LPN CERTIFICATION PREP COURSE

Class #3 Alzheimer's, Dementia, Falls, Incidents, Abuse

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OBJECTIVES

- List the various types of Dementia.
- Outline the Process for Incidents and Accidents.

DISCLOSURE STATEMENT

- **This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91) 2022-0000000716 Approval valid 2 years from Dec.19, 2022. Expires on Dec. 19, 2024.**

ALZHEIMER'S VS DEMENTIA

- **In the medical world, the terms "Alzheimer's" and "dementia" are often thrown around, often interchangeably. However, they refer to two different things: one of them being more a category, the other being a specific disease.**
- **While many of the symptoms, including memory loss and confusion, can occur in dementia diseases as well as Alzheimer's, there are some differences. Knowing what they are can help doctors properly diagnose the problem and administer any available treatments.**
- **Dementia Isn't a Disease**
- **According to Healthline, dementia is a syndrome, unlike its counterpart Alzheimer's, which is a disease. A syndrome, notes the source, is when a symptom doesn't lead to a specific diagnosis. It continues with "Dementia is an overall term used to describe symptoms that impact memory, performance of daily activities, and communication abilities,".**

ALZHEIMER'S VS DEMENTIA (Cont'd)

- **The site acknowledges that symptoms can "overlap," but it's important to treat them as separate entities to best address them medically and otherwise. Both young and elderly people can develop either dementia or Alzheimer's (although the latter is more common in older adults.**
- **While Alzheimer's actually falls under the dementia umbrella, the Alzheimer's Association in Chicago notes there's something called "mixed dementia," which is when "abnormalities linked to more than one cause of dementia occur simultaneously in the brain."**
- **The source notes that studies have shown this may occur more than previously thought. This mixed version often involves Alzheimer's along with what's known as vascular dementia, which was once known as "post-stroke" dementia and is characterized by impaired judgment and difficulty organizing (as opposed to memory loss).**

ALZHEIMER'S VS DEMENTIA (Cont'd)

- **While Alzheimer's is a disease unto itself, dementia symptoms could result from other diseases, notes Alzheimers.net. For example, according to the source, common causes of dementia are Huntington's disease, Parkinson's disease, and Creutzfeldt-Jakob disease.**
- **The latter example (Creutzfeldt-Jakob disease) is actually a fatal neurodegenerative disease, while Huntington's disease results in the death of brain cells (and often emerges in patients in their 30s and 40s, while dementia is often regarded as a condition of aging). Those who have Parkinson's disease, which is most often associated with shaking, will typically develop dementia over a long period of time following the initial diagnosis.**

ALZHEIMER'S VS DEMENTIA (Cont'd)

- **Alzheimers.net explains that once someone is diagnosed with Alzheimer's, the outlook is quite grim. "It is degenerative and incurable at this time," notes the source. Sources note the average life expectancy of a patient following a diagnosis of Alzheimer's is about 8-10-years.**

- **Meanwhile, adds the source, there are some causes of dementia (not already mentioned), such as a negative drug interaction or a vitamin deficiency, that can actually be reversed with the right diagnosis and treatment. "Until a proper diagnosis is made, the best approach to any dementia is engagement, communication and loving care," adds the site.**

ALZHEIMER'S VS DEMENTIA (Cont'd)

- A blog post from the Mayo Clinic explains there can be some "clear differences" between **Alzheimer's and other forms of dementia in the early stages.** One form of the syndrome called Lewy body dementia (LBD) which can mimic symptoms of a variety of diseases, does not have the memory loss associated with Alzheimer's, the clinic explains.
- LBD is the third most common form of dementia, notes the source, and instead of forgetfulness can be marked early on by hallucinations and confusion. However, the source explains as dementia progresses, it can be more difficult to distinguish one type from another.

ALZHEIMER'S VS DEMENTIA (Cont'd)

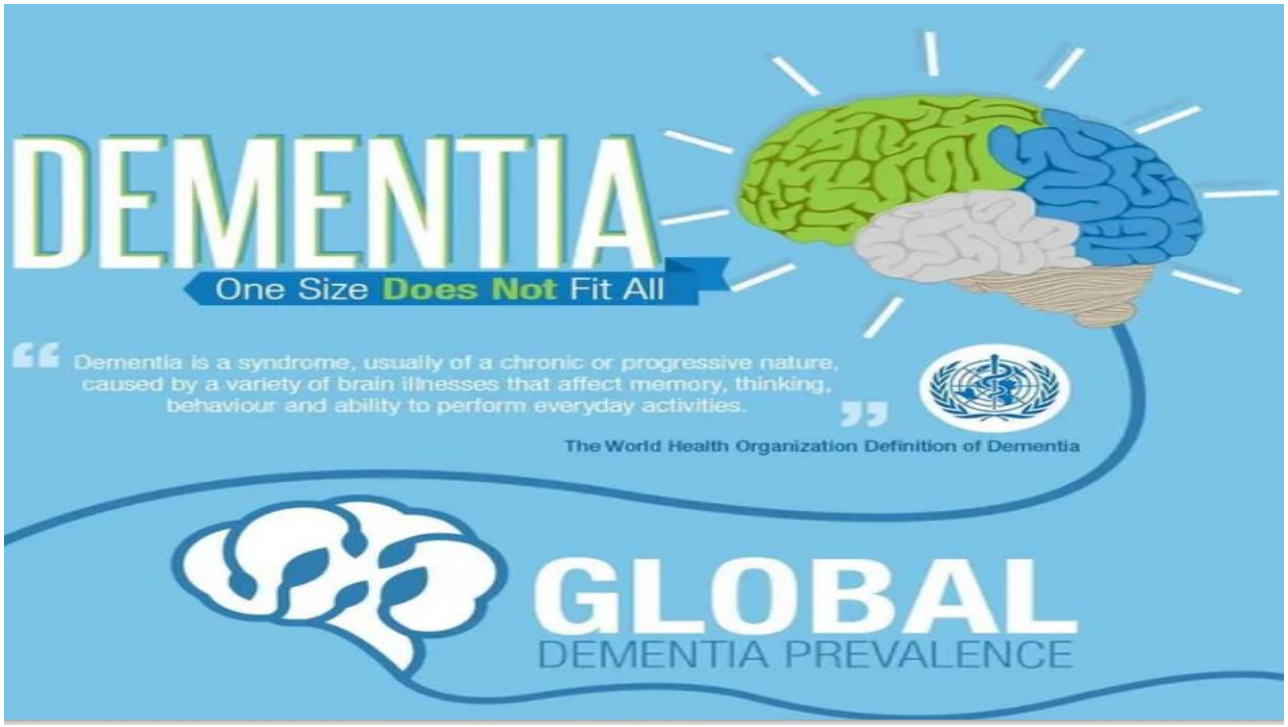
- **The Mayo Clinic says that a whopping 95-percent of Alzheimer' patients are aged 65-or older (that's based on its assertion that only 5-percent of patients develop what is known as early-onset Alzheimer's before age 65).**
- **However, as noted earlier, some other diseases that can develop earlier in life can lead to dementia, so symptoms can show up in middle age.**
- **As Healthline points out, there are a few similarities between "regular" dementia and Alzheimer's, including cloudy memory, impacted cognitive skills, and trouble communicating properly.**

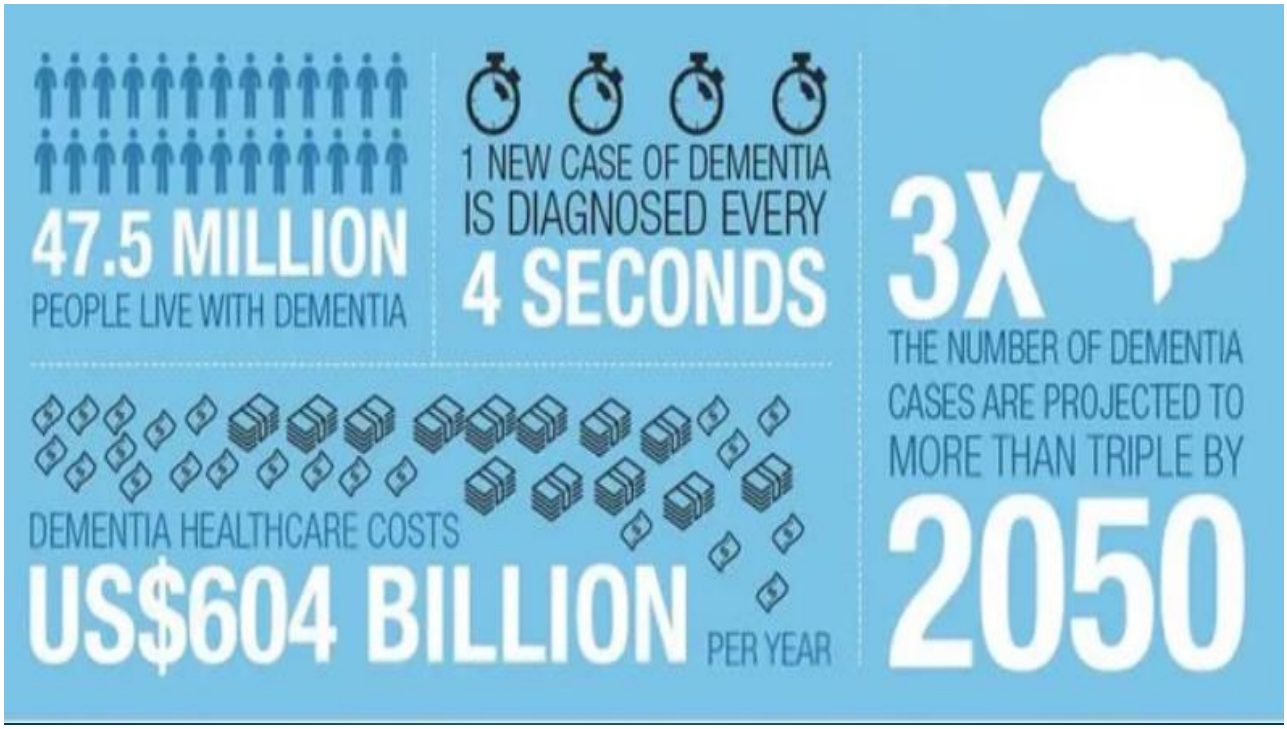
ALZHEIMER'S VS DEMENTIA (Cont'd)

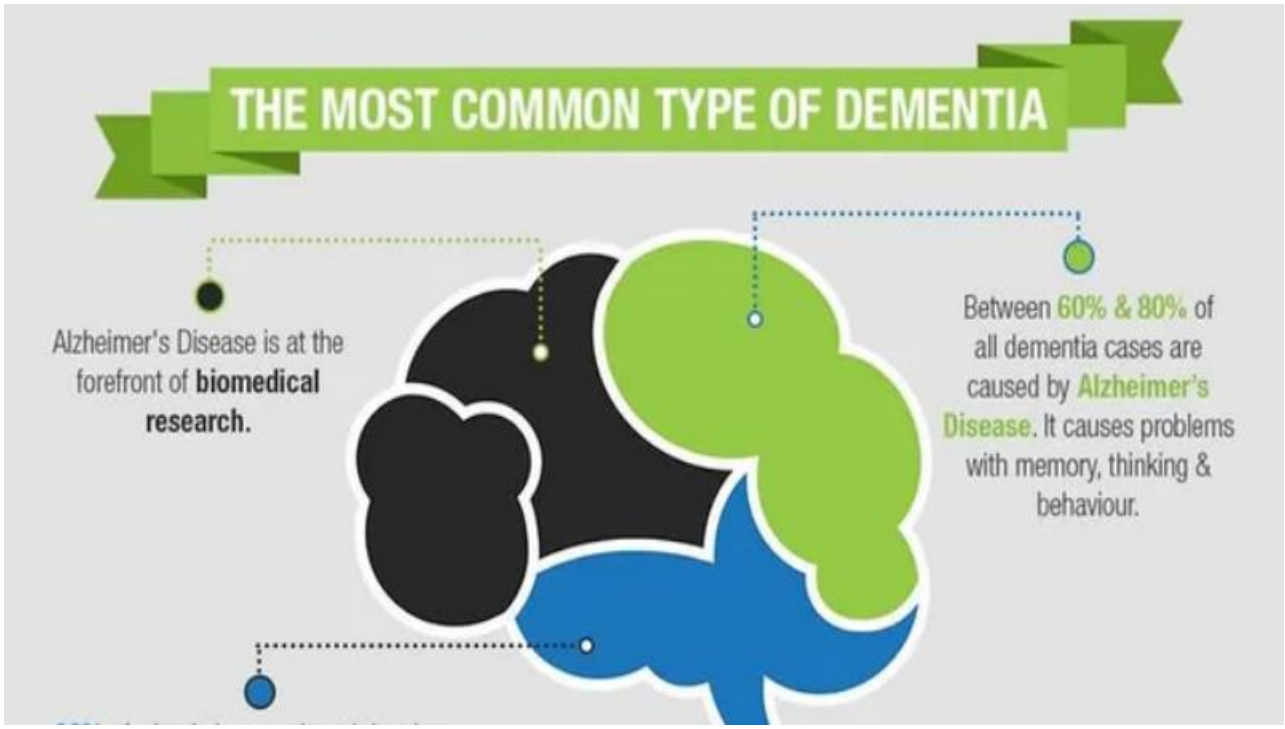
- **However, Alzheimer's can go beyond just a decline in memory or thinking capabilities, adds the source. The disease can cause the patient to have trouble swallowing, as well as difficulty walking in the later stages.**
- **In the case of Alzheimer's disease (and LBD), medical professionals can actually see changes to the brain tissue under a microscope, says the National Institute on Aging.**
- **The source says beta-amyloid proteins form between neurons, which is associated with the disease. It notes that one form of these proteins, in particular, called beta-amyloid 42, "is thought to be especially toxic," and that abnormally high levels of the protein leads it to clump and form plaques that interfere with cellular function.**

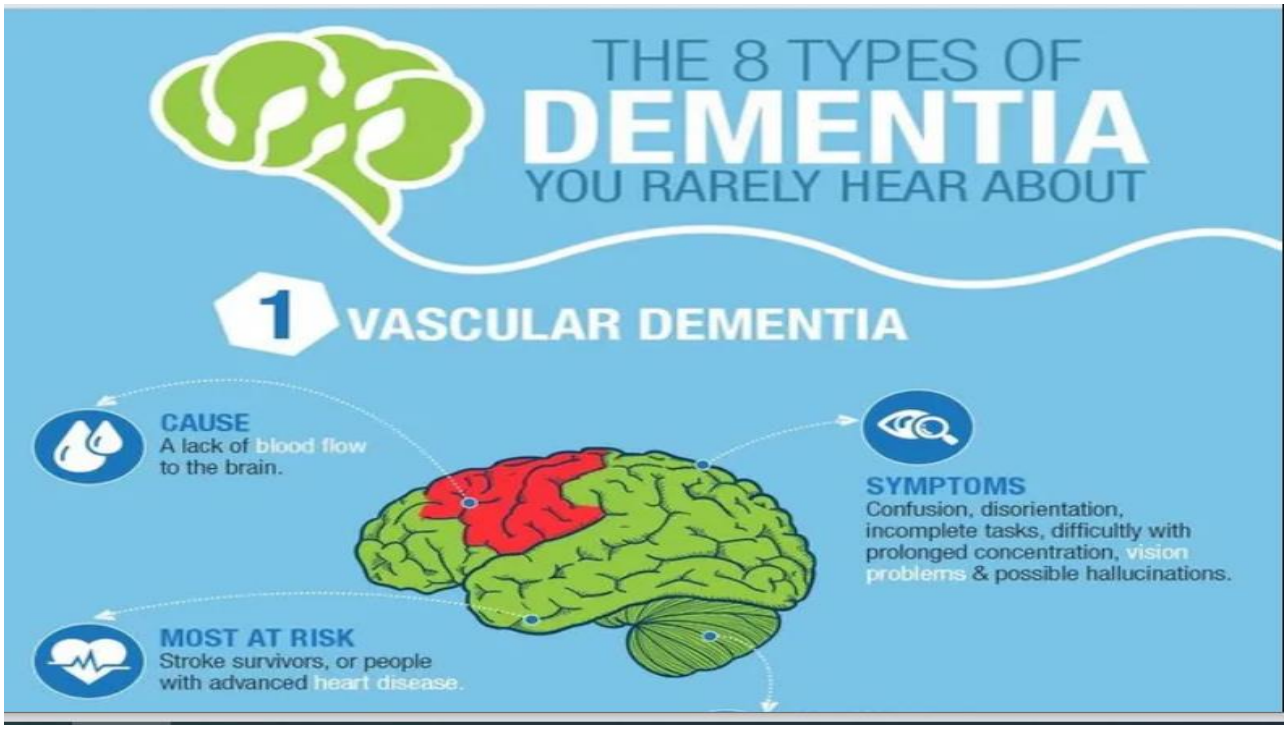
ALZHEIMER'S VS DEMENTIA (Cont'd)

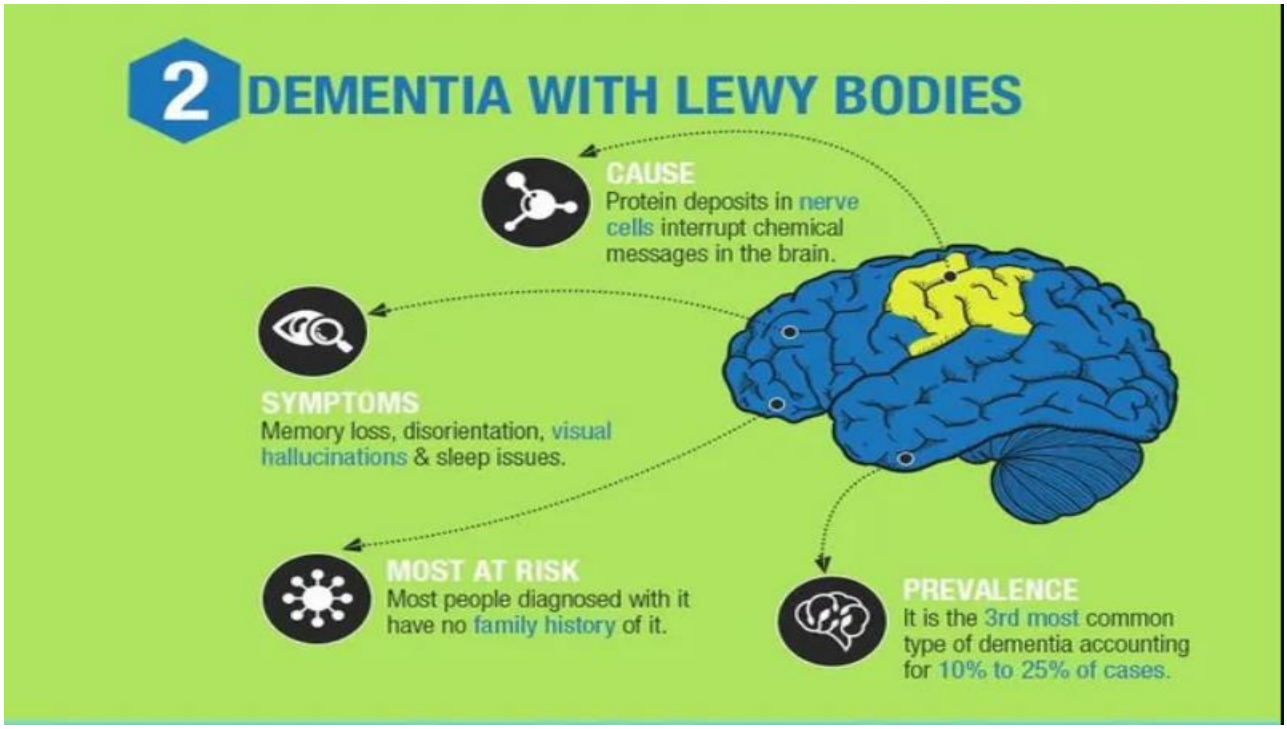
- **There can be more involved in arriving at a diagnosis of Alzheimer's versus other forms of dementia. Aside from reviewing the medical history and ruling out other conditions, the patient might be evaluated by a neuropsychologist trained in brain conditions, notes the Mayo Clinic.**
- **However, they might undergo brain-imaging tests that may indicate a progressive loss of brain cells that are associated with Alzheimer's disease. But, it's difficult to distinguish normal brain cell decline with Alzheimer's using scans, so it's not normally used in the diagnosis. Researchers are working on other methods to distinguish Alzheimer's, such as using a scan that can detect an abnormal protein called tau.**
- **Further to the last point about doctors being able to see the effects of Alzheimer's on the brain tissue, this can only be confirmed after the patient has died, notes LiveScience.com. "Alzheimer's can be diagnosed with complete accuracy only after death, when the brain is thoroughly examined during an autopsy," explains the source.**
- **It notes a microscopic analysis of the brain tissue will reveal the "plaques and tangles," which are the proteins we mentioned that are connected to Alzheimer's disease. Until the patient passes away, doctors cannot rule out other causes, but can provide a diagnosis of dementia based on certain criteria.**

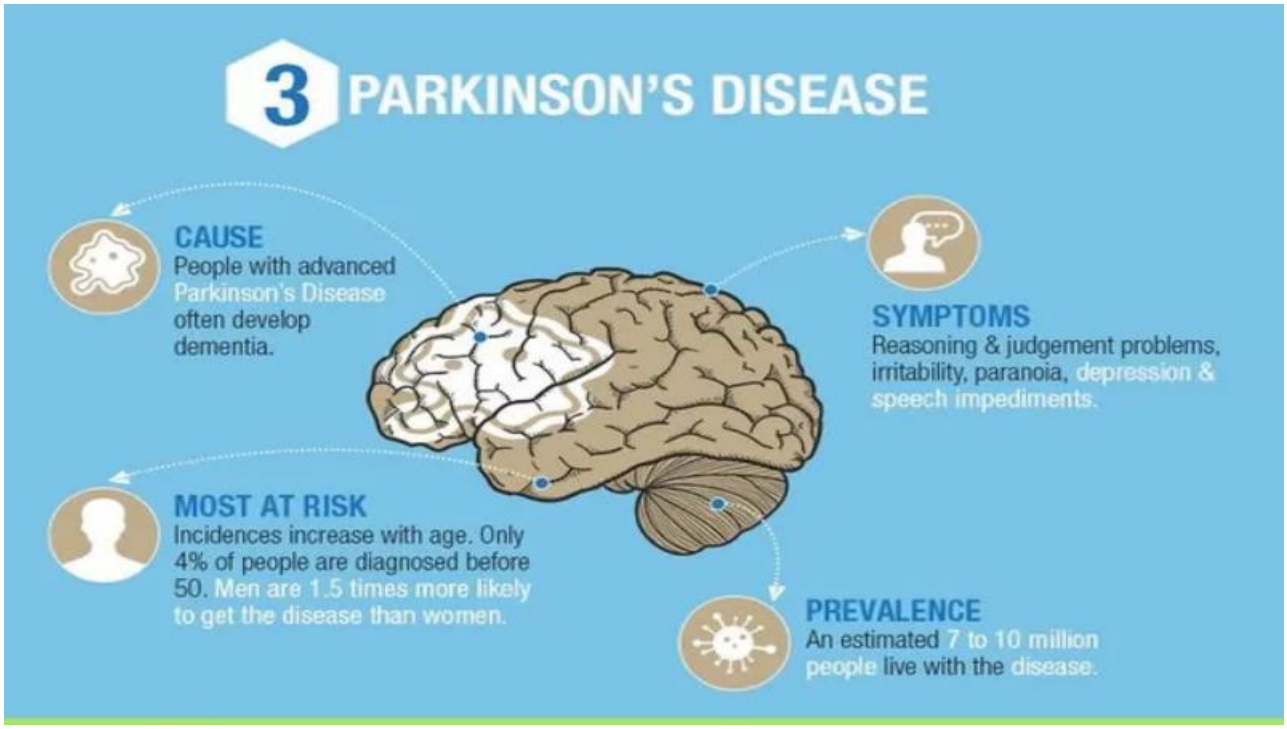


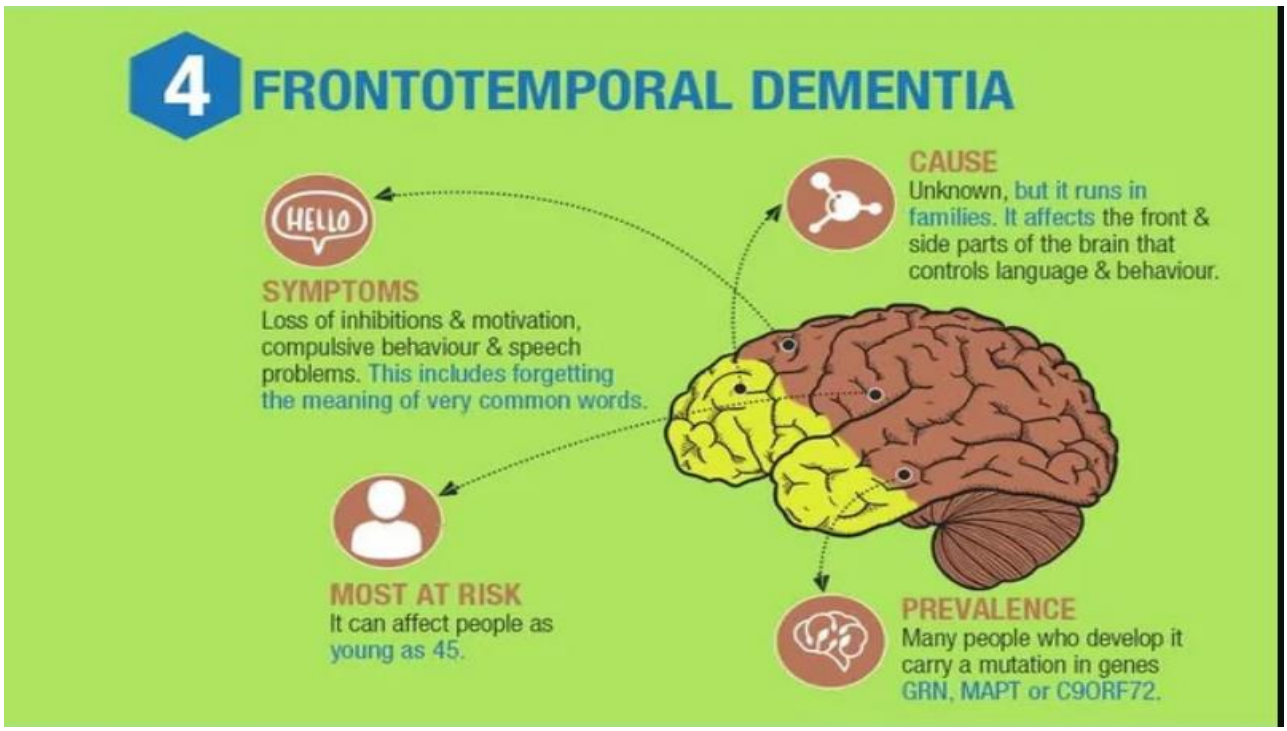

47.5 MILLION
PEOPLE LIVE WITH DEMENTIA
1 NEW CASE OF DEMENTIA
IS DIAGNOSED EVERY
4 SECONDS
3X
THE NUMBER OF DEMENTIA
CASES ARE PROJECTED TO
MORE THAN TRIPLE BY
2050
DEMENTIA HEALTHCARE COSTS
US$604 BILLION
PER YEAR

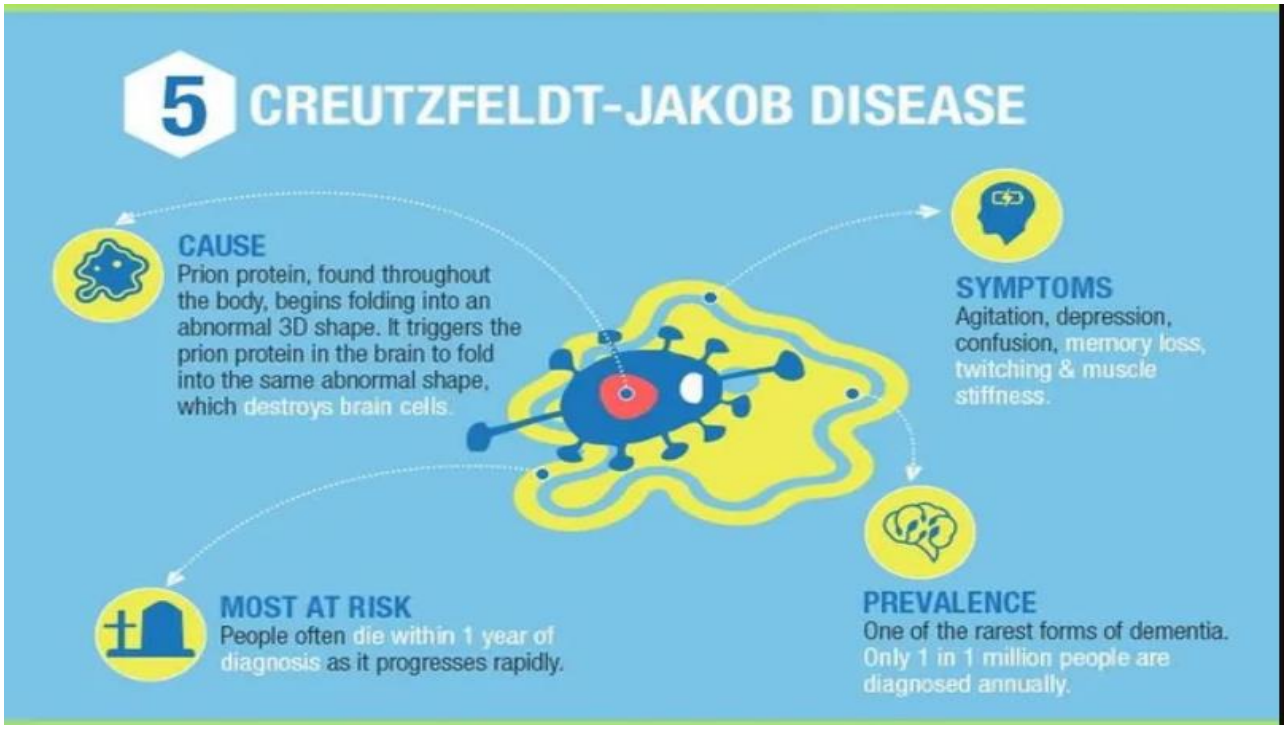

THE MOST COMMON TYPE OF DEMENTIA
Alzheimer's Disease is at the forefront of biomedical research.
Between 60% & 80% of all dementia cases are caused by Alzheimer's Disease. It causes problems with memory, thinking & behaviour.

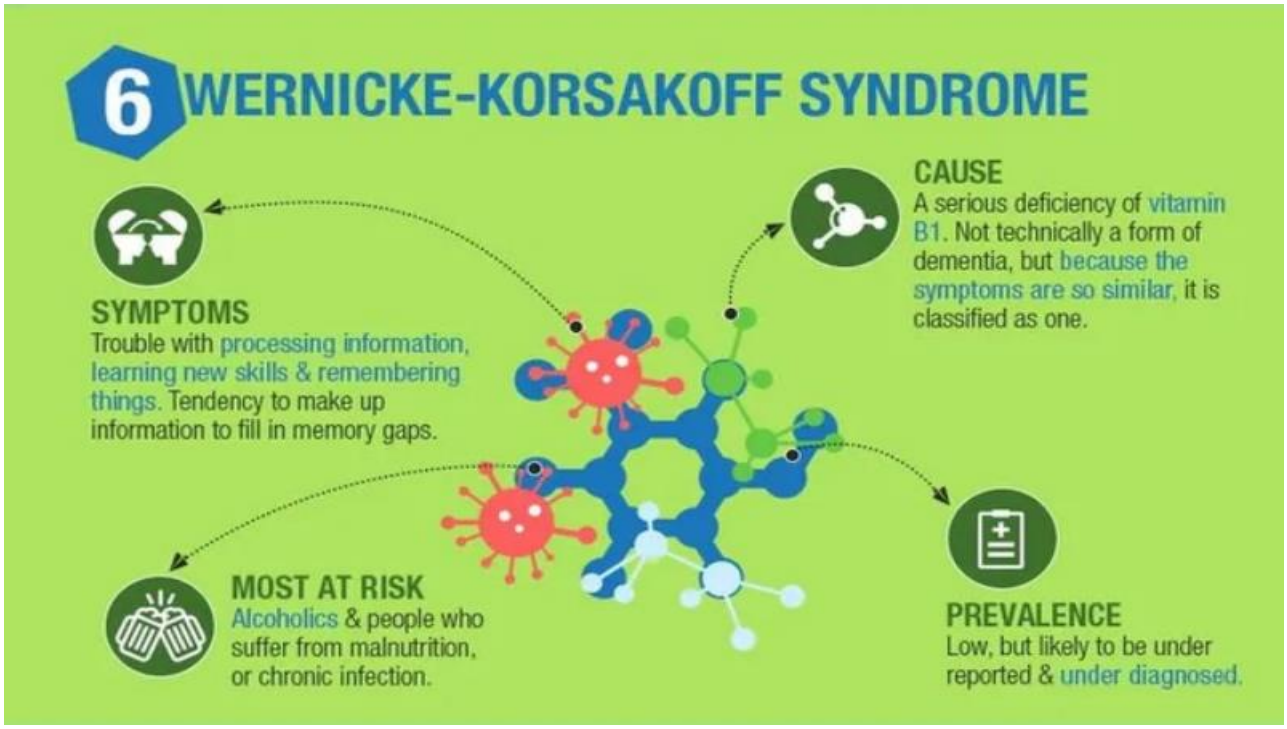

THE 8 TYPES OF
DEMENTIA
YOU RARELY HEAR ABOUT
1 VASCULAR DEMENTIA
CAUSE
A lack of blood flow to the brain.
SYMPTOMS
Confusion, disorientation, incomplete tasks, difficultly with prolonged concentration, vision problems & possible hallucinations.
MOST AT RISK
Stroke survivors, or people with advanced heart disease.


2 DEMENTIA WITH LEWY BODIES
CAUSE
Protein deposits in nerve cells interrupt chemical messages in the brain.
SYMPTOMS
Memory loss, disorientation, visual hallucinations & sleep issues.
MOST AT RISK
Most people diagnosed with it have no family history of it.
PREVALENCE
It is the 3rd most common type of dementia accounting for 10% to 25% of cases.

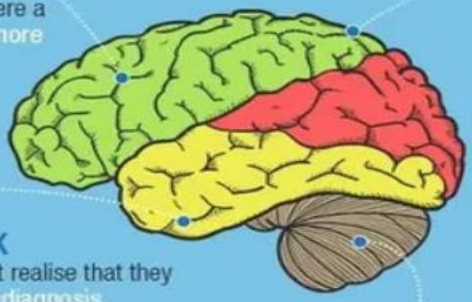

3 PARKINSON'S DISEASE
CAUSE
People with advanced Parkinson's Disease often develop dementia.
SYMPTOMS
Reasoning & judgement problems, irritability, paranoia, depression & speech impediments.
MOST AT RISK
Incidences increase with age. Only 4% of people are diagnosed before 50. Men are 1.5 times more likely to get the disease than women.
PREVALENCE
An estimated 7 to 10 million people live with the disease.


4 FRONTOTEMPORAL DEMENTIA
CAUSE
Unknown, but it runs in families. It affects the front & side parts of the brain that controls language & behaviour.
HELLO
SYMPTOMS
Loss of inhibitions & motivation, compulsive behaviour & speech problems. This includes forgetting the meaning of very common words.
MOST AT RISK
It can affect people as young as 45.
PREVALENCE
Many people who develop it carry a mutation in genes GRN, MAPT or C9ORF72.


5 CREUTZFELDT-JAKOB DISEASE
CAUSE
Prion protein, found throughout the body, begins folding into an abnormal 3D shape. It triggers the prion protein in the brain to fold into the same abnormal shape, which destroys brain cells.
SYMPTOMS
Agitation, depression, confusion, memory loss, twitching & muscle stiffness.
MOST AT RISK
People often die within 1 year of diagnosis as it progresses rapidly.
PREVALENCE
One of the rarest forms of dementia. Only 1 in 1 million people are diagnosed annually.


6 WERNICKE-KORSAKOFF SYNDROME
CAUSE
A serious deficiency of vitamin B1. Not technically a form of dementia, but because the symptoms are so similar, it is classified as one.
SYMPTOMS
Trouble with processing information, learning new skills & remembering things. Tendency to make up information to fill in memory gaps.
MOST AT RISK
Alcoholics & people who suffer from malnutrition, or chronic infection.
PREVALENCE
Low, but likely to be under reported & under diagnosed.

7 MIXED DEMENTIA



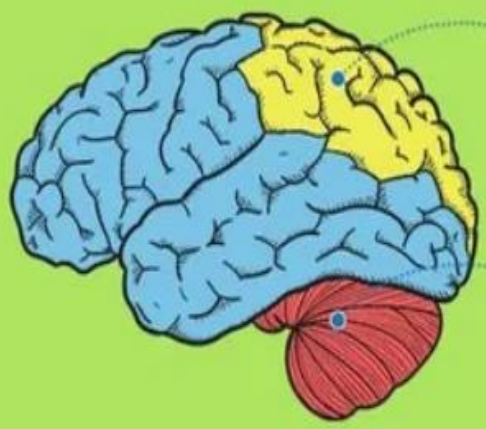
CAUSE
Unknown, it is where a person develops more than 1 type of dementia.

SYMPTOMS
Different symptoms exist in different people. Difficulty speaking & walking are common to all at the later stages of the illness.

MOST AT RISK
People who do not realise that they have it due to misdiagnosis.

PREVALENCE
Very common, up to 45% of dementia patients may have it.

8 OTHER CAUSES OF DEMENTIA



Many diseases can cause dementia in the later stages.

These include MS, HIV patients not taking antivirals & Normal Pressure Hydrocephalus, a condition caused by fluid accumulating in the brain.

CARING FOR A PERSON WITH DEMENTIA

- **When a new admission or current resident is assessed for their mental status, (by a Mini Mental exam or other similar exam) a low or poor score could indicate some dementia. The results would need to be shared with the physician and a more extensive exam would be indicated before dementia could be confirmed.**
- **If a resident does have confirmed dementia or Alzheimer's disease there could be times where certain cares are resisted or refused. When this occurs the best response is to stop the activity and return to complete later. It is never appropriate to try and continue with the task if the resident is physically or verbally resisting or refusing.**

CARING FOR A PERSON WITH DEMENTIA (Cont'd)

- **Another common occurrence with persons who have Dementia is called "Sundowner's Syndrome". You may notice big changes in how they act in the late afternoon or early evening.**
- **Fading light seems to be the trigger. The symptoms can get worse as the night goes on and usually get better by morning. Some interventions which may help with this Syndrome: Prevent the room from becoming totally dark in evening; Provide activities in the afternoon to assist with expending energy; Have frequent contact with the person.**

CARING FOR A PERSON WITH DEMENTIA (CONT'D)

- **Sometimes a person with Dementia can display disruptive or difficult behavior. This can be triggered by a new caregiver or routine. Some things to keep in mind to minimize triggering this behavior would be : Keep the environment the same for the resident when able; when not able, divert the attention away from the change by giving them the opportunity to focus on and complete a task of some sort.**

- **Should a resident with Dementia be observed participating in inappropriate self-stimulating sexual behaviors in a public area the best intervention would be to assist the resident to their room or a private area. It is likely the resident would not understand this behavior should not be done in public, so letting them know that would not be an effective intervention.**

CARING FOR A PERSON WITH DEMENTIA (Cont'd)

- **Some people with Dementia have a need to wander. It is important to provide a supervised area for the resident to wander but to also provide safety.**

- **A good practice to assist in reducing behavior issues with Dementia residents is to assure they get plenty of rest, maintain consistent caregivers, keeping them active during the day and assuring they can be as independent as possible.**

Delirium: Definition, Causes, Treatment

- **Delirium may occur at any age but is more common among older people. At least 10% of older patients who are admitted to the hospital have delirium; 15 to 50% experience delirium at some time during hospitalization. Delirium is also common after surgery and among nursing home residents and intensive care unit (ICU) patients. When delirium occurs in younger people, it is usually due to drug use or a life-threatening systemic disorder.**
- **Delirium is sometimes called acute confusional state or toxic or metabolic encephalopathy.**
- **Delirium and Dementia are separate disorders but are sometimes difficult to distinguish. In both, cognition is disordered; however, the following helps distinguish them:**
  - **Delirium affects mainly attention, is typically caused by acute illness or drug toxicity (sometimes life threatening), and is often reversible.**
  - **Dementia affects mainly memory, is typically caused by anatomic changes in the brain, has slower onset, and is generally irreversible.**

DELIRIUM (Cont'd)

Delirium is characterized primarily by:

- **Difficulty focusing, maintaining, or shifting attention (inattention)**
- **Consciousness level fluctuates; patients are disoriented to time and sometimes place or person. They may have hallucinations, delusions, and paranoia. Confusion regarding day-to-day events and daily routines is common, as are changes in personality and affect. Thinking becomes disorganized, and speech is often disordered, with prominent slurring, rapidity, neologisms, aphasic errors, or chaotic patterns.**
- **Symptoms of delirium fluctuate over minutes to hours; they may lessen during the day and worsen at night.**
- **Other symptoms may include inappropriate behavior, fearfulness, and paranoia. Patients may become irritable, agitated, hyperactive, and hyperalert, or they may become quiet, withdrawn, and lethargic. Very old people with delirium tend to become quiet and withdrawn—changes that may be mistaken for depression. Some patients alternate between the two.**

TREATMENT FOR DELIRIUM

Correction of the cause and removal of aggravating factors and management of agitation:

- Correcting the cause (e.g., treating infection, giving fluids and electrolytes for dehydration) and removing aggravating factors (e.g., stopping drugs) may result in resolution of delirium. Nutritional deficiencies (e.g., of thiamin or vitamin B12) should be corrected, and good nutrition and hydration should be provided.

Supportive care:

- Explaining the nature of delirium to family members can help them cope. They should be told that delirium is usually reversible but that cognitive deficits often take weeks or months to abate after resolution of the acute illness.

MOOD AND BEHAVIOR

- **A loved one's mood changes could be caused by them reacting out of pain or exasperation to a medical condition that you may not even be able to see. In other cases, severe mood swings in seniors could be due to personal frustration with their changing bodies and lifestyles.**
- **People age differently and experience aging differently based on heredity, lifestyle, and attitudes. Aging means change – physical, psychological, relationships, social, environment, situation, behavior, spiritual, and intellectual. Everyone adjusts to aging differently.**
- **How do you deal with an irritable elderly person: Don't show anger, fear, alarm or anxiety, even if you feel it. Showing these emotions could increase the senior's agitation and escalate the situation. Speak using a calm, reassuring voice. Acknowledge the senior's feelings and listen to what they are saying.**
- **Psychologists call the process of change that occurs as we age "personality maturation". ... It turns out that, while our personalities shift in a certain direction as we age, what we're like relative to other people in the same age group tends to remain fairly consistent.**

MOOD AND BEHAVIOR (Cont'd)

- Why are older people argumentative: Family caregivers and elderly relatives often argue over things that are related to health, wellness, grooming, and hygiene. ... Often, it's because the caregiving actions signal a loss of independence or prove that they are no longer capable. It may trigger feelings of fear concerning growing old and all that it means.
- Sometimes an older person can have what is called a "Catastrophic" reaction to a situation. This is an involuntary response that is out of proportion to a situation that is overwhelming to the individual.
- Many times older people will talk about their past. This is normal and healthy and makes a person feel good to share stories of their life and all they have accomplished or experienced. You should listen and encourage the residents to talk about their past if they desire. These discussions help boost the person's self- worth and may help with the feelings of loss of control that can come with communal living or aging.
- There are some older people who become aggressive when assistance is needed with a particular task. This is a reaction to the fact the assistance is needed and trigger feelings of a loss or frustration with their abilities. It is important for staff to understand the reaction and not internalize it. It is best to try and identify the factors that trigger these reactions and try to develop different approaches with the resident when possible. It is never appropriate to argue with a resident if they have become aggressive verbally. Compassion for their situation needs to be shown.

ANTIPSYCHOTIC MEDICATION

- Seniors experience more adverse effects with psychoactive medications such as antipsychotics, with a tendency toward greater seriousness, as compared with younger patients.
- Quality of life is an important element when formulating a pharmaceutical care plan and should be discussed with the patient, family, and caregivers when possible. The debilitating and detrimental effects of late-life psychiatric illness on activities of daily living, cognition, institutionalization, and mortality should also be taken into consideration when formulating the medication's risk-to-benefit ratio. Of note, undertreated or undiagnosed psychiatric illness may complicate underlying medical conditions and place additional stress, directly and indirectly, on the health care system.

ANTIPSYCHOTIC MEDICATION (Cont'd)

- **The majority of undesirable effects of the antipsychotic agents are extensions of their pharmacologic actions. Additionally, there are some allergic and idiosyncratic adverse effects. In an attempt to limit the emergence of side effects associated with antipsychotic agents, elderly patients should receive lower doses than those used in younger patients. Side effects may include:**
  - ***Sedation and Cognition:*** **Sedation may occur in the treatment course and may decrease over time. It is important to note it may take up to 4 weeks to see a benefit with an Antipsychotic.**

SIDE EFFECTS OF ANTIPSYCHOTICS

- ***Extrapyramidal Symptoms (EPS):*** **EPS include *akathisia*, a restlessness that may present as anxiety and agitation and result in inappropriate medication therapy; *dystonia*, an abnormal tonicity featuring prolonged tonic-clonic contractions that may progress and be life threatening; *pseudoparkinsonism*, including bradykinesia (slow movement), rigidity, and tremor; and *tardive dyskinesia*, an abnormal involuntary movement disorder. It has been estimated that half of patients between 60 and 80 years of age taking traditional antipsychotic agents experience EPS.**
- ***Anticholinergic:*** **Anticholinergic effects such as constipation, dry mouth, blurred vision, and urinary retention are particularly problematic in the elderly and may contribute to *delirium*.**
- ***Cardiovascular:*** **Cardiovascular effects include electrocardiographic (ECG) changes and orthostatic hypotension.**
- ***Weight Gain, Diabetes, and Lipid Abnormalities:*** **Weight gain is a substantially significant side effect of antipsychotic agents.**

FALLS AND OLDER ADULTS

- Falls are common and costly, especially among Americans age 65 and older. But falls are preventable and do not have to be an inevitable part of aging.
- Every second of every day, an older adult (age 65+) suffers a fall in the U.S.—making falls the leading cause of injury and injury death in this age group. One out of four older adults will fall each year in the United States, making falls a public health concern, particularly among the aging population.
- Some tips to remind your residents:
  - Remove things you can trip over (like papers, books, clothes, and shoes) from your floor.
  - We do not use throw rugs.
  - Use the grab bars next to the toilet.
  - CALL FOR HELP IF YOU FEEL DIZZY WHEN SITTING ON SIDE OF BED. CHANGE POSITIONS SLOWLY. DO NOT WALK ALONE IF YOU FEEL UNSTEADY OR IF YOU REQUIRE ASSISTANCE. USE THE HANDRAILS IN THE HALLS AND IF CLIMBING ANY STAIRS.
  - Use an assistive device if your MD or Therapy has recommended it for transfers/ambulation.
  - Wear well-fitting shoes with good support inside and outside your room.

FALL EXAMPLE

In this example, what do you think would be the first action needing to be taken?

A resident's daughter comes to you and states her mother has just fallen in the Dining room. You should=

1. Immediately go to the resident and assess the situation
2. Immediately call 911 and then go assist the resident
3. Ask the daughter to assist her mother to her room and that you will be there as soon as possible
4. Ask the nursing assistant or caregiver assigned to this resident to assist the resident to her room.

FALL EXAMPLE CORRECT ACTION

In this example, what do you think would be the first action needing to be taken?

A resident's daughter comes to you and states her mother has just fallen in the Dining room. You should=

1. Immediately go to the resident and assess the situation
2. **Immediately call 911 and then go assist the resident**
3. **Ask the daughter to assist her mother to her room and that you will be there as soon as possible**
4. **Ask the nursing assistant or caregiver assigned to this resident to assist the resident to her room**

RESTRAINTS

Restraints have been regulated for many years and include physical and chemical restraints. The regulations are F604 Right to be Free from Physical Restraints and F605 Right to be Free from Chemical Restraints.

The Guidance was revised in 2017 with the Rules of Participation and states in the SOM under F604 Intent:

The intent of this requirement is for each resident to attain and maintain his/her highest practicable well-being in an environment that:

- **Prohibits the use of physical restraints for discipline or convenience;**
- **Prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity; and**
- **Limits physical restraint use to circumstances in which the resident has medical symptoms that may warrant the use of restraints.**

When a physical restraint is used, the facility must:

- **Use the least restrictive restraint for the least amount of time; and**
- **Provide ongoing re-evaluation of the need for the physical restraint.**

RESTRAINTS (Cont'd)

F605: The intent of this requirement is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of chemical restraints:

- **For discipline or convenience; and**
- **Not required to treat a resident's medical symptoms.**

When a medication is indicated to treat a medical symptom, the facility must:

- **Use the least restrictive alternative for the least amount of time;**
- **Provide ongoing re-evaluation of the need for the medication; and**
- **Not use the medication for discipline or convenience.**

Examples of Restraints could include: Vests, Geri chairs, Behavior controlling medications, alarms, siderails, and others.

INCIDENT AND ACCIDENT REPORTS

- **If a resident falls or has another type of Adverse Event, you need to complete an Incident/Accident Report as soon as possible after assessing the resident and assuring any medical attention indicated is provided. Inform you Supervisor for any Incidents/Accidents. Many are State Reportable and that determination is made by the Leadership Team, usually the Administrator, DON and/or Social Services. An Event the results in serious bodily harm must be reported to the State within 2 hours.**
- **Some examples of Adverse Events besides a Fall would be: (Not all inclusive-FOLLOW FACILITY POLICY GUIDELINES for the Process and Procedure of Incident/Accident Reports and notification).**
  - **Burn**
  - **Skin issue, such as a Skin tear, rash, bruise**
  - **Altercation with another resident, family member, visitor, whether verbal or physical**
  - **Choking**
  - **Loss of consciousness**
  - **Allegation of Abuse, Neglect or Misappropriation of Funds.**
  - **Medication Errors**
  - **Other Adverse Events that are not normally a part of the resident's daily life**

Reporting Cheat Sheet

What is Reportable?

- Maltreatment – Neglect, abuse (verbal, sexual, physical, mental, exploitation, neglect), involuntary seclusion and exploitation.
- Injuries of Unknown Source: if the following are met:
  - Injury was not observed by any person OR the source could not be explained.
  - AND: the injury is suspicious because of the extent of the injury or location of injury
  - OR: the number of injuries observed at one point in time
  - OR the incident of injuries over time.
- Avoidable Accidents: Accidents where the facility failed to assess risk and identify/eliminate hazards or failed to follow the care plan.

How to Manage Reportable:

- First of all assure the resident is safe.
- Reported incident should be routed to supervisor and then up to Administrator/DON.
- If the perpetrator is identified as a staff member suspend immediately, regardless of title or duration of employment.
- Interview potential witnesses (staff and residents)
  - How many residents/staff will be interviewed will be dependent on severity of allegations.
  - Skin checks to be completed on all non-verbal residents.
  - Please assure this is completed on the correct form.

STAFF INCIDENTS

- **If a staff is injured at work, there is a separate staff Incident Report that needs to be completed.**
- **Refer to your organization's Policy on Staff Incidents. Often the Supervisor of the staff injured completes the Incident Report and contacts Human Resources. Not all organizations follow the same protocol so be sure you are familiar with yours.**
- **When completing a staff Incident Report, you want to get the staff's account of what happened as well as any witnesses' statements.**
- **If there were no witnesses or if the witness is a resident who is unable to be a credible witness due to confusion secondary to a diagnosis of Dementia for example, you should note that in the Report.**
- **Take the statement of the staff and be sure to use quotes as this is being stated by them, not you, as you did not witness.**
- **If there was a witness, they need to write down what they observed if able and sign and date their statement. If they are not able to write it down, you can write it and have them read, sign and date.**

Facility Incidents/Accidents Example

- A housekeeper spilled a bottle of acid that is used for cleaning tiles in the hallway. What would your first action be?

A. Throw water on the acid.
B. Pull the fire alarm.
C. Remove residents from that hallway area.
D. Place a towel on the spill to absorb the spill.

Facility Incidents/Accidents Example (answer)

- A housekeeper spilled a bottle of acid that is used for cleaning tiles in the hallway. What would your first action be?

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ELDER ABUSE: From WHO (World Health Organization)

Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect.

- **Around 1 in 6 people 60 years and older experienced some form of abuse in community settings during the past year. (October 2021)**
- **Rates of elder abuse are high in institutions such as nursing homes and other types of care facilities, with 2 in 3 staff reporting that they have committed abuse in the past year.**
- **Rates of elder abuse have increased during the COVID-19 pandemic.**
- **Elder abuse can lead to serious physical injuries and long-term psychological consequences.**
- **Elder abuse is predicted to increase as many countries are experiencing rapidly ageing populations.**
- **The global population of people aged 60 years and older will more than double, from 900 million in 2015 to about 2 billion in 2050.**

ELDER ABUSE (Cont'd)

- Types of Abuse reported by older adults in a communal setting last year: Oct 2021
  - **Psychological Abuse: 11.5%**
  - **Physical Abuse: 2.6%**
  - **Financial Abuse: 6.8%**
  - **Neglect: 4.2%**
  - **Sexual Abuse: 0.9%**
- The percentages are much higher from reports made by staff. Many victims are afraid to report or are unable to report.

ELDER ABUSE (Cont'd)

- **Emerging evidence indicates that the prevalence of elder abuse in both the community and in institutions have increased during the COVID-19 pandemic. A US study, for instance, suggests that rates in the community may have increased by as much as 84%.**

- **Consequences:**
  - **Elder abuse can have serious physical and mental health, financial, and social consequences, including, for instance, physical injuries, premature mortality, depression, cognitive decline, financial devastation and placement in nursing homes. For older people, the consequences of abuse can be especially serious, and recovery may take longer.**
- **Risk factors**
  - **Individual level characteristics which increase the risk of becoming a victim of abuse include functional dependence/disability, poor physical health, cognitive impairment, poor mental health and low income. Individual level characteristics which increase the risk of becoming a perpetrator of abuse include mental illness, substance abuse and dependency – often financial – of the abuser on the victim. At the relationship level, the type of relationship (e.g., spouse/partner or child/parent) and marital status may be associated with an elevated risk of abuse, but these factors vary by country and region. Community- and societal-level factors linked to elder abuse may include ageism against older people and certain cultural norms (e.g., normalization of violence). Social support and living alone reduce the likelihood of elder abuse.**

ELDER ABUSE (Cont'd)

- **Prevention**
  - Many strategies have been tried to prevent and respond to elder abuse, but evidence for the effectiveness of most of these interventions is limited at present. Strategies considered most promising include caregiver interventions, which provide services to relieve the burden of caregiving; money management programs for older adults vulnerable to financial exploitation; helplines and emergency shelters; and multi-disciplinary teams, as the responses required often cut across many systems, including criminal justice, health care, mental health care, adult protective services and long-term care, such as Assisted Living and Nursing Homes.

  - In some countries, the health sector has taken a leading role in raising public concern about elder abuse, while in others the social welfare sector has taken the lead. Globally, too little is known about elder abuse and how to prevent it, particularly in developing countries.

ELDER ABUSE (Cont'd)

- If you suspect a co-worker of abusing a resident, you MUST tell your Supervisor right away. They will conduct an investigation while suspending the alleged perpetrator for their own safety as well as the residents.
- You do not want to stand by and be considered an accomplice. You too could be considered a part of the abuse by not reporting your suspicions, even if they turn out to not be substantiated.
- Remember, you are the voice many times for the residents. You need to be their advocate!
- Each State has their own Abuse Prevention Laws and Reporting mechanisms.
- You do not have to witness abuse to report your suspicions.
- Become familiar with your Organizations Policies and Procedures on Abuse Prevention.

END OF CLASS #3

- **QUESTIONS?**
- Nancy Tuders, nancy@nadona.org
- Cindy Fronning, cindy@nadona.org
- NEXT PLEASE GO TO AND TAKE THE QUIZ FOR CLASS #3.
- I LOOK FORWARD TO TALKING TO YOU IN CLASS #4!