functional change
    - +/- change in vital signs
    - Pleuritic chest pain
    - Other?

Palmer & Metheny, 2008
Dysphagia: Why is Swallowing Important?

What are the interventions?

– Dietary modifications
– Mealtime assistance
– Positioning, mobilization
– Medication modifications
– Oral hygiene
– Refer to OT/SLP, dietician, pharmacist
Oral Hydration

True or False?

• Dysphagia diets with thickened fluids are healthy.
• Older patients are not as thirsty as younger patients.
• Older patients who are not sweating do not feel the heat and are not at risk for dehydration.
Oral Hydration

• Dehydration defined:
  – Depletion in total body water due to disease processes &/or ↓ water intake
  – Results in hypernatremia

• Symptoms?
  – Dry mouth, hypotension
  – Concentrated urine, ↓ urine output
  – Labs: ↑Na⁺/creatinine/BUN

Adapted from: Mentes, 2008
Oral Hydration

Special Populations

– Chronic mental illness
– Dysphagia
– Fasting/NPO for tests/procedures
– End-of-life

Adapted from: Mentes, 2008
Key Messages

• Carefully monitor oral hydration in patients with fever, diarrhea, vomiting or nonfebrile infection.

• Carefully consider hydration status in patients scheduled for tests and procedures.

• Implement fluid/comfort rounds.

• Always offer a trial of oral liquids before starting IV fluids.
Adverse Effects of Diagnostic & Therapeutic Procedures

• Relatively risk free medical and nursing procedures can cause safety issues.

• Iatrogenic “hypos”
  – IV fluids ➔ hypokalemia
  – Antihypertensives ➔ hypotension
  – Transient decreased oral intake ➔ hypoglycemia

Adapted from: Francis, 2008; NICHE Core Curriculum
Adverse Effects of Diagnostic & Therapeutic Procedures

True or False?

• Medical and nursing procedures are safe and effective for older patients with dementia.
• Use of tubes (ie catheterization, chest tubes) may be high-risk procedures for older patients.
• Nurses should not question a doctor’s judgment.
Adverse Effects of Diagnostic & Therapeutic Procedures

Risk Factors:
• High number of medical procedures & therapies
• Complex surgical procedure requiring long anesthesia
• High risk diagnostic tests and procedures
  – Invasive
  – Contrast mediums
  – Radiation
  – Thoracentesis
  – Cardiac catheterization

Adapted from: NICHE Core Curriculum
Adverse Effects of Diagnostic & Therapeutic Procedures

Role of the Registered Nurse

• Early recognition of risk and prevention of iatrogenesis
• Patient advocacy based on gerontological knowledge
• Education for colleagues & interdisciplinary team, including physicians
ASSESSMENT: SPICES

- **S** = Sleep disorders
- **P** = Poor nutrition
- **I** = Incontinence, infection
- **C** = Confusion (delirium, depression)
- **E** = Evidence of fall or functional impairment
  - = Effects (adverse) of drugs/procedures
- **S** = Skin breakdown; safety

Adapted from: NICHE Core Curriculum; Robinson & Weitzel, 2008
CONCLUSION

• Frailty & potential for complications highlights the importance of nurses in preventing iatrogenesis in hospital & during transition to another setting.

• Nursing care makes a significant difference with frail patients who have frequent and subtle disease presentations, higher risk of iatrogenesis & greater baseline risk factors.
CONCLUSION

Prevention

is always the

best intervention
References Iatrogenesis


BC Ministry of Health. Seniors’ Fall prevention, [Online]. Available: [Seniors' Fall Prevention](#)

Beyea, S. Iatrogenesis. Centres for Health and Aging [Online], Available: [Iatrogenesis](#)


**Websites:**
Nurses Improving Care for Health System Elders (NICHE): Iatrogenesis Presentation Module ([www.nicheprogram.org](http://www.nicheprogram.org))


John A. Hartford Foundation Institute for Geriatric Nursing: [ConsultGeriRN](http://www.hartfordinstitute.org)

John A. Hartford Foundation Institute for Geriatric Nursing: [Hartford Institute](http://www.hartfordinstitute.org)

**Other:**

CHALLENGES IN GERIATRIC PHARMACOLOGY

Maureen Shaw, RN, MN
Clinical Nurse Specialist, Gerontology
VCH
OUTLINE

1. Why are Medications an Issue?
2. Drug Action & Aging
3. Medications of Risk:
   - Benzodiazepines
   - Antidepressants
   - Antipsychotics
4. Unique Considerations
   - Alzheimer’s Disease
   - Drug & Alcohol Dependency
5. Medication Principles
6. How Can I Help?
“Avoid antipsychotic drugs for elderly, experts urge, after death risk study”

Doctors should avoid prescribing antipsychotic drugs for elderly people with Alzheimer's. New research shows that people taking these medications have double the risk of dying (CBC, January 9/09)
Why Are Medications a Patient Safety Issue?
People over age 65 experience medication related side effects due to:

**True or False**

1. Age-related physiological changes
2. Polypharmacy
3. Drug Interactions
4. Addiction
5. Cognitive impairment
WHAT’S THE REAL ISSUE?

- Adverse events ↑ 2-7x
- Hospital admissions 2x higher

WHY?
- Higher dosing, less frequent monitoring, incomplete consideration of effects of other drugs, cognitive impairment

RESULTS?
- ↑ Risk for morbidity & mortality
- ↑ Economic costs (drugs, MD visits & hospitalization)
WHY IS THIS HAPPENING?

- Lack of research in older adults
- Lack of professional knowledge
- Lack of patient/family education
- Multiple chronic illnesses
- Normal aging changes
- Polypharmacy
- Drug prescribing culture

A pill to cure everything
Pharmacokinetics—the body's reaction to drugs including:

- Absorption
- Distribution
- Metabolism
- Elimination
DRUG ACTION & AGING

Body Composition

Key Areas of Change

- Digestive*
- Hepatic*
- Renal*
- Cardiac
- Brain
**BODY COMPOSITION**

- Decreased body mass/water *
  - Hydrophilic drugs (ie digoxin, hydromorphone)

- Increased body fat *
  - Lipophilic drugs, ie diazepam (long ½ life)

- Decreased plasma albumin binding
  - Examples: phenytoin, benzodiazepines, oral hypoglycemics, anticoagulants

- Implication: High risk for serum concentration, drug toxicity & delirium
DIGESTIVE CHANGES

- Decreased gastric pH = ↑ gastric acidity
- Decreased GI blood flow & motility
- Examples: Digoxin, levodopa, enteric coated/SR drugs, anti-inflammatories
- Implication: Nausea, GI upset/bleed
  ➢ Why? Poor absorption, ↑ time to peak serum levels

Avoid

Mineral oil, cascara, bisacodyl, antacids (cimetidine)
HEPATIC CHANGES

- Decreased size of liver
- Decreased blood flow (45%), protein metabolism & bile formation
- Decreased liver enzymes result in:
  - Decreased metabolism &
  - Increased blood levels &
  - Increased toxicity
- Examples: amitriptyline, metoprolol, nitroglycerin, propranolol, opioids (codeine, morphine)
RENAL CHANGES

- Decreased renal mass & blood flow
- Decreased number of nephrons
  - Elimination impaired (50%)
- Decreased glomerular filtration rate (GFR)
  - Normal creatinine (Cr)
  - Reduced response to dehydration
DRUGS AFFECTING KIDNEYS

Examples: Atenolol, cefuroxime, nadolol, levofloxacin, chlorpropamid, digoxin
CARDIOVASCULAR CHANGES

- ↑ heart rate
  - Reduced cardiac output & circulation

Overall decrease

- Maximum heart rate
- Efficiency of valves
- Pacemaker response
- Receptor sensitivity
- Baroreflex sensitivity
CARDIAC DRUGS & AGING

- Hypotension & falls
- Impact renal function
- CNS Effects
  - Cross blood-brain barrier
  - Decrease neurotransmission
  - Confusion, headache, nightmares, depression

↑ DELIRIUM RISK
BRAIN CHANGES

- Reduction in weight & volume
- Increased size of ventricles
- Decreased size/number of neurons
- Decreased number/size/transmission of neurotransmitters
  - Serotonin, dopamine, norepinephrine

Function of Neurotransmitters
BRAIN CHANGES

I'm sorry, but you are too highly charged, too large and not lipid soluble. You cannot enter the brain!

Hey! We want in!

To the brain

Fragile blood-brain barrier
MEDICATIONS OF RISK

1. Antidepressants
2. Benzodiazepines
3. Antipsychotics
ANTIDEPRESSANTS

True of False?

• Antidepressants are a good solution for dementia.
• Patients will respond to antidepressants within 1-2 weeks.
• Long acting antidepressants are safer and more effective in older adults.
**ANTIDEPRESSANTS**

- **Serotonin:**
  - Influences mood & behavior &
  - Effects renal, immune, GI systems

- Effect multiple neurotransmitters

- May enhance other drugs (ie beta blockers, neuroleptics, benzos)
ANTIDEPRESSANTS

- Long ½ life (up to one week)
- Indications:
  - Depression, sleep disturbance, anorexia
- 3-6 months to recovery
- Recognizing relapse
ANTIDEPRESSANTS

Selective Serotonin Reuptake Inhibitors (SSRIs)

- Citalopram (Celexa)
- Fluvoxamine (Luvox)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Fluoxetine (Prozac)
ANTIDEPRESSANTS

Others

- Venlafaxine (Effexor)
- Bupropion (Wellbutrin)
- Tricyclic (Amitriptyline)
- Trazadone (Desyrel)
- Mirtazapine (Remeron)
Adverse Effects: Antidepressants

- Anticholinergic (↑ with older drugs)
- Cardiac
  - Orthostatic hypotension, tachycardia
- Cognitive/Neurological
  - Tremors
  - Hallucinations, delusions, suicidal ideation
  - Over sedation, agitation

Avoid Tricyclic Antidepressants:
Nortriptyline, desipramine, imipramine
BENZODIAZEPINES

True of False?

• Benzos are a first line treatment for older adults with aggressive behaviors.
• Long-acting benzos can be helpful in treating anxiety disorders.
• Physical dependence with benzos is not an issue with older patients.
BENZODIAZEPINES

- Indications: anxiety, procedures, ETOH withdrawal
- Prolonged ½ life with liver disease
- Produce physical dependence
- Abrupt stop → withdrawal
  - Anxiety, restlessness, seizures
  - ↑ delirium risk
BENZODIAZEPINES

LONG ACTING
- Diazepam (Valium)
- Clonazepam (Rivotril)

SHORT/INTERMEDIATE
- Lorazepam (Ativan)
- Oxazepam (Serax)
- Alprazolam (Xanax)
- Temazepam (Restoril)
ADVERSE EFFECTS

- Paradoxical* effects
  - Increased confusion, disinhibition, calling out, disrobing, striking out
- Impaired gait/balance
- Falls (safety)
- Sedation
- Memory impairment
- Anticholinergic effects
Anticholinergic Effects

**Definition**

Adverse symptoms due to blocking acetylcholine both inside & outside the brain

**Adverse Effects**

- Cognitive changes
- Psychosis/delirium
- Sedation
- Tachycardia
- Dry eyes/mouth
- Unsteady gait/falls
- Constipation
- Urinary incontinence, retention
- Dysphagia
PHARMACOKINETICS

True or False

- Malnourished older adults should receive the same dose of antipsychotic drugs as younger adults.
- Older adults who are dehydrated should receive their usual dose of antidepressant &/or antipsychotic medications.
- Antipsychotic drugs contribute to falls in older adults.
ALZHEIMER’S DISEASE

- Degenerative brain disease with loss of function, memory
- \( \downarrow \) release of neurochemicals
  - Acetylcholine, dopamine, GABA
- And the problem?
  - Block acetylcholine receptors in the brain
- Result?
  - Increased confusion, delirium, falls
ALZHEIMER’S DISEASE

Treating Alzheimer's Disease
ANTIPSYCHOTICS (NEUROLEPTICS)

Indications

Dementia & Delirium

- Treatment of agitation, aggression, hallucinations, sleep disturbance, psychosis
  2\textsuperscript{nd} to treatment (ie, steroids)
- Enhance effectiveness of other drugs (ie, antidepressants)

Mental Illness

- Treatment of psychosis (ie, bipolar disorder, psychosis, delusional depression)
EXTRAPYRAMIDAL SYMPTOMS (EPS)

DEFINITION

• Adverse symptoms due to blocking dopamine & other brain chemicals

• Symptoms similar to Parkinson’s Disease

SYMPTOMS

• Stiffness

• Shuffling

• Tremor

• Rigidity

• Restlessness

• Confusion

• Delirium
<table>
<thead>
<tr>
<th></th>
<th>Sedation</th>
<th>↓ BP</th>
<th>Anti-Cholinergic</th>
<th>EPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loxapine</td>
<td>Mod</td>
<td>Mild-Mod</td>
<td>Mild-Moderate</td>
<td>Mod</td>
</tr>
<tr>
<td>Nozinan</td>
<td>High</td>
<td>Mod-High</td>
<td>Mod</td>
<td>Mild-Mod</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Mild-Mod</td>
<td>Mild-Mod</td>
<td>None-Mild</td>
<td>Very Mild</td>
</tr>
<tr>
<td>Olanzepine</td>
<td>Mod</td>
<td>Mild-Mod</td>
<td>Mild-Moderate</td>
<td>Mild</td>
</tr>
<tr>
<td>Haldol</td>
<td>Mild</td>
<td>Mild</td>
<td>None?</td>
<td>High</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Mod</td>
<td>Mod</td>
<td>None-Mild</td>
<td>Mod</td>
</tr>
</tbody>
</table>
OTHER DRUGS

1. Anticonvulsants
   - Gabapentin, clonazepam
   - Indications: Aggression, anxiety, mania

2. Acuphase (Dopixol)
   - Blocks dopamine
   - Indications: Aggression, usually with dementia
     ✓ Rapid reduction of symptoms (lasts 2-3 days)

3. Opioids
   - Methadone, oxycodone
   - Indications: Agitation 2° pain and ? dementia
ADVERSE EVENTS & DEMENTIA

Combine dementia & antipsychotics and ↑ risk for:
- Stroke
- Pneumonia
- Death

Risk linked to Risperidone & Olanzepine
Warnings issued in Canada, UK, USA
Implication: Alternative approaches
Drug & Alcohol Dependence

- Involves 2 factors:
  - Physiological (need more to achieve desired effect)
  - Psychological (perceived need for drug)

- Common substances:
  - Alcohol, nicotine, benzos, opioids, OTC, marijuana, amphetamine, coffee

- High risk: delirium, seizures, elopement
Drug & Alcohol Dependence

Consider dependence:

- COPD
- Oral/esophageal cancer
- Pancreatitis
- Changes in liver enzymes

Plus

Geriatric syndrome:
- low mood, sleeplessness,
- Irritability, self neglect,
- malnutrition

Remember, alcoholism impacts all drugs metabolized by the liver
THE REAL CHALLENGE?

IS IT DRUGS, DISEASE, AGING or...?
IS THIS “NORMAL” AGING?

1. Orthostatic Hypotension
2. Falls
3. Movement Disorder
4. Impaired Cognition
5. Depression
6. Malnutrition
7. Incontinence/Retention
MEDICATION PRINCIPLES

GOAL

To enhance the health, cognition, function & quality of life for older adults while minimizing adverse effects of medications
MEDICATION PRINCIPLES

- Use the geriatric principle: **START LOW & GO SLOW!**
- New symptom? Check meds first!
- Recommend drug with lowest potential for adverse effects & ease of administration
- Anticipate & manage adverse effects
- Reassess drugs & dosages when:
  1. Renal function is impaired
  2. Two+ drugs metabolized by the liver
ASSESSING MEDS OF RISK

Questions to Consider:

- Indication: Why is this drug being used?
- Dose: Appropriate for patient’s age/health?
- Length of time: Too short/long?
- Monitoring: Ongoing assessment?
- Opinion of other professionals (MD/pharmacist) & family/caregivers?
ASSESSING MEDS OF RISK

- Simplify
  - Once daily, with meals, SR sometimes
  - Avoid injections when possible
- Support & educate patient, family, caregivers
- Adverse effects:
  - Reduce or D/C?
HOW CAN I HELP?

- Review medication history
  - Consult Beer’s List, PharmaNet, Med Rec
- Provide memory aids for discharge
  - Bubble pack, dosette
  - Charts, pictures
- Ensure readability
  - Language, literacy, font, glasses, hearing aid
MEDICATION SUPER CHALLENGE

- Chronic & acute illnesses
- Complex drug regimens
  - Polypharmacy; Medications of risk
- Patient preferences
- ↓ vision, hearing, dexterity, cognition
- Patient complexities
  - Trading/sharing medications
AGS BEERS CRITERIA FOR POTENTIALLY INAPPROPRIATE MEDICATION USE IN OLDER ADULTS

FROM THE AMERICAN GERIATRICS SOCIETY

This clinical tool, based on The AGS 2012 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (AGS 2012 Beers Criteria), has been developed to assist healthcare providers in improving medication safety in older adults. Our purpose is to inform clinical decision-making concerning the prescribing of medications for older adults in order to improve safety and quality of care.

Originally conceived of in 1991 by the late Mark Beers, MD, a geriatrician, the Beers Criteria catalogues medications that cause adverse drug events in older adults due to their pharmacologic properties and the physiologic changes of aging. In 2011, the AGS undertook an update of the criteria, assembling a team of experts and funding the development of the AGS 2012 Beers Criteria using an enhanced, evidence-based methodology. Each criterion is rated (quality of evidence and strength of evidence) using the American College of Physicians’ Guideline Grading System, which is based on the GRADE scheme developed by Guyatt et al.

The full document together with accompanying resources can be viewed online at www.americangeriatrics.org.

INTENDED USE

The goal of this clinical tool is to improve care of older adults by reducing their exposure to Potentially Inappropriate Medications (PIMs).

- This should be viewed as a guide for identifying medications for which the risks of use in older adults outweigh the benefits.
- These criteria are not meant to be applied in a punitive manner.
- This list is not meant to supersede clinical judgment or an individual patient’s values and needs. Prescribing and managing disease conditions should be individualized and involve shared decision-making.
- These criteria also underscore the importance of using a team approach to prescribing and the use of non-pharmacological clinical approaches and of having economic and organizational incentives for this type of model.

The criteria are not applicable in all circumstances (e.g., patient’s receiving palliative and hospice care). If a clinician is not able to find an alternative and chooses to continue to use a drug on this list in an individual patient, designation of the medication as potentially inappropriate can serve as a reminder for close monitoring so that the potential for an adverse drug effect can be incorporated into the medical record and prevented or detected early.

| TABLE 1: 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults |
| Organ System/Therapeutic Category/Drug(s) | Recommendation, Rationale, Quality of Evidence (QE) & Strength of Recommendation (SR) |
| Anticholinergics (excludes TCAs) | Avoid. |
| First-generation antihistamines (as single agent or as part of combination products) | Highly anticholinergic; clearance reduced with advanced age, and tolerance develops when used as hypnotic; increased risk of confusion, dry mouth, constipation, and other anticholinergic effects/toxicity. Use of diphenhydramine in special situations such as acute treatment of severe allergic reaction may be appropriate. QE = High (Hydroxyzine and Promethazine), Moderate (All others); SR = Strong |
| Brompheniramine | |
| Carboxinidine | |
| Chlorpheniramine | |
| Clemastine | |
| Cyproheptadine | |
| Dextromethorphan | |
| Deschlorpheniramine | |
| Diphenhydramine (oral) | |
| Doxylamine | |
| Dextroamphetamine | |
| Triprolidine | |
| Antiparkinson agents | Avoid. |
| Benztropine (oral) | Not recommended for prevention of extrapyramidal symptoms with antipsychotics; more effective agents available for treatment of Parkinson disease. QE = Moderate; SR = Strong |
| Trihexyphenidyl | |
| Antihistamines | Avoid. |
| Diphenhydramine, oral short-acting* (does not apply to the extended-release combination with aspirin) | Avoid. May cause orthostatic hypotension; more effective alternatives available; IV form acceptable for use in cardiac stress testing. QE = Moderate; SR = Strong |
| Ticlopidine* | Avoid. Safer, effective alternatives available. QE = Moderate; SR = Strong |
| Anti-infective | Nitrofurantoin | Avoid for long-term suppression; avoid in patients with CrCl <60 mL/min. Potential for pulmonary toxicity; safer alternatives available; lack of efficacy in patients with CrCl <60 mL/min due to inadequate drug concentration in the urine. QE = Moderate; SR = Strong |
| Cardiovascular | | |
| Alpha, blockers | Avoid use as an antihypertensive. |
| Alpha agonists | Avoid clonidine as a first-line antihypertensive. Avoid others as listed. |
| Antarrhythmic drugs (Class Ia, Ic, III) | Avoid antiarrhythmic drugs as first-line treatment of atrial fibrillation. |
| | Data suggest that rate control yields better balance of benefits and harms than rhythm control for most older adults. |
| | Amiodarone is associated with multiple toxicities, including thyroid disease, pulmonary disorders, and QT interval prolongation. QE = High; SR = Strong |
| | Avoid. |
| | Diphenhydramine is a potent negative inotrope and therefore may induce heart failure in older adults; strongly anticholinergic; other antiarrhythmic drugs preferred. QE = Low; SR = Strong |
| | Avoid in patients with permanent atrial fibrillation or heart failure. |
| | Worse outcomes have been reported in patients taking dronedarone who have permanent atrial fibrillation or heart failure. In general, rate control is preferred over rhythm control for atrial fibrillation. QE = Moderate; SR = Strong |
| | Digoxin >0.125 mg/day | Avoid. In heart failure, higher dosages associated with no additional benefit and may increase risk of toxicity; decreased renal clearance may increase risk of toxicity. QE = Moderate; SR = Strong |

Used with permission from the American Geriatrics Society; AGS Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (2012), www.americangeriatrics.org
<table>
<thead>
<tr>
<th>Organ System/Therapeutic Category/Drug(s)</th>
<th>Recommendation, Rationale, Quality of Evidence (QE) &amp; Strength of Recommendation (SR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nifedipine, immediate release*</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Potential for hypotension; risk of precipitating myocardial ischemia. QE = High; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Spironolactone &gt;25 mg/day</td>
<td>Avoid in patients with heart failure or with a CrCl &lt;30 ml/min.</td>
</tr>
<tr>
<td>In heart failure, the risk of hyperkalemia is higher in older adults if taking &gt;25 mg/day. QE = Moderate; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Central Nervous System</td>
<td></td>
</tr>
<tr>
<td>Tertiary TCAs, alone or in combination:</td>
<td></td>
</tr>
<tr>
<td>Amantadine</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Highly anticholinergic, sedating, and cause orthostatic hypotension; the safety profile of low-dose doxepin (≤6 mg/day) is comparable to that of placebo. QE = High; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Antipsychotics, first- (conventional) and second- (atypical) generation (see online for full list)</td>
<td>Avoid use for behavioral problems of dementia unless non-pharmacologic options have failed and patient is threat to self or others. Increased risk of cerebrovascular accident (stroke) and mortality in persons with dementia. QE = Moderate; SR = Strong</td>
</tr>
<tr>
<td>Haldol</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Highly anticholinergic and greater risk of QT-interval prolongation. QE = Moderate; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Amobarbital*</td>
<td>High rate of physical dependence; tolerance to sleep benefits; greater risk of overdose at low dosages. QE = High; SR = Strong</td>
</tr>
<tr>
<td>Butalbital</td>
<td>Highly anticholinergic, sedating, and cause orthostatic hypotension; the safety profile of low-dose doxepin (≤6 mg/day) is comparable to that of placebo. QE = High; SR = Strong</td>
</tr>
<tr>
<td>Mesoridazine</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Highly anticholinergic and greater risk of QT-interval prolongation. QE = Moderate; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Benzo diazepines</td>
<td>Avoid benzodiazepines (any type) for treatment of insomnia, agitation, or delirium.</td>
</tr>
<tr>
<td>Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents. In general, all benzodiazepines increase risk of cognitive impairment, delirium, falls, fractures, and motor vehicle accidents in older adults. May be appropriate for seizure disorders, rapid eye movement sleep disorders, benzodiazepine withdrawal, ethanol withdrawal, severe generalized anxiety disorder, periprocedural anesthesia, end-of-life care. QE = High; SR = Strong</td>
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<tr>
<td>Short- and intermediate-acting:</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>Tolerance occurs within 10 days and risk outweighs the benefits in light of overdose with doses only 3 times the recommended dose. QE = Low; SR = Strong</td>
</tr>
<tr>
<td>Clodizepoxide</td>
<td>High rate of physical dependence; very sedating. QE = Moderate; SR = Strong</td>
</tr>
<tr>
<td>Meprobamate</td>
<td>Avoid.</td>
</tr>
<tr>
<td>aronalactone (&gt;90 days)</td>
<td>Avoid chronic use (&gt;90 days)</td>
</tr>
<tr>
<td>Alcohol- and benzodiazepine-opioid agonists that have adverse effects similar to those of benzo diazepines in older adults (e.g., delirium, falls, fractures); minimal improvement in sleep latency and duration. QE = Moderate; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Ergot mesylates*</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Lack of efficacy. QE = High; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Androgens</td>
<td>Avoid unless indicated for moderate to severe hypogonadism.</td>
</tr>
<tr>
<td>Potential for cardiac problems and contraindicated in men with prostate cancer. QE = Moderate; SR = Weak</td>
<td></td>
</tr>
<tr>
<td>Desiccated thyroid</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Concerns about cardiac effects; safer alternatives available. QE = Low; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Estrogens with or without progestins</td>
<td>Avoid oral and topical patch. Topical vaginal cream: Acceptable to use low-dose intravaginal estrogen for the management of dyspareunia, lower urinary tract infections, and other vaginal symptoms. Evidence that vaginal estrogens for treatment of vaginal dryness is safe and effective in women with breast cancer, especially at doses of estradiol &lt;25 mcg twice weekly. QE = High (Oral and Patch), Moderate (Topical); SR = Strong (Oral and Patch), Weak (Topical)</td>
</tr>
<tr>
<td>Growth hormone</td>
<td>Avoid, except as hormone replacement following pituitary gland removal.</td>
</tr>
<tr>
<td>Effect on body composition is small and associated with edema, arthralgia, carpal tunnel syndrome, gynecomastia, impaired fasting glucose. QE = High; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Insulin, sliding scale</td>
<td>Avoid.</td>
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<tr>
<td>Higher risk of hypoglycemia without improvement in hyperglycemia management regardless of care setting. QE = Moderate; SR = Strong</td>
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</tr>
<tr>
<td>Megestrol</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Minimal effect on weight; increases risk of thrombotic events and possibly death in older adults. QE = Moderate; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Sulfonamides, long-duration</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Chlorpropamide</td>
<td>Chlorpropamide: prolonged half-life in older adults; can cause prolonged hypoglycemia; causes SIADH. And Glyburide: higher risk of severe prolonged hypoglycemia in older adults. QE = High; SR = Strong</td>
</tr>
<tr>
<td>Glyburide</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Metoclopramide</td>
<td>Avoid, unless for gastroparesis.</td>
</tr>
<tr>
<td>Can cause extrapyramidal effects including tardive dyskinesia; risk may be further increased in frail older adults. QE = Moderate; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Mineral oil, given orally</td>
<td>Avoid.</td>
</tr>
<tr>
<td>Potential for aspiration and adverse effects; safer alternatives available. QE = Moderate; SR = Strong</td>
<td></td>
</tr>
<tr>
<td>Trimethobenzamide</td>
<td>Avoid.</td>
</tr>
<tr>
<td>One of the least effective antihypertensive drugs; can cause extrapyramidal adverse effects. QE = Moderate; SR = Strong</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 1: 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults**

Used with permission from the American Geriatrics Society: AGS Updated Beers Criteria for Potentially Inappropriate Medication Use In Older Adults (2012), www.americangeriatrics.org
Table 1: 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

<table>
<thead>
<tr>
<th>Organ System/Therapeutic Category/Drug(s)</th>
<th>Recommendation, Rationale, Quality of Evidence (QE) &amp; Strength of Recommendation (SR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Medications</td>
<td>Avoid. Not an effective oral analgesic in dosages commonly used; may cause neurotoxicity; safer alternatives available. QE = High; SR = Strong</td>
</tr>
<tr>
<td>Non-COX-selective NSAIDs, oral</td>
<td>Avoid chronic use unless other alternatives are not effective and patient can take gastroprotective agent (proton pump inhibitor or misoprostol). Increases risk of GI bleeding/peptic ulcer disease in high-risk groups, including those &gt;75 years old or taking oral or parenteral corticosteroids, antiagulants, or antiplatelet agents. Use of proton pump inhibitor or misoprostol reduces but does not eliminate risk. Upper GI ulcers, gross bleeding, or perforation caused by NSAIDs occur in approximately 1% of patients treated for 3–6 months, and in about 2%–4% of patients treated for 1 year. These trends continue with longer duration of use. QE = Moderate; SR = Strong</td>
</tr>
<tr>
<td>Indomethacin, includes parenteral</td>
<td>Avoid. Increases risk of GI bleeding/peptic ulcer disease in high-risk groups (See Non-COX selective NSAIDs). Of all the NSAIDs, indomethacin has most adverse effects. QE = Moderate (Indomethacin), High (Ketorolac); SR = Strong</td>
</tr>
<tr>
<td>Pentazocine</td>
<td>Avoid. Opioid analgesic that causes CNS adverse effects, including confusion and hallucinations, more commonly than other narcotic drugs; is also a mixed agonist and antagonist; safer alternatives available. QE = Low; SR = Strong</td>
</tr>
<tr>
<td>Skeletal muscle relaxants</td>
<td>Avoid. Most muscle relaxants poorly tolerated by older adults, because of anticholinergic adverse effects, sedation, increased risk of fractures; effectiveness at dosages tolerated by older adults is questionable. QE = Moderate; SR = Strong</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Avoid due to adverse CNS effects. Avoid antipsychotics for behavioral problems of dementia unless non-pharmacologic options have failed and patient is a threat to themselves or others. Antipsychotics are associated with an increased risk of cerebrovascular accident (stroke) and mortality in persons with dementia. QE = High; SR = Strong</td>
</tr>
<tr>
<td>History of falls or fractures</td>
<td>Avoid unless safer alternatives are not available; avoid anticonvulsants except for seizure. Ability to produce ataxia, impaired psychomotor function, syncope, and additional falls; shorter-acting benzodiazepines are not safer than long-acting ones. QE = High; SR = Strong</td>
</tr>
</tbody>
</table>

Table 2: 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults Due to Drug-Drug or Drug-Syndrome Interactions That May Exacerbate the Disease or Syndrome

<table>
<thead>
<tr>
<th>Disease or Syndrome</th>
<th>Drug(s)</th>
<th>Recommendation, Rationale, Quality of Evidence (QE) &amp; Strength of Recommendation (SR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syncope</td>
<td>Acetylcholinesterase inhibitors (AChEIs)</td>
<td>Avoid. Increases risk of orthostatic hypotension or bradycardia. QE = High (Alpha blockers), Moderate (AChEIs, TCAs and antipsychotics); SR = Strong (AChEIs and TCAs), Weak (Alpha blockers and antipsychotics)</td>
</tr>
<tr>
<td>Delirium</td>
<td>All TCAs</td>
<td>Avoid. In older adults with or at high risk of delirium because of inducing or worsening delirium in older adults; if discontinuing drugs used chronically, taper to avoid withdrawal symptoms. QE = Moderate; SR = Strong</td>
</tr>
<tr>
<td>Dementia &amp; cognitive impairment</td>
<td>Anticholinergics (see online for full list)</td>
<td>Avoid. Anticholinergics increase risk for full list, except for quetiapine and clozapine</td>
</tr>
<tr>
<td>Parkinson's disease</td>
<td>All antipsychotics (see online publication for full list, except for quetiapine and clozapine)</td>
<td>Avoid. Dopamine receptor antagonists with potential to worsen parkinsonian symptoms. Quetiapine and clozapine appear to be less likely to precipitate worsening of Parkinson disease. QE = Moderate; SR = Strong</td>
</tr>
</tbody>
</table>

Used with permission from the American Geriatrics Society: AGS Updated Beers Criteria for Potentially Inappropriate Medication Use In Older Adults (2012), www.americangeriatrics.org
Table 2: 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults Due to Drug-Disease or Drug-Syndrome Interactions That May Exacerbate the Disease or Syndrome

<table>
<thead>
<tr>
<th>Disease or Syndrome</th>
<th>Drug(s)</th>
<th>Recommendation, Rationale, Quality of Evidence (QE) &amp; Strength of Recommendation (SR)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td></td>
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</tr>
<tr>
<td>Chronic constipation</td>
<td>Oral antimuscarinics for urinary incontinence</td>
<td>Avoid unless no other alternatives.</td>
</tr>
<tr>
<td></td>
<td>■ Darifenacin</td>
<td>QE = High (For Urinary Incontinence), Moderate/Low (All Others); SR = Strong</td>
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<tr>
<td></td>
<td>■ Fesoterodine</td>
<td></td>
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<tr>
<td></td>
<td>■ Oxybutynin (oral)</td>
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<tr>
<td></td>
<td>■ Solifenacin</td>
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<tr>
<td></td>
<td>■ Tolterodine</td>
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<tr>
<td></td>
<td>■ Tropium</td>
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<tr>
<td>Non-dihydropyridine CCB</td>
<td>Diltiazem</td>
<td></td>
</tr>
<tr>
<td>First-generation antihistamines as single agent or part of combination products</td>
<td>Verapamil</td>
<td></td>
</tr>
<tr>
<td>■ Brompheniramine (various)</td>
<td>■ Carboxinamide</td>
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<tr>
<td>■ Chlorpheniramine</td>
<td>■ Clemastine (various)</td>
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<tr>
<td>■ Cyproheptadine</td>
<td>■ Clidinium-chlordiazepoxide</td>
<td></td>
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<tr>
<td>■ Dextromethorphan</td>
<td>■ Chlorpheniramine (various)</td>
<td></td>
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<tr>
<td>■ Diphenhydramine</td>
<td>■ Doxyamine</td>
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<tr>
<td>■ Hydroxyzine</td>
<td>■ Promethazine</td>
<td></td>
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<tr>
<td>■ Triprolidine</td>
<td>■ Verapamil</td>
<td></td>
</tr>
<tr>
<td>Anticholinergics/antispasmodics (see online for full list of drugs with strong anticholinergic properties)</td>
<td>■ Antipsychotics</td>
<td></td>
</tr>
<tr>
<td>■ Belladonna alkaloids</td>
<td>■ Clidinium-chlordiazepoxide</td>
<td></td>
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<tr>
<td>■ Dicyclomine</td>
<td>■ Hyoscymine</td>
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<tr>
<td>■ Propantheline</td>
<td>■ Scopolamine</td>
<td></td>
</tr>
<tr>
<td>■ Tertiary TCAs (amitriptyline, clomipramine, doxepin, imipramine, and trimipramine)</td>
<td>■ Antipsychotics</td>
<td></td>
</tr>
<tr>
<td><strong>History of gastrointestinal ulcers</strong></td>
<td>■ Aspirin (&gt; 325 mg/day)</td>
<td>Avoid unless other alternatives are not effective and patient can take gastroprotective agent (proton-pump inhibitor or misoprostol).</td>
</tr>
<tr>
<td>Non-COX-2 selective NSAIDs</td>
<td>■ Carisoprodol</td>
<td>May exacerbate existing ulcers or cause new/additional ulcers.</td>
</tr>
<tr>
<td></td>
<td>■ Codeine</td>
<td>QE = Moderate; SR = Strong</td>
</tr>
<tr>
<td><strong>Kidney/Urinary Tract</strong></td>
<td>■ Diclofenac</td>
<td></td>
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<tr>
<td>Chronic kidney disease stages IV and V</td>
<td>■ Indomethacin</td>
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<tr>
<td>NSAIDs</td>
<td>■ Naproxen</td>
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<tr>
<td>Triamterene (alone or in combination)</td>
<td>■ Ketoprofen</td>
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<tr>
<td>■ Niflumic acid</td>
<td>■ Ketorolose</td>
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<td>■ Probenecid</td>
<td>■ Oxaprotil</td>
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<td>■ Sodium salicylate</td>
<td>■ Pentazocine</td>
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<td>■ Sulindac</td>
<td>■ Procainamide</td>
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<td>■ Tranexamime</td>
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<td>■ Tolmetin</td>
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<td>■ Tropisetan</td>
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<td>■ Indoprofen</td>
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GET Program DAY 3

Meeting the Challenges in Older Adults Care
# Day 3: Meeting the Challenges in Older Adults Care

**November 15, 2013**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830</td>
<td>Introduction</td>
</tr>
<tr>
<td>0900</td>
<td>Ethics Discussion with Bethan Everett, Ethicist VCH</td>
</tr>
<tr>
<td></td>
<td>• End of life care and tube feeding</td>
</tr>
<tr>
<td>1030</td>
<td>Break</td>
</tr>
<tr>
<td>1045</td>
<td>Pain in the Cognitively Impaired Older Adult</td>
</tr>
<tr>
<td>1145</td>
<td>Group Preparation Work for QI Presentation</td>
</tr>
<tr>
<td>1200</td>
<td>Lunch</td>
</tr>
<tr>
<td>1245</td>
<td>Quality Improvement Project Presentations</td>
</tr>
<tr>
<td>1445</td>
<td>The Palliative Approach with Pat Porterfield</td>
</tr>
<tr>
<td>1530</td>
<td>Course Wrap-up Questionnaire and Evaluation</td>
</tr>
</tbody>
</table>
Day 3: Meeting the Challenges in Older Adults Care  
November 15, 2013

Please indicate your level of agreement with the statements below:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The content was organized and easy to follow</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>The objectives were clearly identified</td>
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<td>Participation and interaction were encouraged</td>
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<tr>
<td>Questions and exchanges were encouraged</td>
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<tr>
<td>The material covered was relevant</td>
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<tr>
<td>The amount of time allowed to cover the material was sufficient</td>
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<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>The training session met my expectations</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Would you recommend this session to someone else?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>

See reverse
What did you find was the most helpful?

Any suggestions on what should be changed to improve the program.

Please use the area below for any additional comments:

Thank you for your feedbacks
OBJECTIVES

1. To identify 5 myths related to pain.
2. To discuss the challenges of pain assessment in older adults with cognitive/language impairment.
3. To apply concepts of pain assessment and management to older adults.
4. To utilize the Hierarchy of Pain Assessment Techniques for the assessment, management & evaluation of pain.
Myths about Pain

TRUE or FALSE?

• Pain is a normal part of aging.
• Pain perception decreases with aging.
• Distractible/inattentive/sleeping older patients are not in pain.
• Pain is often associated with behavior change in the cognitively impaired.
• Opioids cause addiction/respiratory arrest in older adults.
SUB-OPTIMAL PAIN MANAGEMENT: IMPLICATIONS for PATIENTS

- Inaccurate assessment
- Inadequate management
- Functional & cognitive decline
- Poor wound healing, delirium, impaired immune function, stress response, increased metabolic needs/fall risk

Adapted from: Hadjistavropoulos et al., 2007
SUB-OPTIMAL PAIN MANAGEMENT: BARRIERS to OPTIMAL CARE

• Social, language &/or cultural barriers
• Co-existing illnesses with different sources/conditions/presentations of pain (2+)
• *Variable* pain presentations/response to treatment
• Staff knowledge
• System obstacles
Background: Definitions of Pain

Whatever the patient says it is & occurs whenever the patient says it does

(McCaffery & Beebe, 1989)
# Background: Does Cognition Matter?

<table>
<thead>
<tr>
<th>Losses of Dementia</th>
<th>Demands of Pain Assessment</th>
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<tr>
<td>Memory gaps</td>
<td>Requires cognitive ability to:</td>
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<tr>
<td>Visual spatial deficits</td>
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<tr>
<td>Attention decline</td>
<td>• process the task</td>
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<td>Behavioral issues</td>
<td>• use short/long term memory &amp;</td>
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<td>Aphasia</td>
<td>• communicate pain experience</td>
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<td>Vision/hearing loss</td>
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Background:

The FACES of Pain

What is Pain?
An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (IASP, 1986)

What are the Types?
- Acute
- Persistent/chronic
- Nociceptive
- Neuropathic
Background: The FACES of Pain

Acute Pain

- **Defined:** Begins suddenly; secondary to tissue damage &/or inflammation such as surgery, procedure, or injury/trauma
- **Described:** Sharp in quality, radiating
- Usually associated with change in vital signs & emotional distress
- Usually time limited

Persistent/Chronic Pain

- **Defined:** Pain that continues for a longer period of time (3+ months)
- Influenced by environmental, emotional, cultural, spiritual & psychological factors.
- Usually no time limit
# Is There a Difference? Nociceptive & Neuropathic Pain

## Nociceptive Pain
- **Defined:** Pain produced in response to injury and/or inflammation & associated with tissue damage
- Produced 2° to acute (ie, angina) and chronic conditions (ie, arthritis, angina)
- **Described:** Diffuse, dull, aching, throbbing

## Neuropathic Pain
- **Defined:** Pain produced by damage to or dysfunction in the peripheral or CNS.
- Produced by radiation, carpal tunnel, post-stroke, diabetes, shingles.
- **Described:** Burning, tingling, feeling of coldness, electric shocks, shooting, stabbing
# Common Painful Conditions

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<td>Oral Hygiene/Disease</td>
<td>• <em>Refusing</em> to eat/drink; dull/sharp, gnawing</td>
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Adapted from: Miaskowski, 1999; Stein & Ferrell, 1996
# Behavioral Assessment of Pain: Creating a Picture

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<th>Category</th>
<th>Description</th>
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</thead>
</table>
| Facial expression                     | • Sad expression, frightened look; closed eyes  
• Rapid blinking; grimacing; any distorted expression |
| Vocalizations                         | • Sighing, moaning, groaning, noisy breathing  
• Verbally abusive; asking for help |
| Body movements                        | • Pacing, rocking; pushing away; restricted movements; guarding, rigid, tense posture             |
| Change in social interactions         | • Aggressive, combative; irritable; resisting care  
• Bed-seeking; withdrawn; ↑ pacing; rocking |
| Change in routines/activities         | • Change in gait, transfer, self-care; ↑ rest periods  
• Refusing food; change in sleep/routines |
| Change in mental status               | • Crying, ↑ confusion, irritable/easily distressed                                                |

Adapted from: American Geriatric Society, 2009
“FACES” of Pain

Acute Pain

Chronic Pain
Pain in Older Adults

Pain and Cognitive Impairment: Reading the Cues
Case Study #1

- **Mrs. S:** 89 year old female admitted after a fall at home with a # pelvic rami, facial lacerations/bruising
- **History:** Osteoarthritis, spinal stenosis, GI bleed, CHF, ADL decline over past 2 weeks
- **Meds:** Hydromorphone, tylenol, ramipril, lasix, ativan
- **Situation:** Forehead wrinkled, eyes tightly closed, yelling repeatedly “help, please help,” resistive to care, strikes out when approached
Geriatric Pain Assessment: Assumptions

• Accept the patient &/or family/caregiver’s word (verbal & nonverbal) about their pain.
• Older adults with cognitive/language impairment may not exhibit typical pain behaviors.
  – Consider a behavioral disturbance as pain-related until proven otherwise.
• Assume painful procedures/diseases cause pain.
• Set goals to reduce pain (acceptable level) & improve function & cognition.
Hierarchy of Pain Assessment Techniques

ASSESS
- Focus on present pain
- Involve the family
- Identify pain history
- Identify pain sources
- Use screening tools
- Observe behaviors

MAKE a NURSING DIAGNOSIS
- Acute pain due to ….
- Nonverbal pain indicators….
- Incident pain due to ….

DEVELOP PLAN
- Identify goals/outcomes
- Identify acceptable level of pain
- Recommend Analgesic Trial
- Use nonpharmacological approaches

IMPLEMENT PLAN

EVALUATE GOALS
- Interventions effective?
- Acceptable level?
- Verbal/nonverbal indicators
**NRS, VDS & FACES Pain Scales**

<table>
<thead>
<tr>
<th></th>
<th>NRS</th>
<th>VDS</th>
<th>FPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild Pain</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Moderate Pain</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Severe Pain</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Pain As Bad As It Could Be</td>
<td>10</td>
<td>10</td>
<td></td>
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**Figure.**
## Pain in Advanced Dementia (PAINAD)

<table>
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## Checklist of Nonverbal Pain Indicators (CNPI)

**Instructions:** Observe the patient for the following behaviors both at rest and during movement.

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<td><strong>3.</strong> Bracing (Clutching or holding onto furniture, equipment, or affected area during movement)</td>
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<td><strong>4.</strong> Restlessness (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)</td>
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<td><strong>5.</strong> Rubbing (Massaging affected area)</td>
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<td></td>
</tr>
<tr>
<td><strong>6.</strong> Vocal complaints: verbal (Words expressing discomfort or pain [e.g., &quot;ouch,&quot; &quot;that hurts&quot;]; cursing during movement; exclamations of protest [e.g., &quot;stop,&quot; &quot;that's enough&quot;] )</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Subtotal Scores**

**Total Score**
Case Study #2

• **Mr. C:** Admitted 4 weeks ago for CHF/renal insufficiency/fall with a # left wrist; unable to return home due to dementia; awaiting LTC in hospital

• **Meds:** Tylenol prn, nifedipine, lasix, metoclopramide

• **History:** Decline in ADLs over past 2 days; unable to bathe independently; bed seeking/refusing to mobilize, facial grimacing, irritable, seems more confused than usual

• Denies any pain/discomfort
Hierarchy of Pain Assessment Techniques

**When pain is not relieved: Advocate**

Use structured rationale to support treatment changes:

- Estimated intensity of pain
- Change in pain scores over past 24 hours
- Amount of regular & breakthrough/24 hours
- Patient’s acceptable level of pain
- Effect of unrelieved pain on patient
- Recommendations for specific changes/referral

Adapted from: McCaffery & Passero, 2011; WRHA, 2012
Principles for Geriatric Pain Management

- Use WHO Principle:
  - By the mouth (safest route)
  - By the clock (regular dosing)
  - By the ladder (step approach)
  - For the individual (renal/liver function, patient preferences)
- Provide PRNs for procedure-related (incident) pain
- Consider potential side effects
  - Constipation, drowsiness, nausea, CNS effects
Principles for Geriatric Pain Management

• Start low & go slow but give enough to make a difference
  ➢ Titrate upward to desired effect is reached

• Remember: If the analgesic trial appears ineffective, do not assume pain is not present
  ➢ Dose may need to be titrated upward before seeing an improvement in pain/discomfort indicators

Adapted from: Horgas & Yoon, 2008; VCH 2013, in press
World Health Organization (WHO) Analgesic Ladder
ANALGESIC TRIAL: Medication Ladder

• Acetaminophen
• Opioids
• Adjuvants:
  ➢ Anticonvulsants
  ➢ NSAIDs, Other

World Health Organization Analgesic Ladder
Medication Ladder: Acetaminophen

• Indications
  – Mild to moderate pain
  – Mechanism of action unclear

• Dose:
  – 4 gm/24 hours
  – Ceiling effect

• Little effect on cognition, gastric/renal function

Adapted from AGS, 2009; Kave et al., 2010
### Medication Ladder: Opioids: Selected Analgesics

<table>
<thead>
<tr>
<th>Indications</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild –</strong></td>
<td>• Morphine, Codeine*</td>
</tr>
<tr>
<td><strong>Moderate Pain</strong></td>
<td>• Tramadol/Tramacet*</td>
</tr>
<tr>
<td></td>
<td>• Hydromorphone</td>
</tr>
<tr>
<td></td>
<td>• Oxycodone*/Oxycontin (SR)</td>
</tr>
<tr>
<td></td>
<td>• Percocet (ceiling effect)</td>
</tr>
<tr>
<td></td>
<td>• Fentanyl</td>
</tr>
<tr>
<td></td>
<td>• Methadone</td>
</tr>
</tbody>
</table>

Adapted from AGS, 2009; Herr, 2006; Kave et al., 2010
Medication Ladder: Anticonvulsants

• **Indications**
  – Neuropathic pain
  – Trigeminal neuralgia, PVD, shingles

• **Example:**
  – Gabapentin (max: 3600 mgm/day)
  – Pregabalin (Lyrica)

Adapted from AGS, 2009; Kave et al., 2010
Medication Ladder: Other

**NSAIDs**
- Ibuprofen, Advil, Aleve, Ketorolac (Toradol)
- COX-2 Inhibitor- Celebrex
- GI upset/bleed, cognitive effects

**Calcitonin**
- Titrate dose upward
- Analgesic effect; GI upset

**Baclofen (Lioresal)**
- Relieves spasticity;
- CNS effects; caution with antipsychotics

Adapted from AGS, 2009; Kave, et al., 2010
Key Points

• Always suspect pain as a cause of a behavioral disturbance.
• Use pain scales/behavioral indicators to identify pain intensity/change from baseline.
• Collaborate with the patient, family/caregiver to identify an acceptable level of pain.
• Consider an Analgesic Trial to assess the presence of pain.
### Common Painful Diseases/Conditions

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Adapted from: Miaskowski, 1999; Stein & Ferrell, 1996
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Subtotal Scores

Total Score

**Scoring:**

Score a 0 if the behavior was not observed. Score a 1 if the behavior occurred even briefly during activity or at rest. The total number of indicators is summed for the behaviors observed at rest, with movement, and overall. There are *no clear cutoff scores* to indicate severity of pain; instead, the presence of any of the behaviors may be indicative of pain, warranting further investigation, treatment, and monitoring.

**Sources:**

Pain in Older Adults
Case Study: Mr. BW

Past History:
Stroke with aphasia; hypertension; chronic renal insufficiency; BPH, UTI

Medications:
Tylenol PRN, Advil PRN, atenolol, lasix, warfarin, Flomax, Citalopram

- Mr. BW is an 86 year old man, admitted from home after being found unresponsive by his wife.
- Wife cares for husband at home. They have 2 adult children who live in Ontario.
- Wife states that her husband has a history of strokes and “problems getting his words out” (aphasia) but can usually get around by himself without help.
- After falling at home three weeks ago, Mr. BW had a fracture (healing) of his right humerus and a T7 compression fracture. His right upper arm is still bruised and his right hand is swollen. He now needs help with bathing and dressing.
- Mr. BW has been incontinent for the past two weeks and has been increasingly restless, with worsening of aphasia.
- His wife tried to take him to the family doctor, but he refused to get in the car.
- Had one previous episode of unresponsiveness with admission to hospital.
Assessment

Mr. BW is awake and you begin a pain assessment. Denies pain but winces, moans and guards his right arm when he moves.

You try to obtain a self-report of pain with VAS, but Mr. BW is now inattentive and dozing.

Question

• What do you do now?
Assessment

You decide to do the CNPI-screens positive for pain.

Results: Facial-wincses; Vocal-moans; Bracing-guards right arm; Rubbing-none

Questions

• What information do you need now?
• What is your nursing diagnosis?
• What is included in the plan of care? What are the goals?
• How would you evaluate Mr. BW’s response to treatment?
• Which issues (ie, social, cultural, knowledge) pose barriers to pain management?
Pain in Older Adults Case Study

About the Patient:

• Mr. BW is an 86 year old man, admitted from home after being found unresponsive by his wife.
• Wife cares for husband at home. They have 2 adult children who live in Ontario.
• Wife states that her husband has a history of strokes and “problems getting his words out” (aphasia) but can usually get around by himself without help.
• After falling at home three weeks ago, Mr. BW had a fracture (healing) of his right humerus and a T7 compression fracture. His right upper arm is bruised and with right hand is swollen. Now needs help with bathing.
• Mr. BW has been incontinent for the past two weeks and has been increasingly restless, with worsening of aphasia.
• His wife tried to take him to the family doctor, but he refused to get in the car.
• One previous episode of unresponsiveness with admission to hospital.
Pain in Older Adults Case Study

Problems Reported by Wife:
1. Increasing restless, just prior to unresponsiveness. Worsening of aphasia
2. Unable to walk around the neighborhood. Refusing to wear a sling indoors/outdoors.
3. Unsure if husband is taking medications correctly

Past History:
• Stroke with aphasia; hypertension; chronic renal insufficiency; BPH, UTI

Medications:
• Tylenol PRN, Advil PRN, atenolol, lasix, warfarin, flomax, Citalopram

Questions:
1. What further information, related to points 1-3 above, do you need (ie, history of dementia, delirium, depression, previous pain/treatment)?
2. Is Mr. BW experiencing pain? Why?
Pain in Older Adults Case Study

Assessment:

• Mr. BW is awake and you begin a pain assessment. Denies pain but winces when his right arm is moved.

• You try to obtain a self-report of pain with VAS, but Mr. BW is now inattentive and dozing.

Question:

• What do you do now?
**Pain in Older Adults Case Study**

**Assessment:**
- You decide to do the CNPI-screens positive for pain

**Questions:**
- What information do you need now?
- What is your nursing diagnosis?
- What is included in the plan of care? What are the goals?
- How would you evaluate Mr. BS’s response to treatment?
- Which issues (ie, social, cultural, knowledge) pose barriers to pain management?
Hierarchy of Pain Assessment Techniques

A. Assessment/Identify Problems:

1. **Focus on the Present Pain/Elicit the Patient’s Self-Report**
   - Use simple yes/no questions (i.e. "Knee aches?", "Toes burn?") or to a numeric rating (NRS) or visual descriptor scale (VDS) with older patients
   - Ask the patient about the present pain rather than the history of pain. If the patient cannot understand the word ‘pain’, try other words such as ache, burn, hurt or discomfort.

2. **Involve the Family/Caregiver**
   - Ask family or caregivers whether the patient’s current behavior (e.g., calling out, restlessness) is a change from baseline.

3. **Identify Pain History**
   - Past pain history (i.e., trauma/falls, comfort measures, treatment effectiveness; impact of pain on sleep, mood, behavior, ADLs).
   - Location, quality, aggravating/relieving factors
   - Physiological indicators
   - Impact of current illness on pain
   - Pain experiences (i.e, meaning/distress caused by pain).

4. **Identify Sources of Pain/Discomfort**
   - Identify potential sources of acute/persistent/chronic/neuropathic pain.

5. **Use Pain Screening Tools in Patients with Mild to Moderate Cognitive/Language Impairment**
   - Combining self-report and physical assessment is the best source of data for verbal patients.
   - Three tools are: FACES-R or NRS or VDS.

6. **Observe Discomfort/Behavioral Indicators in Patients with Advanced Cognitive/Language Impairment**
   - Observe verbal/nonverbal discomfort or behavioral indicators and changes in functional ability that suggests pain. The three main pain indicators are:
     - Facial expressions, verbalizations/vocalizations and body movements.
   - Use a observational pain assessment tool (ie PAINAD, CNPI) to identify the presence of pain and to evaluate the effectiveness of treatment.

B. Develop a Problem Statement/Nursing Diagnosis

**Examples:**
- Acute pain (NRS 7/10) due to # right hip
- Nonverbal indicators of pain in both lower limbs due to diabetes as evidenced by calling out and hitting staff with movement.
- Incident pain with dressing change due to sacral wound as evidenced by facial expression and yelling during the procedure.
- Delirium due to unresolved pain, recent infection, sensory deprivation and environment change.
C. Develop/Implement a Plan of Care
Set comfort/function goals or acceptable level of pain with the patient/family/caregiver.

1. Recommend an Analgesic Trial
   - Collaborate with the physician/NP to initiate an Analgesic Trial to evaluate the presence of pain.
   - Based on the estimated intensity of pain, recommend a regularly scheduled non-opioid for mild to moderate pain plus an opioid for more severe pain.
   - If the analgesics reduce discomfort/behavioral indicators and relieve pain, it may be assumed that pain was the cause and the analgesic should be continued.
   - Notes:
     1. For neuropathic pain, recommend an anticonvulsant.
     2. Ensure that the patient receives PRN, or breakthrough, analgesic prior to procedures known to cause pain such as wound care, turning, transferring and mobilizing.
     3. If the analgesic trial appears ineffective, do not assume that pain is not present. The dose may need to be titrated upwards before seeing an improvement.

2. Implement Nonpharmacologic Approaches
   Examples of Nonpharmacologic Interventions:
   - Developing a positioning schedule
   - Assessing the need for therapeutic mattress and seating
   - Providing assistive devices to maintain participation in ADLs
   - Promoting adequate periods of rest during the day and sleep and night
   - Frequent reassurance and acknowledgement of suffering, as appropriate
   - Providing the patient/family with information about pain and what to expect
   - Using strategies that patient used successfully at home to relieve pain
   - Distraction, relaxation

   For patients with moderate to severe pain, provide pain medications in addition to non-pharmacologic interventions

D. Implement the Plan

E. Evaluate the Plan of Care
The effectiveness of analgesia is evaluated by:

1. NonVerbal Behavior Indicators
   The behavioral indicators (i.e. PAINAD, CNPI) and/or the family/caregiver report relief of pain.

2. Verbal Indicators
   The patient verbally expresses that:
   - their goals for comfort/function are attained, and
   - he/she is satisfied with the pain management plan and/or
   - FACES-R, NRS or VDS scores consistently demonstrates lower scores of pain intensity

Adapted from: Herr et al., 2006; Pasero & McCaffery, 2011
About the Patient:

- Mr. BW is an 86 year old man, admitted from home after being found unresponsive by his wife.
- Wife cares for husband at home. They have 2 adult children who live in Ontario.
- Wife states that her husband has a history of strokes and “problems getting his words out” (aphasia) but can usually get around by himself without help.
- After falling at home three weeks ago, Mr. BW had a fracture (healing) of his right humerus and a T7 compression fracture. His right upper arm is bruised and with right hand is swollen. Now needs help with bathing.
- Mr. BW has been incontinent for the past two weeks and has been increasingly restless, with worsening of aphasia.
- His wife tried to take him to the family doctor, but he refused to get in the car.
- One previous episode of unresponsiveness with admission to hospital

Problems Reported by Wife:

1. Increasing restless, just prior to unresponsiveness. Worsening of aphasia
2. Unable to walk around the neighborhood. Refusing to wear a sling indoors/outdoors.
3. Unsure if husband is taking medications correctly

Past History:

- Stroke with aphasia; hypertension; chronic renal insufficiency; BPH, UTI

Medications:

Tylenol PRN, Advil PRN, atenolol, lasix, warfarin, flomax, Citalopram

Questions:

1. What further information, related to points 1-3 above, do you need (ie, history of dementia, delirium, depression, previous pain/treatment)?
2. Is Mr. BW experiencing pain? Why?

Assessment:

- Mr. BW is awake and you begin a pain assessment. Denies pain but winces when his right arm is moved.
- You try to obtain a self-report of pain with VAS, but Mr. BW is now inattentive and dozing.

Question:

What do you do now?

Assessment:

- You decide to do the CNPI-screens positive for pain

Questions:

- What information do you need now?
- What is your nursing diagnosis?
- What is included in the plan of care? What are the goals?
- How would you evaluate Mr. BW’s response to treatment?
- Which issues (ie, social, cultural, knowledge) pose barriers to pain management?
References & Resources:
Pain in the Older Adult with Cognitive/Language Impairment


Arnstein, P. (2010). Assessment of nociceptive versus neuropathic pain in older adults, Try This: Best practices in nursing care to older adults, SP1. Available at: Geriatric Nursing Resources for Care of Older Adults


Flaherty, E. (2007). Pain in Older Adults, Try This: Best practices in nursing care to older adults, Z. Available at: Geriatric Nursing Resources for Care of Older Adults


Horgas, A. L. (2007). Assessing pain in older adults with dementia, Try This: Best practices in nursing care to older adults, D2. Available at: Geriatric Nursing Resources for Care of Older Adults

McLennon, S. M. (2008). Persistent pain management. In M. G. Titler (Series Ed.). *Series on evidence-based practice guidelines for older adults*. Iowa City, IA: University of Iowa College of Nursing Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core. Available at: [Evidence-Based Practice Guidelines](#).


Winnipeg Regional Health Authority (2012). *Pain Assessment and Management: Clinical Practice Guidelines*. Available at: [Pain Assessment & Management](#).

**Website Resources:**
- Canadian Pain Society
- City of Hope: Pain Resource Center
- Geriatric Pain Resources
- Hartford Institute for Geriatric Nursing
- International Association for the Study of Pain
- National Nursing Home Survey
- Pain Assessment and Management (Winnipeg Regional Health Authority)
- Pain BC
- Registered Nurses Association of Ontario

M. Shaw
GET Program, November 15, 2013
Food for Thought
What ethical considerations should be taken into account when offering feeding tubes?

JS was an eighty two year old female who lived in a care home for several years. She had a history of dysphagia and psychotic depressions (e.g. heard voices that said she was a “terrible mother and didn’t deserve to have children”). Despite multiple admissions to acute care over the past 10 years and although it was recorded that the patient had refused a feeding tube because it was “unnatural”, there was no record of a reassessment of her wishes and a competency assessment. Although Js’ daughter had POA, there was no Advance Directive or Representation Agreement.

JS’ daughter has severe anxiety and other mental health issues but nothing that would disqualify her from acting as her mother’s temporary substitute decision maker. Their relationship was described by social work as “strained”. It was difficult for both physicians, nurses, and allied health to form a therapeutic relationship with the daughter and it was not clear if she understood her mother’s wishes.

At one point, the care home called outreach psychiatry to assess JS’s mental health as she was clearly having delusions as well as dysphagia with severe coughing. However, JS would not go to hospital. JS was then certified under the Mental Health Act and admitted to a geriatric mental health centre as a no code which accorded with the care facility’s level of intervention. JS had a severe choking episode with severe respiratory distress. The Critical Care Outreach Team attended and then called a Code Blue and patient was admitted to ICU where a tube feeding was inserted. It is not know who consented to the tube or if it was part of routine care.

Two weeks later, the patient was transferred to the ward as a no code, no intubation and no readmission to ICU. A large number of antipsychotic medications were ordered to try to control delirium and psychosis. JS’ feeding tube accidentally got pulled out and RNs were unable to reinsert. The following day a GJ tube was inserted after nutritional/dysphagia assessment, trial PO and unsuccessful attempts to insert Entriflex. It is not known who gave consent for this.

Two days later, the patient, who was normally withdrawn, became increasingly agitated, confused and remained up all night restless in her wheelchair. When JS became aggressive, restraints were put in place despite the ward’s least restraint policy. Many medical assessments and interventions occurred, including consideration of ECT. The goal in the chart remained “to get patient to care home by the end of this week”. There was no plan for end of life care.

That night the patient began vomiting and RT was called to do deep suctioning which JS resisted. JS slowly lost consciousness and died within the next 4 hours with the nurses present. Because end-of-life care was not addressed, the physician was called to pronounce death.

Recommendations:
1. Emphasize clinician understanding of and responding to the patient’s wishes
2. Appreciate the importance of Advance Directives and how they can be used to provide care especially at the end-of-life
3. Establish unit-based guidelines for initiating, implementing and stopping tube feeds
4. Emphasize the team/family meeting and goals of care prior to starting tube feeds
5. Improve understanding of older adult mental health in acute care

Brown Bag Ethics Discussion Sept 24, 2013
INTRODUCTION

Eating and drinking by mouth are sometimes difficult or impossible due to a person’s medical condition.

Tube feeding is a common form of support in such situations. It can be used as a short term measure, where the expectation is that the patient will be able to survive without it in the future. Tube feeding may also be used as a long term, life-sustaining measure, where there is no expectation that the patient will ever be independent of it.

Decisions about providing, withholding or withdrawing tube feeding are ethically significant and sensitive:

- Providing food and fluids to another in need is commonly taken for granted as basic human care. In light of this, tube feeding may be regarded by some as not a “medical treatment” in the usual sense of that term. Thus, depending on one’s values and beliefs, tube feeding may be viewed as a life-sustaining medical intervention, basic humane care, or an accommodation to disability. (reference 1)

- Tube feeding can be a benefit to the patient. It may also be associated with poor survival and significant health complications. (reference 2) Sometimes it is of no benefit and may cause harm e.g. patients with end-stage organ failure or end-stage metastatic cancer. Medical information and values of patients (including clients and residents), families and health care providers are relevant to decision making.

- When health conditions are chronic and/or degenerative, situations are often complex and distressing. While tube feeding is a regular part of work in health care settings, it is probably being faced for the first time by any given patient or family. Patients (including clients and residents) and families may struggle to understand complicated medical information and have difficulty accepting the possibility that they or their loved one is declining or dying. Health care providers may face conflicts in values with patients/families or between themselves in determining the most appropriate feeding options.

In light of these factors, it is important that:

- Consideration be given to who the most appropriate person(s) is to make the decision and who needs to be informed and consulted about the decision making process.

- All involved in a specific decision regarding tube feeding are given time to understand these various perspectives.

- Decisions concerning feeding should be made on an individual basis.

- There must be very good ethical reasons for withholding or withdrawing food and fluids. When uncertain, one should always choose to maintain a human life and then seek further clarification.

- When conflicts about feeding decisions cannot be resolved, consideration should be given to involving the VCH Ethics Service.
DETERMINING APPROPRIATE FEEDING OPTIONS  
(See the VCH Clinical Ethics Decision Making Framework)

1. CAPABLE PATIENTS  
The fully informed, voluntary, capable patient’s decision about tube feeding should be respected (principle of autonomy).

It is important to be as certain as possible concerning the patient’s capability, comprehension of information, and voluntariness (i.e. informed consent). Special attention should be paid to conditions such as depression, which may be treatable.

2. INCAPABLE PATIENTS  
If there is an Advance Directive as per the September, 2011 legislation, it should be honored in accord with this legislation.

When the patient being offered the option of tube feeding is not capable and there is no advance directive, the decision should made by their substitute decision-maker (SDM) (principle of autonomy) in consultation with the health care team.

a. When the SDM knows the wishes and/or values (possibly by means of a Representation Agreement) of the now incapable patient he/she should ask the question, “If this patient could speak for her/himself, what would s/he choose?”

b. When a patient is not capable, and their wishes/values are not known, the principle of beneficence or well-being comes more prominently into play and a decision should be based on the “best interests” of the patient. This usually involves a determination of what a reasonable person in the patient’s position would want.

What is regarded as “best interests” or “reasonable” is shaped by a person’s basic beliefs and values. Therefore, in an effort to honor as much as possible the patient’s autonomy, it is important to find out as much as possible about the patient’s worldview (beliefs and values) by consulting with those who know the patient and/or her/his culture, religion and/or spiritual beliefs. Then ask, “From that perspective what is seen as “reasonable”?

In addition, there are two conditions that are widely recognized as ethically valid considerations for assessing what is in a patient’s best interests:

- Whether or not the patient is in an irreversible final stage of dying, and tube feeding would only prolong the dying.
- Whether or not the patient’s condition and/or prognosis has reached the point when it will be a struggle to cope with the tube feeding. This involves weighing the benefits and burdens of the tube feeding. (principles of beneficence and nonmaleficence)

It is important that the SDM is fully informed. Health care providers should meet with the SDM to discuss all aspects of the patient’s situation and care. Good communication requires trust and respect (virtues) among those involved.
To help ensure that the decision of the patient or SDM is truly a voluntary one, health care providers should be aware of power dynamics in families and of the discrepancy in power that typically exists between health care providers and patients and families.

Families and health care providers often fear that withholding or withdrawing tube feeding will cause the patient discomfort or pain. They should be informed that there is a growing body of literature to support the view that any discomfort as a result of withholding or withdrawing foods and fluids can be successfully treated. (reference 3) Benefits and burdens (for example decreased alertness/arousal) would be reviewed.

Families may need assurance that a decision to withhold or withdraw tube feeding does not imply withholding care and that appropriate comfort measures will always be available.

3. **INTENT OF DECISION**

If the aim (e.g. reduce suffering or removing an intervention that is prolonging the dying process) is the same, there is no ethical difference between withholding versus withdrawing food and fluids or any life-sustaining treatment. It is important for health care providers to understand that the intent of a decision or action is not to cause death although death may be a foreseeable outcome.

4. **ADDITIONAL CONSIDERATIONS**

A sound ethical decision must be based on an understanding of the patient’s diagnosis, prognosis, condition, and expressed or inferred preferences, personal values and beliefs. A careful work-up assembling this information and any other contextual features relevant to the decision should be made. (The grid below may be helpful in collecting this information.) It is beneficial to start these conversations early as families often need time to think through alternatives and may want to consult others.

5. **GOALS AND DOCUMENTATION**

When tube feeding is initiated, clear goals should be documented and a review time and evaluation date set. The process of setting and evaluating the achievement of goals should continue as long as tube feeding remains in place. There should be full documentation of goals and review times in the patient’s chart.

**PROCESS FOR ETHICAL DECISION MAKING REGARDING FEEDING OPTIONS**

A family/team meeting should be held to:

1. Identify the issue of concern. What is the ethical issue? Why is there difficulty coming to a decision? Would the input of an ethicist or ethics committee be helpful?

2. Gather pertinent information from all relevant sources (may include patient, family/decision-maker, supports chosen by the patient, attending physician, family physician, nurses, social worker, dietician, gastroenterologist, ethicist, physiotherapist, occupational therapist, speech-language pathologist, spiritual care, interpreter, risk management).
The following grid is a useful tool to gather and clarify important considerations.

<table>
<thead>
<tr>
<th>Clinical Information</th>
<th>Patient’s Goals and Preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the patient’s medical status, overall and as related to feeding?</td>
<td>• What is the patient’s/decision-maker’s understanding of the situation? Do they understand potential benefits and risks?</td>
</tr>
<tr>
<td>• What is oral intake status?</td>
<td>• What is the patient’s choice?</td>
</tr>
<tr>
<td>• What is the result of the swallowing assessment?</td>
<td>• What are the patient’s values, hopes, and goals?</td>
</tr>
<tr>
<td>• Is the problem acute? chronic? critical? emergent? reversible?</td>
<td>• If the patient lacks decision-making capacity, who is the decision-maker for the patient and do they know the patient’s previously expressed preferences about tube feeding or other medical interventions?</td>
</tr>
<tr>
<td>• What are the potential benefits and disadvantages of tube feeding?</td>
<td>• If the patient’s wishes are not known, what would others from similar backgrounds and in similar situations generally prefer?</td>
</tr>
<tr>
<td>• What is the usual experience of patients in similar conditions?</td>
<td></td>
</tr>
<tr>
<td>• Will tube feeding likely be temporary or long term?</td>
<td></td>
</tr>
<tr>
<td>• What are the plans if tube feeding does not provide the desired benefits?</td>
<td></td>
</tr>
<tr>
<td>• What is the patient’s prognosis with and without tube feeding?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>View of Life</th>
<th>Contextual Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How does the patient view his/her current life?</td>
<td>• Are there family issues, past medical experiences, religious beliefs, financial considerations, or cultural factors that may influence the patient’s/decision-maker’s preference?</td>
</tr>
<tr>
<td>• What gives/gave the patient enjoyment and meaning in their life?</td>
<td>• What are the patient’s/decision-maker’s previous experiences with medical interventions, hospitalization, and death of loved ones?</td>
</tr>
<tr>
<td>• What are the prospects, given various feeding options, of being able to continue with these?</td>
<td>• Are there resource limitations or facility constraints with certain options?</td>
</tr>
<tr>
<td>• What physical, mental, and social challenges is the patient likely to experience with tube feeding?</td>
<td>• Do any of the options impact discharge possibilities?</td>
</tr>
<tr>
<td>• How does the patient evaluate this potential life?</td>
<td>• Is there moral distress among any health care providers and, if so, how is it managed?</td>
</tr>
<tr>
<td>• Does the patient have past experiences that may help guide this decision?</td>
<td></td>
</tr>
<tr>
<td>• Are there biases or previous experiences that might affect the decision-maker’s/health care providers’ decision?</td>
<td></td>
</tr>
</tbody>
</table>

3. Identify and be aware of health care providers’ personal values, biases, self-interest, and stressors that may impact a decision.

4. Exhibit kindness, caring, patience, and courage and seek common ground.

5. Identify all options. Be creative and tailor the options to the patient’s particular circumstances.
6. Evaluate the various alternatives considering: the patient's choices, values, and beliefs; the best interests of the patient; the patient's contextual factors.


ACKNOWLEDGEMENTS WITH THANKS:
Much of this framework has been derived, with modifications, from 1) Vancouver Coastal Health Guidelines Concerning the Delivery of Food and Fluids by Artificial Means (July, 2001) and 2) Providence Health Care Ethical Decision Making Framework for Feeding Options (http://www.providencehealthcare.org/ethics_services/resources.html, June 25, 2012)

REFERENCES


ADDITIONAL RELEVANT RESOURCES
VCH Consent Guidelines CA_1000, Clinical Administrative, November 8, 2004
VCH Ethical Decision-making Framework (March 2012)
Resolution of Disputes about Demands for Care that is not offered. VCH Risk Management Bulletin Issued: November 12, 2004
Resolution of Objections to Decisions made by Authorized Substitute Decision Makers. VCH Risk Management Bulletin Issued: November 12, 2004 (From VCH Guidelines to Special Consent Situations)

VCH Ethics Service (April 9, 2013): Terry Anderson, Bethan Everett, Jenny Young
APPROVED BY VCH ETHICS SERVICE REGIONAL COUNCIL: April 18, 2013
REVISED: May 30, 2013
GET Program DAY 4

Celebrating Learning
## Geriatric Education & Training Program
### Course Schedule

**Day 4: Celebrating Learning**  
**December 10, 2013**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830</td>
<td>Focus Groups</td>
</tr>
<tr>
<td>0930</td>
<td>Break</td>
</tr>
<tr>
<td>1000</td>
<td>Panel discussion:</td>
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<tr>
<td></td>
<td>&quot;Ready or Not: Providing Person-Centered Care for Older Adults in Acute Care&quot; with</td>
</tr>
<tr>
<td></td>
<td>Dr. Alison Phinney, Associate Professor, UBC School of Nursing</td>
</tr>
<tr>
<td></td>
<td>Dr. Sandra Lauck, Clinical Nurse Specialist, The Heart Centre, St. Pauls' Hospital</td>
</tr>
<tr>
<td></td>
<td>Mrs. Mary Kjorven, Clinical Nurse Specialist, Specialized Geriatric Program,</td>
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<tr>
<td></td>
<td>Interior Health BC</td>
</tr>
<tr>
<td>1115</td>
<td>Presentation of GET Program Certificates of Completion</td>
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</tbody>
</table>
GET Program

OTHER RESOURCES

Summary of Educational Strategies
IMPLEMENTING THE GET PROGRAM: A TOOLKIT FOR EDUCATORS
Content

Toolkit for educators.................................................................................................................................................. 2

1. Geriatric content: Relevant online references for guidelines and best practices .................................................. 2

2. Selecting your educational strategies .................................................................................................................. 2

Table 1: Active Learning Strategies .......................................................................................................................... 3

Table 2: Suggestions of implementation strategies for case studies ........................................................................ 5

Table 3: Passive Learning Strategies ........................................................................................................................ 7

References ................................................................................................................................................................. 8
Toolkit for educators

1. Geriatric content: Relevant online references for guidelines and best practices

   - Senior Friendly Hospital Promising Practices (Ontario, Canada): http://seniorfriendlyhospitals.ca/processes/processes-care
   - Geriatric Emergency Management Network (Ontario, Canada) The Regional Geriatric Program Of Toronto: http://gem.rgp.toronto.on.ca/
   - RNAO –Best Practice Guidelines (Ontario, Canada): http://rnao.ca/bpg
   - GeriRN The Hartford Institute for Geriatric Nursing (US): http://consultgerrn.org/

2. Selecting your educational strategies

   - A list of educational strategies is presented below to help educators chose the methods which will best suit their audience, their resources and the content they wish to communicate. The choice of strategies will vary according to the needs of the participants and their level of expertise.
Not all educational strategies are presented as we believe some are less suitable for this curriculum (e.g., problem-based learning, simulation, mentoring etc.). In determining your approach, many suggest a key consideration is the use of interactive strategies or a combination of strategies. The table below provides some example of how strategies can match specific learning needs.

**Educational strategies and expected learning outcomes**

The first table presents a list of active learning strategies: These teaching modalities are called active as they illicit learner’s participation. In general, these approaches are more likely to stimulate critical thinking than passive strategies.

### Table 1: Active Learning Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Learning objectives</th>
<th>Notes</th>
<th>Advantages and disadvantages</th>
</tr>
</thead>
</table>
| **Case studies** 5,7 | - Critical thinking  
- Clinical judgment  
- Decision making  
- Understanding of complex situations  
- Ability to recognize abnormal/changing situation  
- Identification of appropriate action and interventions  
- Problem solving skills | - Requires support and feedback  
- May become frustrating for nurses who are more used to traditional methods  
- More likely to lead to behavior change  
- Case studies can be presented in various ways depending on time available (see Table 2 for more details) | - Constructing case studies may be time consuming                     |
| **Debate or buzz sessions** 2,3,5,7 | - Analytical skills  
- Judgment  
- Reasoning  
- Ability to construct and present | - Ideal to address topics for which there could be multiple perspectives or that rise ethical dilemmas  
- Debate may be “artificially provoked” | - Learning is not limited to identifying issues, but forces one to examine different perspectives |
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Learning objectives</th>
<th>Notes</th>
<th>Advantages and disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>an argument</td>
<td></td>
<td>Need to allow sufficient time</td>
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<tr>
<td></td>
<td>▪ Communication skills</td>
<td>(assigned position), forcing people to</td>
<td>for preparation for an</td>
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<td></td>
<td></td>
<td></td>
<td>consider a different viewpoint</td>
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<td>A synthesis is done by the facilitator</td>
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<td></td>
<td></td>
<td></td>
<td>following the debate.</td>
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<td></td>
<td><strong>Buzz session:</strong> multiple groups discussing an</td>
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<td></td>
<td>issue/question and all present the result of</td>
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<td>their discussion (eg. of clear concise</td>
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<td></td>
<td>question: “agree on one advantage or</td>
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<td>disadvantage of...”)</td>
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<tr>
<td></td>
<td>▪ Communication skills</td>
<td></td>
<td>Can meet the diverse needs of</td>
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<tr>
<td></td>
<td>▪ Problem solving skills</td>
<td></td>
<td>nurses with various backgrounds and levels of</td>
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<tr>
<td></td>
<td>▪ Critical thinking</td>
<td></td>
<td>experience</td>
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<tr>
<td></td>
<td>▪ Decision making</td>
<td></td>
<td>Immediate feedback</td>
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<td></td>
<td></td>
<td></td>
<td>Less threatening environment</td>
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<tr>
<td></td>
<td>Structure “Brief, run and debrief “:</td>
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<td>Can meet the diverse needs of</td>
</tr>
<tr>
<td></td>
<td>- Develop a brief outline of a scenario and</td>
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<td>nurses with various</td>
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<tr>
<td></td>
<td>- May include an observer for feedback and</td>
<td></td>
<td>backgrounds and levels of</td>
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<tr>
<td></td>
<td>- May give the impression of “not being the real thing” or frustrating for nurses who are more used to traditional methods</td>
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<tr>
<td></td>
<td>- The safe environment allows to experience ethically sensitive situations</td>
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</tr>
</tbody>
</table>

**Role play** 4, 5, 7

| | | | |
| | Communication skills | Structure “Brief, run and debrief “: | Can meet the diverse needs of nurses with various backgrounds and levels of experience |
| | Problem solving skills | - Develop a brief outline of a scenario and assign roles. | Immediate feedback |
| | Critical thinking | - May include an observer for feedback and analysis | Less threatening environment |
| | Decision making | - May give the impression of “not being the real thing” or frustrating for nurses who are more used to traditional methods | |
Table 2 has been developed in the context of the GET Program case study module. The table presents various ways of presenting case studies in a classroom context. Even though this was developed for the case studies component of the program, the information provided below could be applicable to other educational strategies such as role play.

**Table 2: Suggestions of implementation strategies for case studies**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Process</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| **Instructor led case study** | Class process/discussion | - Allows instructor to demonstrate the nursing process that needs to take place  
- Serves as an exemplar/guiding process for subsequent case studies  
- Allows to draw emphasis on most important points/concepts | - May be less challenging for more experienced nurses  
- Participants may feel less engaged |
| **Small groups** | | - Depending on the group size, ensures a more active participation from all participants  
- Allow participants to discuss and debate ideas in smaller group, which might be less intimidating | - Requires more resources:  
- Time: participant-led process could be more time consuming  
- Facilitator: depending on the number of participants, may require more than one facilitator to assist the reflection process of all groups |
| **Groups work on same case(s)** | Review in class discussion | - Everyone is exposed to the same new knowledge  
- Allow rich exchange among participants  
- Allows learning from other participants  
- Allows to cover more cases in less time | - Less cases (and therefore content) covered |
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Process</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups work on different cases</td>
<td>With group presentations</td>
<td>- Provides an opportunity for feedback and exchanges</td>
<td>- More time consuming</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Allows all participants to hear the feedbacks and nursing process for all</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>cases without them working on all cases</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Serves the purpose of having participants organizing and verbalizing their</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>nursing process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Without presentations</td>
<td>- Less time consuming</td>
<td>- May not allow proper feedback period</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- All participants are not exposed to same learning process and knowledge</td>
</tr>
</tbody>
</table>
The next table (Table 3) presents a short list of passive learning strategies. These strategies have the advantage of facilitating the acquisition of new ideas and knowledge. Despite the negative connotation that could be associated with the strategies referred to as “passive”, they are by no means less valuable than active strategies. Again selecting a strategy will vary according to the content, the instructor and the learners.

Table 3: Passive Learning Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Learning objective</th>
<th>Notes</th>
<th>Advantages and disadvantages</th>
</tr>
</thead>
</table>
| Traditional lectures | Knowledge development | To make the knowledge more context specific, it may include a component to familiarize themselves with the organization’s existing internal resources | Preparation from instructor may be time consuming  
Time efficient for covering content  
Allows the educator to control the content  
Can be used to clarify complex or conflicting information  
Students may feel less involved if the knowledge is easy to understand and readily available somewhere else |
| Free Web-based resources | Knowledge development | Respects individual needs and rhythm  
Requires self-motivation  
Examples: try this series, RNAO, GNEC webinars | Inexpensive  
Easily accessible  
Flexible  
Can be used by students independently |
<p>| Video              | Maybe presented in classroom or sent via | | Inexpensive |</p>
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Learning objective</th>
<th>Notes</th>
<th>Advantages and disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>email</td>
<td></td>
<td>▪ Technology required for in-class projection</td>
<td>▪ Easily accessible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ May be used to support learning experience when used in classroom context</td>
<td></td>
</tr>
<tr>
<td>Email and social media</td>
<td></td>
<td>▪ Maybe used to send references to publication, online material</td>
<td>▪ Keep participants engaged outside of class time</td>
</tr>
</tbody>
</table>