

Discussing strategies of care for elderly dementia sufferers nursing essay



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Caring for older people highlights many special and difficult issues for nurses and carers, such as separation, illness, loneliness, death and how to provide continued care (Morrissey et al, 1997). This essay discusses the strategies of care delivered for an older person with dementia during my recent clinical placement. Discussions will focus on normal ageing process taking into account the relevant biological, sociological and physiological perspectives and the impact this had on this individual's life experience. Ropers' model is used as a frame work in which care is delivered. Other related issues to be considered include the role of informal carers and the impact this had on him. Confidentiality is maintained in conjunction with NMC 2010 code of conduct. Thus a pseudonym (Scot) is adopted where the client's name is mentioned.

Scot is a 70 year old man with a long term history of psychosis. Recently he had been diagnosed with dementia. He had been well managed on quetiapin until he had stopped taking the medication and his psychosis had worsened. And due to his decline in his mental state, he has also been refusing access to his carer (his wife) and was at risk of self neglect.

Dementia is a disorder manifested by multiple cognitive defects, such as impaired memory, aphasia, apraxia and a disturbance in occupational or social functioning, Howcroft (2004). Disturbances in executive functioning are also seen in the loss of the ability to think abstractly, having difficulty performing tasks and the avoidance of situations, which involves processing information. Scot suffers from Alzheimer's disease, a type of dementia, which affects the brain cells and brain nerve transmitters, which carry instructions around the brain. The brain shrinks as gasps develops in the

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temporal lobe and hippocampus. The ability to think, speak remember and make decisions is interrupted (ADS, 1997).

The national strategy for carers (1999) defines an informal carer as ‘ someone providing care without payment for a relative or friend who is disabled, sick, vulnerable or frail’. Scot and his wife had been married for over 50 years when scot developed dementia. Initially his wife managed well, but as time went by and the dementia worsened, she found it increasingly difficult to look after her husband, do her household chores and have any life for herself. She could not leave him alone while she shopped, and it was too difficult to take him along. Eventually the stress, the low morale and the frustration of caring for Scot began to toil on her.

Fitting et al (1986) found that women more often feel obliged to give care than men and have more difficulty in coping with the dependency of their dementing relative. What seemed to have been the last straw for Scots wife was when he started squatting in corners and urinating on the floor. Scot began to progressively have less interest inside and outside home, which is highlighted by intellectual, emotional and memory disturbances of dementia (Dexter et al, (1999). The deterioration again led him to becoming absent-minded, forgetting appointments, forgetting about his meals and forgetting things he has left in the house. It further progressed to extreme situations where he would recall past events of his youthful days but not about the recent events. He would also get up in the middle of the night wandering around the house, which resulted in many falls and injuries to himself. This major memory disturbance resulted in manifestation of confusion affecting his daily structure and routine of life.

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On this current admission his care plan was formulated to meet his needs to carry on activities of daily living. Due to his mental state at that time his assessment was done in consultation with his wife which highlighted four main areas of concern, namely his personal hygiene, nutritional intake, safe environment and sleeping (Roper et al, 1996). The degree of Scots safety was assessed due to his potential risk of falling and causing harm to himself. With regards to sleep, it was identified that he has unstructured and lesser sleep patterns which is a contributing factor to his restless and agitations during the day. He also has difficulty in hearing. All the identified needs of scot were integrated into his care plan approach and the appropriate interventions were taken.

The care plan was for scot to be given one to one counselling sessions each day and encouraged to discuss topics related to reality such as current affairs, his family, home life or social life. The rationale for this action is supported by Schultz and Videbeck (2002), who assert that familiarity with, and trust in staff members can decrease a client's fears and suspicions, leading to decreases anxiety. Discussing familiar topics also stimulates patients to maintain contact with the real world and their place in it (Stuart and Laraia, 1998). He is to be monitored on his medication and a mental state in order for him to maintain optimum level of physical and mental well being. This was to include exercise, social group activities and a good balance of fluid and food intake. He was also to be encouraged and engage in social activities during the day to help him have adequate sleep during the night. It was also included that Scot should be on primary observation to ensure his safety on the ward.

To promote safe environment for Scot, all potential hazardous objects were removed, and that familiar objects including pictures, calendars, activity sheets were rather put in place to orientate him to his surroundings. To reinforce this he was discussed with what was happened around him. All interaction with Scot also involved communicating clearly about one topic at a time so that he is not confused with excessive information (Holden et al, 1982). He was given hearing aid equipment, which was constantly checked for proper functioning. This was emphasised with effective verbal and non verbal communication. During these times it was imperative to use tone of voice which was conducive to his hearing, appropriateness of touch, good eye contact, gestures and allowing Scot to express his fears and desires, all in an atmosphere of acceptance and reassurance. This was to build a rapport and maintain a trusting therapeutic relationship with him (Egan 2002). To reduce some of the night time disturbances, Scot was involved in a sleep hygiene programme which included maintaining regular times for rising and going to bed, avoiding stimulants such as alcohol and tobacco and using the bedroom only for sleep. Taking him for a walk, attending OT sessions and other social group activity also increased his daytime activity. Relaxation and breathing exercises was part of the caring process for Scot, which were intended to give him mastery over his symptoms especially when he became anxious or unable to sleep. And although there seemed to be no significant process being made by Scot on the breathing exercise, the programme continued to be reassessed and reviewed.

His care programme also took into account some of the normal ageing process associated with old age such as the presence of pathology affecting

the overall functioning of the individual. For instance, during Scots assessment for nutritional intake it was important to take into account the fact that many older people have a reduced food intake as result of being less active and reduced lean body mass which leads to a low intake of nutrients such as vitamins and minerals (Norman, et al 1997). A further factor considered was that of the medication which when used to treat certain conditions can in fact cause depression, which is bought on by the toxicity of the drugs. ' The elderly are more prone to toxicity because of their impaired absorption, metabolism, and excretion of drugs' (Cosgray and Hanna, 1993). It is imperative to note that the older person tend to take medication errors such as omission of doses and incorrect dosage when they are self administering a drug and many elderly people tend to take a number of different drugs for different ailments which causes further confusion. This all non-prescription medications such as bottles, out of date prescription items were also removed from the reach of Scot. This was to prevent Scot having access to potentially dangerous medication and inadvertently taking them incorrectly. Until his condition improved, his medication was given to staff on the ward. However, he continued to be educated to enable himself to self medicate on discharge.

Furthermore, assessment of other age related physiological and psychological degeneration of vision, auditory, speech, impaired cognition etc are essential for baseline assessment and understanding the effects of physical and mental capabilities of an older person (Kenny, 1989).

Scot constantly brought up the issue of dying during every one to one session with him. Although he did not want to end his present condition by <https://assignbuster.com/discussing-strategies-of-care-for-elderly-dementia-sufferers-nursing-essay/>

committing suicide, he accepted death as an invertible end, which he anticipates will inevitably come soon for him. His main concern was to be able to work and spend time in his garden again on discharge before he died. However, he did have the tendency to be rather depressed of what he sees as not doing much in his prime days to fulfil his ambitions. This sometimes brings on a sense of guilt and sadness to Scot.

The national Service Framework for older people (DoH, 2001) emphasised the need to support carers in their role. Scot's wife was therefore educated about how to handle the decline capabilities of her husband including how to provide safe environment for Scot and help him with respite programmes that will give her a break from her care-giving responsibilities. Scot's wife also received education and information about how and why her husband behaves in his condition and how she can reduce the feelings of anxiety, tension and loss of control that has resulted from the impact of Scots deterioration.

By the end of my placement, evaluations showed that although there have not been significant changes in Scots mental and physical state, it is also imperative to note that he has been supported and maintained well to carry some of the daily activities of living. Whilst Scots care plan continued to be reviewed, there is also an ongoing support and educational programmes for his wife, which will enable her to effectively care for Scot. Having gained experience working with older people, I have understood that whenever you care for a person especially the older person, one must take a holistic view of the person's physiological and psychological and social circumstance in order to provide effective and continuous care.

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