

Free case study on nursing older people dementia

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Nursing Older People: Dementia

The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) defines dementia as (1) a syndrome that is caused by a chronic or progressive disease of the brain, that (2) causes multiple disturbances of higher cortical functions, and (3) is characterized by impairment in memory without impairment in consciousness. Dementia affects all areas of the brain and can occur at any age but is more common in people over 65 years of age, affecting 20% of those aged over 80 (Gulland, 2012).

A clinical diagnosis of dementia is made when a patient develops cognitive impairment severe enough to interfere with normal daily activities (ICD-10). The primary goal is to not just diagnose or rule out dementia but to optimize cognition and delay further decline (Etgen, 2011). The secondary goal is to reduce the impact of dementia on the patient's quality of life, and on the caregiver's. The focus is on function, not cure (Grand, Caspar, & MacDonald, 2011, Lorenzl, Füsgen, & Noachtar, 2012).

The first step in the management of dementia is to undertake a systematic comprehensive physical evaluation of the patient (Grand, Caspar, & Macdonald, 2011). Special attention should be paid to cognitive and functional assessment to identify the type of dementia and select the best treatment protocol. In particular, treatable reversible dementias must be identified for immediate treatment (Kim et al, 2012). Cognitive assessment includes the CAM (cognitive assessment method) test for delirium, the Standardized Mini Mental Exam (SMME) for mental assessment, and the Geriatric Depression Scale (GDS) test (Grand, Caspar, & Macdonald, 2011,

Lorenzl, Füsgen, & Noachtar, 2012). Red flags for an assessment include a frail and elderly patient aged over 75 years, and three or more of the following symptoms: confusion or delirium, assistance with Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL), history of falls, lives alone, incontinence, and more than two hospital admissions for acute care during the past year (Grand, Caspar, & Macdonald, 2011, Lorenzl, Füsgen, & Noachtar, 2012). The real challenge for the clinician is to diagnose the type of dementia as there are many types of dementias with overlapping symptoms (Alves, et al., 2012, Espay & Litvan, 2011), but the clinical data can help categorize the dementia into one of the four main categories: cortical and sub-cortical, reversible and non-reversible, pre-senile and senile, or dementias associated with disease (Current Nursing, 2011, George, Whitehouse, & Ballenger, 2011).

Cortical and sub cortical dementias are associated with multiple sub cortical or cortical infarcts (George, Whitehouse, & Ballenger, 2011). The most striking differences between these two sub-categories are that sub cortical dementias cause diminished executive function, decreased rate of cognitive processing, dysarthric speech, impaired coordination, and adventitious movements. In contrast, cortical dementia is characterized by aphasia, impaired calculation, and euthymia. Certain dementias can be treated because they are caused by reversible conditions like inflammatory disease, infections, alcohol toxicity, metabolic imbalance, sleep disorders, or nutritional deficiencies (Kim et al., 2012). Although these types of dementia can be cured with management of the underlying disease, the symptoms of dementia can resume with the return of the disease. Pre-senile and senile

dementias are essentially similar except that pre-senile dementia occurs in a younger cohort of people between 40 and 50 years of age, and senile dementia occurs after the age of 65 (George, Whitehouse, & Ballenger, 2011). People who develop pre-senile dementia die roughly a decade after diagnosis and thus represent the greatest clinical challenge.

Because of the frequency of contacts, a nurse is in a unique position to help caregivers and family members with the management of dementia.

Caregivers and family members should be provided with information regarding the specific type of dementia diagnoses and the associated problems and issues (Siemens, 2011). A nurse can also discuss such issues as powers of attorney and advanced care directives (ACD).

There is no cure for the majority of dementias; thus, after clinical assessment and diagnosis, the next step is the management of dementia. First, short-term and long-term goals have to be established, both for the patient and the caregiver. The main focus in the management of dementia is to slow down cognitive decline (Etgen, 2011) and the caregiver can play a critical role in protecting the cognitive integrity of the patient. The first step is to control environmental conditions to reduce confusion; for example, by developing a regular schedule plan for the patient, removing superfluous objects, and providing environmental clues (Zupancic, Mahajan, & Handa, 2011). It is just as critical to consider patient safety, beginning with medications; people with dementia tend to forget medication; thus, caregivers should help manage therapeutics (Siemens, 2011). It is also essential for a person with dementia to remain physically active; thus, the environment should be secured to allow the patient to navigate with

confidence (Burge, 2012). Communication is key to safety, and people with dementia have problems expressing ideas, so it is important to discover ways to help the patient communicate. A good approach is to give the patient time to formulate ideas, and to identify alternate ways of communication (Zupancic, Mahajan, & Handa, 2011).

Two other factors that impact dementia are nutrition and hygiene (Pivi, Bertolucci, & Schultz, 2012). Nutritional supplements may be necessary, and good hygiene is essential to prevent infections that can impact the overall health and wellbeing the patient. People with dementia also tend to suffer from sleep disorders, which can exacerbate the symptoms of dementia (Siemens, 2011). Medications or relaxation techniques can help the patient regulate sleep patterns. Finally, people with dementia, perhaps more than others, are in need of personal contact and socialization (Siemens, 2011). It is essential for family members to keep in close contact with the patient. Knowing the type of dementia can help personalize the management of dementia. A patient that has been diagnosed with sub cortical dementia should be advised to grant power of attorney to some trusted person, to mitigate the problems of diminished executive function and decreased rate of cognitive processing. The patient should also be referred to a speech therapist to learn how to cope with the symptoms of dysarthric speech, and the caregiver should understand the impact of dysarthric speech on communication (Espay & Litvan, 2011). A person with impaired coordination and adventitious movements is prone to falls, and might need mechanical devices to aid in ambulation. Adventitious movements may also interfere with the performance of skills necessary in daily life, so steps may be

necessary to help the patient perform or to prevent accidents; for example, providing the individual with easy to use utensils and removing any fragile items from danger.

A patient with cortical dementia has problems with communication due to aphasia, and should undergo speech therapy (Espay & Litvan, 2011).

Caregivers and family members should recognize the symptoms of aphasia and device alternate ways for communication. Aphasia may be associated with bouts of anxiety so a patient with cortical dementia should also be referred to psychological counselor, although euthymia could help mitigate anxiety. It is also difficult for patients with this type of dementia to perform calculations so a caregiver must be prepared to assist the patient with the management of finances and the reading of clocks and calendars.

People diagnosed with secondary dementias must take steps to prevent a recurrence of the disease that triggered the dementia. Caregivers should help monitor meal intake to ensure proper nutrition, treat infections at their early stages, ensure the patient is getting enough sleep, and manage inflammatory diseases. Alcohol is to be kept away from the patient. It is also necessary to adhere to the treatment protocol to control the underlying disease.

Pre-senile dementias represent a challenge to the patient, the caregiver, and the family because they are known for their rapid progression (Ridgway et al., 2012). It is difficult to make the necessary physical and psychological adjustments necessary to manage the disorder. For this reason, patients with pre-senile dementia are in the greatest need of psychological or psychiatric therapy, and of family support. Spiritual guidance is also recommended;

especially at the early stages, when the patient first learns that people with pre-senile dementia may die within a decade of diagnoses.

The number of people with dementia is increasing, there is no cure for the disorder, and the side effects of medications can cause problems of their own (Aisen, 2012, Gulland, 2012). Clinicians are moving away from pharmacological treatment of dementia towards the management of cognitive decline through behavioural modification (Sawdowsky & Galvin, 2012). Doyle (1992) evaluated a number of innovative dementia programmes that used a variety of techniques to modify the behaviour of patients with dementia. The idea is that people with dementia are equipped with sufficient neurological capacity to be able to learn new ways of coping with the symptoms of dementia (Etgen, 2011).

One programme focused on prosthetic environments. The concept behind a prosthetic environment is to modify the physical environment to compensate for the patient's disabilities and restore function (Burge, 2012). One example is to prevent nocturnal wandering by leaving on a light at night, for studies have shown a correlation between darkness and cognitive impairment. Other programmes relied on therapies to modify behaviour. Reminiscence therapy used a variety of techniques to improve memory and was shown to decrease symptoms of depression. Reality orientation therapy involved identification of the patient's personal mechanism of coping with memory loss to help the caregiver adopt the right attitude towards the patient (Doyle, 1992).

Thus, there are a variety of approaches to the management of dementia that can help individualize treatment of the various types of dementias.

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