

Trends and Issues

Objectives

1. Describe the subjective and objective ways that aging is defined.
2. Identify personal and societal attitudes toward aging.
3. Define *ageism*.
4. Discuss the myths that exist with regard to aging.
5. Identify recent demographic trends and their impact on society.
6. Describe the effects of recent legislation on the economic status of older adults.
7. Identify the political interest groups that work as advocates for older adults.
8. Identify the major economic concerns of older adults.
9. Describe the housing options that are available to older adults.
10. Discuss the health care implications of an increase in the population of older adults.
11. Describe the changes in family dynamics that occur as family members become older.
12. Examine the role of nurses in dealing with an aging family.
13. Identify the different forms of elder abuse.
14. Recognize the most common signs of abuse.
15. Describe approaches that are effective in preventing elder abuse.

Key Terms

abuse (p. 22)

chronologic age (krö-nö-LÖJ-ĭk) (p. 2)

cohort (KÖ-hört) (p. 8)

demographics (dēm-ö-GRÄF-ĭks) (p. 6)

geriatric (jēr-ē-ĀT-rĭk) (p. 2)

neglect (nĭ-glĕkt) (p. 22)

respite (RĒS-pĭt) (p. 26)

INTRODUCTION TO GERIATRIC NURSING

HISTORICAL PERSPECTIVE ON THE STUDY OF AGING

Until the middle of the nineteenth century, only two stages of human growth and development were identified: childhood and adulthood. In many ways, children were treated like small adults. No special attention was given to them or to their needs. Families had to produce many children to ensure that a few would survive and reach adulthood. In turn, children were expected to contribute to the family's survival. Little or no concern was given to those characteristics and behaviors that set one child apart from another.

As time passed, society began to view children differently. People learned that there were significant differences between children of different ages and that children's needs changed as they developed. Childhood is now divided into substages (e.g., infant, toddler, preschool, school age, and adolescence). Each stage is associated with unique challenges related to the individual child's stage of growth and development. Because the substages are related to obvious

physical changes or to significant life events, this classification method is now accepted as logical and necessary.

Until recently, society also viewed adults of all ages interchangeably. Once you became an adult, you remained an adult. Perhaps society perceived dimly that older adults were different from younger adults, but it was not greatly concerned with these differences because few people lived to old age. In addition, the physical and developmental changes during adulthood are more subtle than those during childhood; therefore, these changes received little attention.

Until the 1960s, sociologists, psychologists, and health care providers focused their attention on meeting the needs of the typical or average adult: people between 20 and 65 years of age. This group was the largest and most economically productive segment of the population; they were raising families, working, and contributing to the growth of the economy. Only a small percentage of the population lived beyond 65 years of age. Disability, illness, and early death were accepted as natural and unavoidable.

In the late 1960s, research began to indicate that adults of all ages are not the same. At the same time, the focus of health care shifted from illness to wellness. Disability and disease were no longer considered unavoidable parts of aging. Increased medical knowledge, improved preventive health practices, and technologic advances helped more people live longer, healthier lives.

Older adults now constitute a significant group in society, and interest in the study of aging is increasing. The study of aging is expected to be a major area of attention for years to come.

WHAT'S IN A NAME: GERIATRICS, GERONTOLOGY, AND GERONICS

The term **geriatric** comes from the Greek words “geras,” meaning old age, and “iatro,” meaning relating to medical treatment. Thus, *geriatrics* is the medical specialty that deals with the physiology of aging and with the diagnosis and treatment of diseases affecting the aged. Geriatrics, by definition, focuses on abnormal conditions and the medical treatment of these conditions.

The term **gerontology** comes from the Greek words “gero,” meaning related to old age, and “ology,” meaning the study of. Thus, *gerontology* is the study of all aspects of the aging process, including the clinical, psychological, economic, and sociologic problems of older adults and the consequences of these problems for older adults and society. Gerontology affects nursing, health care, and all areas of our society—including housing, education, business, and politics.

The term **geronics**, or gerontic nursing, was coined by Gunter and Estes in 1979 to define the nursing care and the service provided to older adults. The aim of gerontic nursing is “to safeguard and increase health to the extent possible and to provide comfort and care to the extent necessary.” This textbook focuses on gerontic nursing. It addresses ways to promote high-level **functioning** and methods of providing care and comfort for older adults.

The objectives of this book are as follows:

- Examine some of the trends and issues that affect the older person’s ability to remain healthy.
- Explore the theories and myths of aging.
- Study the normal changes that occur with aging.
- Review the pathologic conditions that are commonly observed in older adults.
- Emphasize the importance of effective communication in working with older adults.
- Explore the general methods used to assess the health status of older adults.
- Describe the specific methods of assessing functional needs.
- Identify the most common nursing diagnoses associated with older adults, and discuss the nursing interventions related to these diagnoses.

- Explore the impact of medication and medication administration on older adults.

The dictionary defines *old* as “having lived or existed for a long time.” The meaning of *old* is highly subjective; to a great degree, it depends on how old we ourselves are. Few people like to consider themselves old. Old age seems to come later as we become older. A recent study reveals that people younger than 30 years view those older than 63 as “getting older.” People 65 years of age and older do not think people are “getting older” until they are 75.

Aging is a complex process that can be described chronologically, physiologically, and functionally. **Chronologic age**, the number of years a person has lived, is most often used when we speak of aging because it is the easiest to identify and measure. Unfortunately, chronologic age is probably the least meaningful measurement of aging. Many people who have lived a long time remain functionally and physiologically young. These individuals remain physically fit, stay mentally active, and are productive members of society. Others are chronologically young but physically or functionally old.

When we use chronologic age as our measure, authorities use various systems to categorize the aging population (see Table 1-1). To many people, 65 is a magic number in terms of aging. The wide acceptance of age 65 as a landmark of aging is interesting. Since the 1930s, the age of 65 has come to be accepted as the age of retirement, when it is expected that a person willingly or unwillingly stops paid employment. However, before the 1930s, most people worked until they decided to stop working, until they became too ill to work, or until they died. When the New Deal politicians established the Social Security program, they set 65 as the age at which benefits could be collected, but the average life expectancy of the time was 63. The Social Security program was designed as a fairly low-cost way to win votes because most people would not live long enough to collect the benefits. If 65 was considered old then, it certainly is not now. If the same standards were applied today, the retirement age would be 77. However, for various reasons, society

Table 1-1 Categorizing the Aging Population

AGE (YEARS)	CATEGORY
55 to 64	Older
65 to 74	Elderly
75 to 84	Aged
85 and older	Extremely aged
	or
60 to 74	Young-old
75 to 84	Middle-old
85 and older	Old-old

clings to 65 as the “retirement age” and resists political proposals designed to move the start of Social Security benefits to a later age. Despite the resistance, the age to qualify for full Social Security benefits is changing. Individuals born before 1937 still qualify for full benefits at age 65, but there are incremental increases in age for all persons born after that time. Individuals born in 1960 or later must wait until age 67 to qualify for full benefits. Reduced benefits are calculated for

individuals who claim Social Security benefits after age 62 but before the full retirement age.

ATTITUDES TOWARD AGING

Before we look at the attitudes of others, it is important to examine our own attitudes, values, and knowledge about aging. The three Critical Thinking boxes that follow are designed to help you assess how you feel about aging.

? Critical Thinking

Your Views and Attitudes About Aging

- How many “old people” do you know personally?
- Do you think they are old, or do they think they are old?
- How do you personally define old?
- Why is getting old an issue today?
- Should Social Security laws be changed to reflect today's longer life expectancy?

Please complete the following statements. Write as many applicable comments as you can. *There are no right or wrong answers.*

A person can be considered old when _____.

When I think about getting old, I _____.

Growing old means _____.

When I get old I will lose my _____.

Seeing an old person makes me feel _____.

Old people always _____.

Old people never _____.

The best thing about getting old is _____.

The worst thing about getting old is _____.

Looking back at my responses, I feel that aging is _____.

? Critical Thinking

Your Values About Aging

Quickly name three older adults who have had an impact on your life. List five characteristics that you associate with each person. *There are no right or wrong answers.*

Person 1

Person 2

Person 3

Name _____

Name _____

Name _____

Relationship _____

Relationship _____

Relationship _____

CHARACTERISTICS:

1. _____

1. _____

1. _____

2. _____

2. _____

2. _____

3. _____

3. _____

3. _____

4. _____

4. _____

4. _____

5. _____

5. _____

5. _____

Look at the characteristics you described, and think about the feelings you experienced as you considered these individuals. Do your feelings correspond to your attitudes about aging? Were these three people's characteristics similar or different? What do these characteristics say about your values?

Critical Thinking

Your Current Knowledge About Aging

Respond to the following questions to the best of your knowledge.

You are old at age _____.

There are _____ older adults in the United States.

Most older people live in _____.

Economically, older people are _____.

With regard to health, older people are _____.

Mentally, older people are _____.

Our attitudes are the product of our knowledge and values. Our life experiences and our current age strongly influence our views about aging and old people. Most of us have a rather narrow perspective, and our attitudes may reflect this. We tend to project our personal experiences onto the rest of the world. Because many of us have a somewhat limited exposure to aging, we are likely to believe quite a bit of inaccurate information. When dealing with older adults, our limited understanding and vision can lead to serious errors and mistaken conclusions. If we view old age as a time of physical decay, mental confusion, and social boredom, we are likely to have negative feelings toward aging. Conversely, if we see old age as a time for sustained physical vigor, renewed mental challenges, and social usefulness, our perspective on aging will be quite different.

It is important to separate fact from myth when examining our attitudes about aging. The single most important factor that influences how poorly or how well a person will age is attitude. This statement is true not only for others but also for ourselves.

Throughout time, youth and beauty have been desired (or at least viewed as desirable), and old age and physical infirmity have been loathed and feared. Greek statues portray youths of physical perfection. Artists' works throughout history have shown heroes and heroines as young and beautiful, and evildoers as old and ugly. Little has changed to this day. Few cultures cherish their older members and view them as the keepers of wisdom. Even in Asia, where tradition demands respect for older adults, societal changes are destroying this venerable mindset.

Cultural Considerations

The Role of the Family

Cultural heritage may work as a barrier to getting help for an older parent. Many cultures emphasize the importance of intergenerational obligation and dictate that it is the role of the family to provide for both the financial and personal assistance needs of older adults. This can lead to high stress and excessive demands, particularly on lower-income families.

Nurses need to recognize the impact that culture has on expectations and values and how these cultural values affect

the willingness to accept outside assistance. Nurses need to be able to identify the workings of complex family dynamics and determine how decision making takes place within a unique cultural context.

Critical Thinking

Caregiver Choices

- What expectations does your cultural heritage dictate regarding obligations to frail older family members?
- Who in your family culture makes decisions regarding the care of older family members?
- Should Medicare or insurance plans pay low-income family members to stay at home and provide care for infirm older adults?
- To what extent should family members sacrifice their personal lives to keep frail or infirm older adults out of institutional care?
- Can filial obligations be met in a society that provides little support or relief to caregivers?

For the most part, mainstream American society does not value its elders. The United States tends to be a youth-oriented society in which people are judged by age, appearance, and wealth. Young, attractive, and wealthy people are viewed positively; old, imperfect, and poor people are not. It is difficult for young people to imagine that they will ever be old. Despite some cultural changes, becoming old retains many negative connotations. Many people continue to do everything they can to fool the clock. Wrinkles, gray hair, and other physical changes related to aging are actively confronted with makeup, hair dye, and cosmetic surgery. Until recently, advertising seldom portrayed people older than 50 years except to sell eyeglasses, hearing aids, hair dye, laxatives, and other rather unappealing products. The message seemed to be, "Young is good, old is bad; therefore, everyone should fight getting old." It is significant that trends in advertising appear to be changing. As the number of healthier, dynamic senior citizens with significant spending power has increased, advertising campaigns have become increasingly likely to portray older adults as the consumers of their products, including exercise

equipment, health beverages, and cruises. Despite these societal improvements, many people do not know enough about the realities of aging, and, because of ignorance, they are afraid to get old. Interestingly, some studies of the media have found that people who watch more television are likely to have more negative perceptions about aging.

GERONTOPHOBIA

The fear of aging and the refusal to accept older adults into the mainstream of society is known as **gerontophobia**. Senior citizens and younger persons can fall prey to such irrational fears (Box 1-1). Gerontophobia sometimes results in very strange behavior. Teenagers buy antiwrinkle creams. Thirty-year-old women consider facelifts. Forty-year-old women have hair transplants. Long-term marriages dissolve so that one spouse can pursue someone younger. Too often these behaviors may arise from the fear of growing older.

Ageism

The extreme forms of gerontophobia are ageism and age discrimination. **Ageism** is the disliking of aging and older people based on the belief that aging makes people unattractive, unintelligent, and unproductive. It is an emotional prejudice or discrimination against people based solely on age. Ageism allows the young to separate themselves physically and emotionally from the old and to view older adults as somehow having less human value. Like sexism or racism, ageism is a negative

belief pattern that can result in irrational thoughts and destructive behaviors such as intergenerational conflict and name-calling. Like other forms of prejudice, ageism occurs because of myths and stereotypes about a group of people who are different from ourselves.

The combination of societal stereotyping and a lack of positive personal experiences with the elderly affects a cross section of society. Many studies have shown that health care providers share the views of the general public and are not immune to ageism. Few of the “best and brightest” nurses and physicians seek careers in **geriatrics** despite the increasing need for these services. They erroneously believe that they are not fully using their skills by working with the aging population. Working in intensive care, the emergency department, or other high technology areas is viewed as exciting and challenging. Working with the elderly is viewed as routine, boring, and depressing. As long as negative attitudes such as these are held by health care providers, this challenging and potentially rewarding area of service will continue to be underrated, and the elderly will suffer for it.

Ageism can have a negative effect on the way health care providers relate to older patients, which, in turn, can result in poor health care outcomes in these individuals. Research by the National Institute on Aging reports that (1) older patients receive less information than do younger patients with regard to resources, health management, and illness management; (2) less information is provided to older adults on lifestyle changes such as weight reduction and smoking cessation; (3) limited rehabilitation is available for older adults with chronic disease, despite studies demonstrating that individuals older than 85 years do benefit from rehabilitation programs; and (4) only 47% of physicians feel that older adults should receive the same evaluation and treatment for acute illness as their younger counterparts.

Because an increasing portion of the population consists of older adults, health care providers need to do some soul searching with regard to their own attitudes. Furthermore, they must confront signs of ageism whenever and wherever they appear. Activities such as increased positive interactions with older adults and improved professional training designed to address misconceptions regarding aging are two ways of fighting ageism. The Nursing Competence in Aging (NCA) initiative, which was started in 2002, focuses on enhancing competence in geriatrics by expanding nurses’ knowledge, skills, and attitudes. Research coming from this initiative can help nurses regardless of their area of practice. Becca Levy, a Yale University professor, found that young people who hold positive feelings toward the elderly live 7.5 years longer than those with negative perceptions of aging. On a purely self-serving basis, health care providers should work to stamp out ageism.

Age discrimination reaches beyond emotions and leads to actions. Age discrimination results in different

Box 1-1 Aging: Myth Versus Fact

MYTH

- Most older people are pretty much alike.
- They are generally alone and lonely.
- They are sick, frail, and dependent on others.
- They are often cognitively impaired.
- They are depressed.
- They become more difficult and rigid with advancing years.
- They barely cope with the inevitable declines associated with aging.

FACT

- They are a very diverse age group.
- Most older adults maintain close contact with family.
- Most older people live independently.
- For most older adults, if there is decline in some intellectual abilities, it is not severe enough to cause problems in daily living.
- Community-dwelling older adults have lower rates of diagnosable depression than younger adults.
- Personality remains relatively consistent throughout the life span.
- Most older people successfully adjust to the challenges of aging.

treatment of older people simply because of their age. Refusing to hire older persons, barring them from approval for home loans, and limiting the types or amount of health care they receive are all examples of discrimination that occur despite laws prohibiting them. Some older individuals respond to age discrimination with a passive acceptance, whereas others are banding together to speak up for their rights.

The reality of getting old is that no one knows what it will be like until it happens. But that is the nature of life—growing older is just the continuation of a process that started at birth. Older adults are fundamentally no different from the people they were when they were younger. Physical, financial, social, and political conditions may change, but the person remains essentially the same. Old age has been described as the “more-so” stage of life because some personality characteristics may appear to amplify. Old people are not a homogeneous group. They differ as widely as any other age group. They are unique individuals with unique values, beliefs, experiences, and life stories. Because of their extended years, their stories are longer and often far more interesting than those of younger persons.

Aging can be a freeing experience. Aging seems to decrease the need to maintain pretenses, and the older adult may finally be comfortable enough to reveal the real person that has existed beneath the facade. If a person has been essentially kind and caring throughout life, he or she will generally reveal more of these positive personal characteristics as time marches on. Likewise, if a person was miserly or unkind, he or she will often reveal more of these negative personality characteristics as he or she grows older. The more successful a person has been at meeting the developmental tasks of life, the more likely he or she will successfully face aging. Perhaps the best advice to all who are preparing for old age is contained in the Serenity Prayer:

O God, give us the serenity to accept what cannot be changed; courage to change what should be changed; and wisdom to distinguish one from the other.

Reinhold Niebuhr

DEMOGRAPHICS

Demographics is the statistical study of human populations. Demographers are concerned with a population's size, distribution, and vital statistics. Vital statistics include birth, death, age at death, marriage(s), race, and many other variables. The collection of demographic information is an ongoing process. The most inclusive demographic research in the United States is compiled every 10 years by the Bureau of the Census. The most recent census was completed in the year 2010. It will take some time for the full analysis of these data to be compiled.

Demographic research is important to many groups. Demographic information is used by the government as a basis for granting aid to cities and states, by cities to project their budget needs for schools, by hospitals to determine the number of beds needed, by public health agencies to determine the immunization needs of a community, and by marketers to sell products. The politicians of the 1930s used demographics to formulate plans for the Social Security program. Demographic studies provide information about the present that allows projections into the future.

One important piece of demographic information is life expectancy. Life expectancy is the number of years an average person can expect to live. Projected from the time of birth, life expectancy is based on the ages of all people who die in a given year. If a large number of infants die at birth or during childhood, the life expectancy of that year's group tends to be low. The life expectancy throughout history has been low because of environmental hazards, wars, accidents, food and water scarcity, inadequate sanitation, and contagious diseases.

- During biblical times, the average life expectancy was approximately 20 years. Some people did live significantly longer, but 40 years was considered a good, long life.
- By 1776, when the Declaration of Independence was signed, the life expectancy had risen to 35 years. It was not uncommon for people to live into their sixties.
- By the 1860s, at the time of the American Civil War, the life expectancy had increased to 40 years. The 1860 census revealed that 2.7% of the American population was older than 65 years.
- By the beginning of the twentieth century, the overall life expectancy had increased to 47 years, and 4% of the American population was 65 years of age or older. In a span of more than 2000 years, life expectancy had increased by only 27 years.
- During the twentieth century, the life expectancy of Americans has increased by approximately 29 years. A child born in the United States in the year 2004 has an average life expectancy of nearly 77.4 years.
- Projections indicate that a child born in 2010 will have a life expectancy of 78.4 years.

Since the beginning of the twentieth century, advances in technology and health care have dramatically changed the world, especially in industrialized nations where food production exceeds the needs of the population. Diseases such as cholera and typhoid have been eliminated or significantly reduced by improved sanitation and hygiene practices. Dreaded communicable diseases that at one time were often fatal (e.g., smallpox, measles, whooping cough, and diphtheria) are now preventable through immunization. Even pneumonia and influenza are no longer the fatal diseases they once were. Today, vaccines can be given to those who are at higher risk, and treatment can be given to those who become infected. It is hoped that changes

in the geopolitical climate of the world will lessen the number of deaths resulting from war.

A longer life is a worldwide phenomenon. Almost 8% of the world's population is age 65 or older. Developed countries, including Japan, Australia, Canada, and Sweden, lead the world in longevity statistics. Germany, the United Kingdom, Switzerland, Norway, and France, including Jordan and South Korea, exceed the United States. The standing of the United States has declined over the last few decades, and the United States now ranks 49th among countries with large percentages of senior citizens. Some possible explanations for the disparity between the United States and other countries include higher levels of accidental and violent deaths, obesity, relatively high infant mortality, and the high cost of health care. Much of the world's net gain in older persons has occurred in the still-developing countries in Africa, South America, and Asia (Figure 1-1).

SCOPE OF THE AGING POPULATION

According to the U.S. Department of State, for the first time in recorded history, the number of people over age 65 is projected to exceed the number of children under age 5. In 2008, an estimated 39 million people,

or 1 out of 8 people, age 65 or older, lived in the United States. By 2050, this is expected to increase to 72 million people age 65 or older. This is 1 out of 5, or about 20% of the total population of the United States. Individuals older than 85 years now make up 4% of the entire U.S. population and represent the fastest-growing segment of the older population. We are becoming an increasingly older society (Figure 1-2).

GENDER AND ETHNIC DISPARITY

The Administration on Aging projects that minority populations will represent 26.4% of the older population by 2030, an increase from 16% in 2000. It is projected that by 2030, the white non-Hispanic population will increase by 77%. During the same time period, the percentage of minority persons of the same age cohort is expected to grow by 223% (Hispanics, 342%; African Americans, 164%; American Indians, Eskimos, and Aleuts, 207%; and Pacific Islanders, 302%).

The life expectancy is variable within the U.S. population. The populations of men and women are not equal, and in the older-than-65 age group, this disproportion is very noticeable. There are 22.4 million older women to 16.5 million older men. Women currently outlive men by approximately 7 years. Women

Life expectancy world map

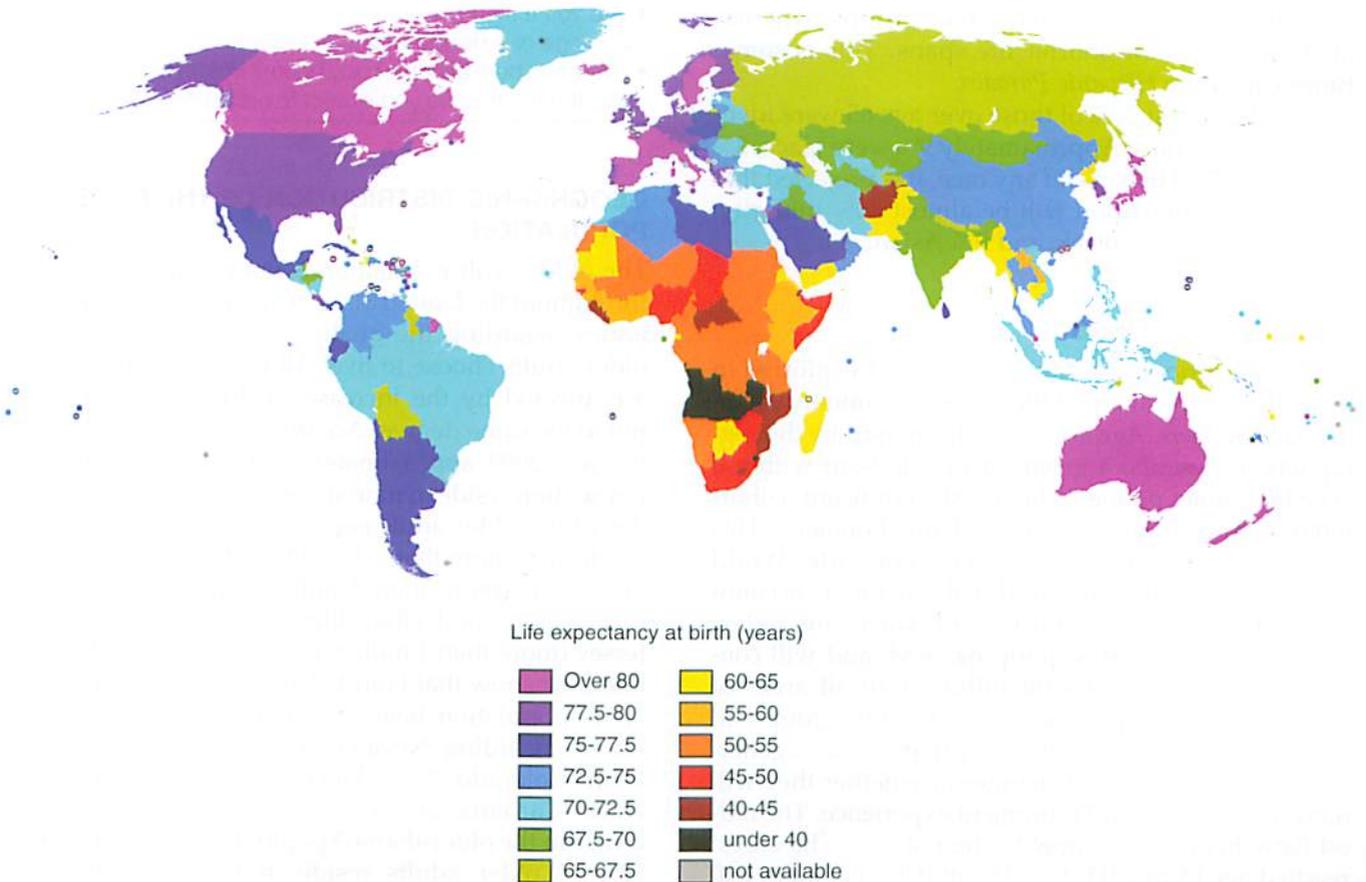


FIGURE 1-1 Life expectancy world map.

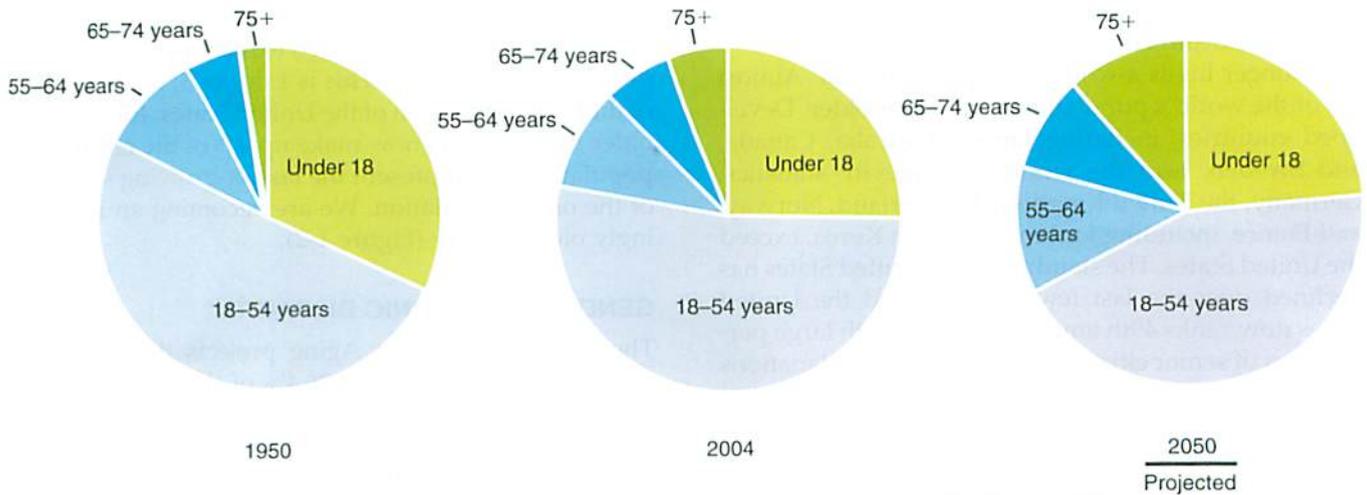


FIGURE 1-2 Percentage of population in five age groups: United States, 1950, 2004, and 2050.

tend to live longer than men, and whites tend to live longer than blacks, although disparities seem to be declining.

White women have the longest life expectancy, about 81 years. Black women have a life expectancy of about 76.9 years; white men, 76 years; and black men, 70 years. Because of the lack of precision in defining a Hispanic status (surname, country of origin, etc.), statistics for a Hispanic life expectancy are unclear and often contradictory. Some studies show Hispanics living longer than other groups, whereas other studies show shorter life spans. This is sometimes called the *Hispanic Paradox*.

In 2008, almost 20% of those over age 65 were identified as minorities. Approximately 9% were black, 3% Asian, and 7% Hispanic of any race. It is projected that by 2050 the population will be almost 40% minority: 20% Hispanic, 12% black, and 9% Asian.

THE BABY BOOMERS

A major contributing factor to this rapid explosion in the elderly is the aging of the cohort, commonly called the *Baby Boomers*. Age **cohort** is a term used by demographers to describe a group of people born within a specified time period. The most significant cohort today is the group known as Baby Boomers. This cohort consists of people who were born after World War II between 1946 and 1964. Baby Boomers account for approximately one-third of all Americans today. Because of its size, this group has had, and will continue to have, a significant influence in all areas of society. It remains to be seen whether this group will experience aging in the same way that previous generations have experienced changes or whether they will reinvent the aging and retirement experience. The oldest Baby Boomers are now in their sixties. The oldest reached age 65 in 2011. By 2029 all Baby Boomers will be age 65 or older. Based on the sheer size of this group,

the older population in 2030 will be twice the number it was in 2000. The implications of this for all areas of society, particularly health care, are unprecedented.

? Critical Thinking

Demographics and You

- What impact will the changing demographics have on you personally?
- How is your community's age distribution changing?
- Are you a member of the baby-boom cohort? Is this an advantage or a disadvantage as you age?
- Were you born after the baby boom? Before the baby boom? What difficulties do you expect to encounter as you age?

GEOGRAPHIC DISTRIBUTION OF THE ELDERLY POPULATION

The older adult population is not equally distributed throughout the United States. Climate, taxes, and other issues regarding the quality of life influence where older adults choose to live. All regions of the country are affected by the increases in life expectancy, but not to the same degree. According to census data from the year 2000, approximately half of the older-than-65 population reside in nine states only. In descending order of the older adult population, the nine states are California (more than 3.8 million); Florida, New York, and Texas (more than 2 million each); Pennsylvania (1.9 million); and Ohio, Illinois, Michigan, and New Jersey (more than 1 million each). Population distribution data show that Florida leads the nation, with 17% of its population being older than 65 years. Eleven states, including Nevada, Alaska, Hawaii, Arizona, Utah, Colorado, New Mexico, Wyoming, Delaware, North Carolina, and Texas, have shown a rapid increase in the older-than-65 population. Approximately 78% of older adults reside in metropolitan areas, with approximately 27% residing in the central city.

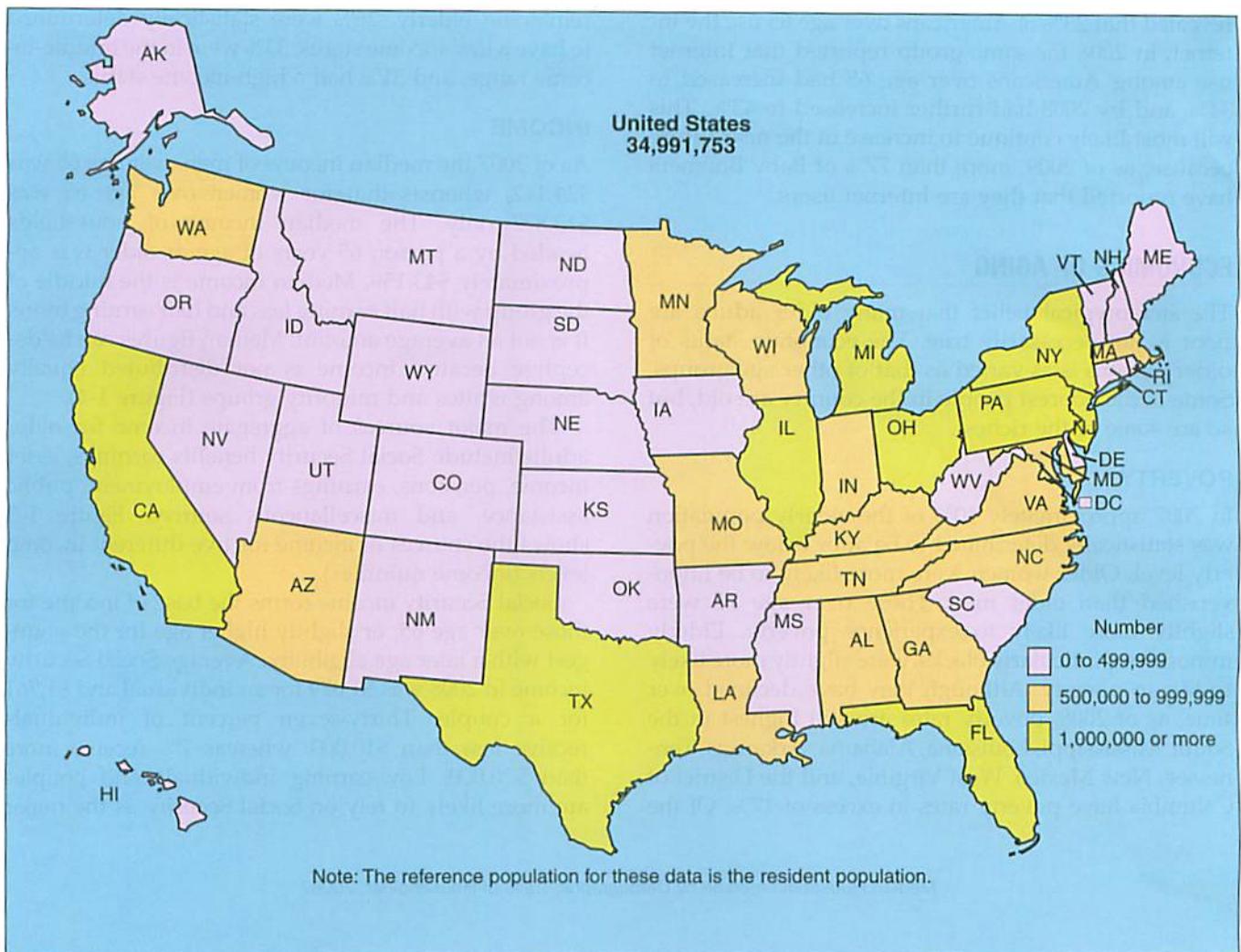


FIGURE 1-3 Population age 65 and over by state, 2000.

Only 23% of older adults reside in nonmetropolitan areas (Figure 1-3).

Statistical evaluation of minority populations reveals that groups tend to concentrate in a limited number of states. Half of elderly blacks live in New York, Florida, California, Texas, Georgia, North Carolina, Illinois, and Virginia; 70% of the Hispanic elderly live in California, Texas, Florida, and New York; and 60% of elderly persons of Asian, Hawaiian, or Pacific Island descent favor California, Hawaii, and New York. The majority of elderly people of Native American or Native Alaskan descent live in California, Oklahoma, Arizona, New Mexico, Texas, and North Carolina.

MARITAL STATUS

In 2008 three-fourths (75%) of men over age 65 were married compared to 57% of older women. The percentage of married individuals drops significantly as age progresses, but the percentage of the oldest old men who are married remains high at 55%. At age 65, 42% of women were widows compared with only 14% of men. By age 85, 76% of women were widows compared

to only 38% of men. The percentage of older adults who are separated or divorced has increased significantly to 11%. An increase in the number of divorced elders is predicted as a result of a higher incidence of divorce in the population approaching age 65.

The number of single, never-married seniors remains somewhat consistent at about 4% of the older-than-65 population.

EDUCATIONAL STATUS

The educational level of the older adult population in the United States has changed dramatically over the past three decades. In 1970, only 28% of senior citizens had graduated from high school. By 2008, 78% were high school graduates or more, and 21% had a bachelor's degree or higher. Twenty-seven percent of older men hold bachelor's degrees as contrasted with 16% of older women.

In addition to being better educated, today's older adult population is more technologically sophisticated. A Pew research study conducted in 2004

revealed that 23% of Americans over age 65 use the Internet. In 2006 the same group reported that Internet use among Americans over age 65 had increased to 34%, and by 2008 had further increased to 43%. This will most likely continue to increase in the near future because, as of 2009, more than 77% of Baby Boomers have reported that they are Internet users.

ECONOMICS OF AGING

The stereotypical belief that many older adults are poor is not necessarily true. The economic status of older persons is as varied as that of other age groups. Some of the poorest people in the country are old, but so are some of the richest.

POVERTY

In 2007 approximately 10% of the elderly population was statistically determined to be at or below the poverty level. Older women were more likely to be impoverished than older men. Those over age 75 were slightly more likely to experience poverty. Elderly minorities, particularly blacks, were slightly more likely to live in poverty. Although they have declined over time, as of 2008, poverty rates are still highest in the South. Mississippi, Louisiana, Alabama, Arkansas, Tennessee, New Mexico, West Virginia, and the District of Columbia have poverty rates in excess of 17%. Of the

remaining elderly, 26% were statistically determined to have a low-income status, 33% were in the middle-income range, and 31% had a high-income status.

INCOME

As of 2007 the median income of men over age 65 was \$24,142, whereas that for women over age 65 was \$13,877 only. The median income of households headed by a person 65 years of age or older was approximately \$43,159. Median income is the middle of the group with half earning less and half earning more. It is not an average amount. Median figures can be deceptive because income is not distributed equally among whites and minority groups (Figure 1-4).

The major sources of aggregate income for older adults include Social Security benefits earnings, asset income, pensions, earnings from employment, public assistance, and miscellaneous sources. Figure 1-5 shows the sources of income for five different income levels (income quintiles).

Social Security income forms the base of income for those over age 65, or slightly higher age for the youngest with a later age eligibility. Average Social Security income in 2008 was \$1,079 for an individual and \$1,761 for a couple. Thirty-seven percent of individuals receive less than \$10,000, whereas 7% receive more than \$20,000. Low-earning individuals and couples are more likely to rely on Social Security as the major

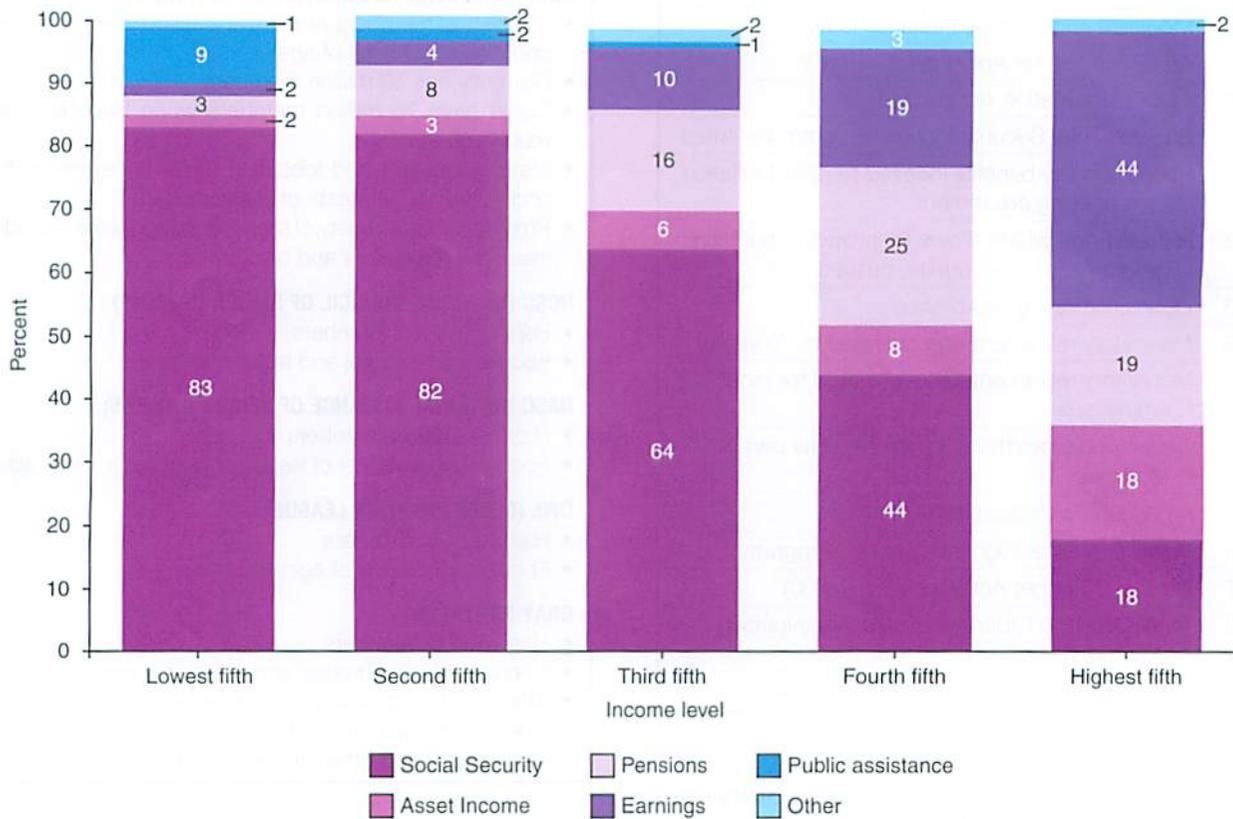
Median Household Income by Demographic Traits of Householder, 20087



Source: Both figures from CRS analysis of the March 2008 *Current Population Survey*.

FIGURE 1-4 Median individual income by demographic traits, 2007.

Sources of income for married couples and nonmarried people who are age 65 and over, by income quintile, percent distribution, 2008



NOTE: A married couple is age 65 and over if the husband is age 65 and over or the husband is younger than age 55 and the wife is age 65 and over. The definition of "other" includes, but is not limited to, public assistance, unemployment compensation, worker's compensation, alimony, child support, and personal contributions. Quintile limits are \$12,082, \$19,877, \$31,303, and \$55,889 for all units; \$23,637, \$35,794, \$53,180, and \$86,988 for married couples; and \$9,929, \$14,265, \$20,187, and \$32,937 for nonmarried persons.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009

FIGURE 1-5 Sources of income.

source of income. High earners are less reliant on Social Security.

An area of concern is that Social Security funding could become inadequate as the number of retirees drawing benefits increases, while the pool of workers paying into the system decreases. Plans to ensure the long-term survival of the Social Security program have been proposed by many both within and outside of the government.

Asset income, income derived from investments such as stocks, bonds, and other retirement accounts, has dropped drastically since 2008. The economic downturn has been compared in severity to the Great Depression of the 1930s. Many retirees and those near retirement lost a large percentage of the monies they had saved and invested for retirement. Many of those who invested personally and those who had their money in employer-directed programs were severely affected. These financial losses have forced many individuals nearing retirement to reconsider whether they can afford it.

In 2007 slightly more than one-third of people age 65 and older received pensions from public or private sources. People who worked for a governmental agency were much more likely to receive a pension than those who worked for a private industry or business. Not only are former government employees more likely to receive a pension, but also government pensions tend to be far more generous than those in the private sector. The median government pension in 2007 was \$16,629, whereas the median private sector pension was \$7,200 only.

Early retirement was popular from until about 1985. Since then the trend has shown more people working for pay after age 65. For those over 65 who work, the median wages in 2007 were \$20,000. This is significantly less than what the person earned earlier in life and reflects a decrease in hours worked and in wages.

Earnings make up a substantial portion of income for many people over age 65. Those who are in higher income brackets, generally professionals, may

Table 1-2 Legislation That Has Helped Older Adults

YEAR	LEGISLATION
1965	Medicare and Medicaid established Administration on Aging established
1967	Age Discrimination Act passed
1972	Supplemental Security Income Program instituted Social Security benefits indexed to reflect inflation, cost-of-living adjustment
1972	Nutrition Act, which allows for providing nutrition programs for older adults, passed
1973	Council on Aging established
1978	Mandatory retirement age changed to 70 years
1986	Mandatory retirement age eliminated for most employees
1988	Catastrophic health insurance became part of Medicare
1990	Americans with Disabilities Act
1992	Vulnerable Elder Rights Protection Program
1997	Balanced Budget Act (Medicare Part C)
2000	Amendment to Older Americans Act (Nutrition programs)
2006	Drug Benefit Program added to Medicare

continue to work well beyond age 65 as long as they are healthy and interested in what they are doing. Socialization, time away from a retired spouse, intellectual challenge, and a sense of self-worth are verbalized as reasons for working, particularly by those in the baby boom generation. Some Baby Boomers need to continue to work to maintain a standard of living they desire. Some need to work because they neglected to save enough for retirement or need to make up for losses in their investments. Those in lower income brackets may need to continue to work, or to seek work, to pay for necessities of life or a few luxuries.

Legislation and political activism among older people have helped improve the economic outlook for older adults (Table 1-2). Through activist organizations, older adults have united to consolidate their political power and to use the power of the vote to initiate programs that benefit them (Box 1-2). Over the past 25 years, these groups have done much to improve the economic welfare of older adults. The Federal Housing Authority and other lending agencies have proposed the use of reverse mortgages, which are plans that allow older adults to remain in their homes and receive monthly payments based on their equity in the property. Monthly income realized from these plans could range from as little as \$100 to as much as several thousand dollars, depending on the value of the property and the age of the residents. This money could be a much-needed income supplement for older adults. Plans such as these are likely to become more common

Box 1-2 Politically Active Senior Citizen Groups**AARP (AMERICAN ASSOCIATION OF RETIRED PERSONS)**

- Consists of members who are at least 50 years of age and spouses regardless of age
- Currently has 30 million members
- Could have 76 million members when Baby Boomers reach age 50
- Uses volunteers and lobbyists to advance the political and economic interests of older adults
- Provides a wide variety of membership benefits, including insurance programs and discounts

NCSC (NATIONAL COUNCIL OF SENIOR CITIZENS)

- Has 4.5 million members
- Focuses on political and legislative issues

NASC (NATIONAL ALLIANCE OF SENIOR CITIZENS)

- Has two million members
- Focuses on a variety of issues of concern to older adults

OWL (OLDER WOMEN'S LEAGUE)

- Has 20,000 members
- Focuses on needs of aging women

GRAY PANTHERS

- Has 75,000 members
- Consists of local groups and a national organization
- Attempts to increase public awareness of the needs of older adults by means of demonstrations, door-to-door canvassing, and other attention-getting methods

in the future when more elderly people recognize their economic benefits.

Older people may choose not to seek help, despite the availability of assistance programs designed to aid them. Many older adults are suspicious of "getting something for nothing" or are reluctant to disclose the details of their financial status, which is necessary to qualify for most assistance programs. Many older people feel that asking for help is humiliating. Some may fear they will lose what little they have if they seek assistance. Other older people have no difficulty seeking or, in some cases, demanding financial assistance or concessions. The term *greedy geezers* was coined to describe those older individuals who expect the government to provide more money and services or for businesses to provide discounts based on senior status. Factors that can affect the financial well-being of older adults are described in Box 1-3.

Sensitivity is needed when dealing with the financial issues of older adults. The Critical Thinking box on page 13 should help you assess your attitudes, and therefore your sensitivity, toward these kinds of situations. Many older adults who find it easy to talk about their intimate physical and medical problems are reluctant to discuss finances. Nurses may suspect financial need if an older person lacks adequate shelter, clothing, heat, food, or medical attention. When an economic problem causes real or potential dangers, nurses must be prepared to respond appropriately.

Box 1-3 Factors That Influence the Economic Conditions of Older Adults

- Many older adults bought their homes when housing costs and inflation were low. If they paid off their mortgages before retirement, their housing costs are limited to taxes, maintenance, and utility bills.
- The number of older adults who receive pensions is greater now than it will be in the future. The current changes in business conditions are resulting in the offering of smaller pensions to fewer employees.
- Older adults qualify for several tax breaks that are unavailable to younger people.
 - Most older adults pay no Social Security taxes, whereas younger working adults pay increasingly higher rates.
 - Social Security and government pensions are largely exempt from taxation.
 - Taxpayers older than 65 years of age can take extra tax deductions.
 - A one-time capital gains tax exclusion applies when the house is sold.
- Most older adults qualify for government income programs.
 - The income from Social Security exceeds the program contributions of most recipients.
 - Medicare covers 70% of medical costs.
 - Programs such as Social Security, SSI, Medicare, housing programs, and energy assistance provide an annual average of \$9,000 per every older adult.

? Critical Thinking

Your Sensitivity to the Financial Problems of Older Adults

Respond to the following statements:

- Older adults control all of the money in the country.
- Most older adults are poor.
- Older adults have it easy; the younger working people have it rough.
- Older adults have too much political power, and they get too many benefits and entitlements.
- Older adults worked for what they are getting, and they deserve everything they receive from the government.
- A society that does not care for its older people is cruel and uncivilized.
- The property of older adults should be used to pay for their physical needs and medical care.

Because regulations covering assistance programs change often, it is difficult for older patients and the nurses trying to help them to keep current and up to date. Nurses may be called on to help older adults deal with the paperwork required when applying for assistance, to provide emotional support as they work through the frustration of bureaucratic processes, or to arrange transportation to the appropriate agencies. Nurses usually are not expected to be experts in this area, but they should know how to locate appropriate resources. Nurses working in community health should be aware of community agencies that provide

assistance to older adults so that appropriate referrals can be made. Nurses working in hospitals and nursing homes can initiate referrals to social workers or other professionals who are knowledgeable about assistance programs. Most states and counties throughout the United States have services for the elderly or departments on aging. These are typically listed in the government section of a telephone directory. Many publish directories of resources available in their specific community.

WEALTH

Although many older people receive less cash on a yearly basis from Social Security and pensions than some younger individuals earn, a substantial number have accumulated assets and savings from their working years. Frugal lifestyles and self-reports by older adults of being “poor” must be viewed cautiously. Some individuals are truly impoverished, whereas others have significant estates to leave to their children or to charities.

Approximately 80% of households headed by a person older than 65 years of age own their homes. Of these homes, 68% are owned outright. In 2007 the median value of homes owned by older persons was \$168,654 (with a median purchase price of \$45,191). A home is usually an older person’s largest asset. Many older people choose not to sell their houses because they fear they will have nowhere to live. Many prefer to remain “house rich and cash poor,” making do on a limited income, rather than selling their homes. Economic reversals in recent years have led to a high foreclosure rate resulting in a glut of houses for sale. This makes a profitable sale of property by the elderly more difficult to achieve. Additional considerations regarding homeownership and housing options are discussed in more detail later in the chapter.

Economic well-being is usually measured in terms of income, which is the amount of money a household receives on a weekly, monthly, or yearly basis. However, this measurement is not always a reliable indicator of financial security in older adults. People older than 65 years of age generally have more discretionary income (i.e., money left after paying for necessities such as housing, food, and medical care) available than do younger people. Younger individuals, particularly those with growing families, may have a higher income, but they also have higher nondiscretionary demands.

HOUSING ARRANGEMENTS

When asked where older adults live, most people say that they live in senior citizen housing or nursing homes. They are wrong. More than two-thirds of older adults (68%) live independently in a family setting.

Twenty-seven percent live in modified but not institutional settings, including senior citizen housing, group homes, and apartments, or with family members. Approximately 5% of all older adults are institutionalized, and this percentage increases with advancing age. Only 1% of 65- to 74-year-old individuals are institutionalized. This rate increases to 4.7% with individuals 75 to 84 years of age and reaches 18.2% with people older than age 85.

Older individuals often try to keep their homes, despite the physical or economic difficulties in doing so. A house is more than just a physical shelter; it represents independence and security. The home holds many memories. Being in a familiar neighborhood close to friends and church is important. A sense of community is important to many aging people, who dislike the thought of leaving security for the unknown. The physical exertion and emotional trauma involved in moving can be intimidating, even overwhelming, to older adults. Moving to a different, often smaller, residence is a difficult decision, particularly when it involves giving up precious possessions because of the lack of space.

For some older people, keeping the family home is not a sensible option for many reasons. Many of the houses owned by older adults are in central cities with high crime rates. Expenses, including increasingly high property taxes and ongoing maintenance costs, often present excessive strain on older persons with limited financial resources. Home maintenance, including even simple tasks such as housecleaning, becomes increasingly difficult with advancing age or illness. Ownership may require more effort in terms of money and time than some older people possess; yet many struggle to remain independent and keep their houses.

Some older individuals remain in their own houses and refuse to give them up long after it is safe for them to be alone. They may be able to cope as long as family, friends, and neighbors are willing to help. However, if there is a change in their support system, dangerous, life-threatening situations may arise. Some older people try to live in their houses, despite broken plumbing, inadequate heat, and insufficient access to food. Families, health care professionals, and social service agencies may have to step in to protect the welfare of these aging individuals.

Some older people recognize the problems associated with living alone and decide to seek housing arrangements that are more in keeping with their needs and abilities. They may choose to move into an apartment, condominium, senior citizen complex, or some other type of housing. As the older adult population grows, a variety of new types of housing and living arrangements is evolving (Figure 1-6). The following Critical Thinking box should help you determine your attitudes toward housing for older adults.

Critical Thinking

Your Attitudes Toward Housing for Older Adults

- Is it safe for older adults to remain indefinitely in their own houses?
- When should an older person sell his or her house?
- Once a house is sold, what are the best types of living accommodations for older adults?
- What kinds of alternative housing for older adults are available in your community?
- Should older adults live in housing that is separated from people in other age groups? Why? Why not?

Independent or assisted-living centers are becoming common. These centers combine privacy with easily available services. Most consist of private apartments that are either purchased or rented. For additional charges, the residents can be served meals in restaurant-style dining rooms and receive laundry and housekeeping services. Different levels of medical, nursing, and personal care services are available. Health care services may include assistance with hygiene, routine medication administration, and even preventive health clinics. Many centers have communal activity rooms, art-and-craft hobby centers, swimming pools, lounges, beauty salons, mini-grocery stores, greenhouses, and other amenities. Transportation to church, shopping, and other appointments is provided by some of these facilities. Most independent and assisted-living facilities are privately operated, and costs are significant. Some states offer subsidies to older individuals with limited resources because these living arrangements are often more cost-effective than other housing alternatives.

A study reported in the *Journal of the American Geriatrics Society* described an interesting alternative to assisted living—"Cruise Care." The article asserted that, with slight modifications for help with the activities of daily living, a senior citizen might be better off living on a cruise ship than in an assisted-living facility. The ship provides a higher employee-to-resident ratio, more activities, more and better choices of food, better scenery, and more companionship for a comparable price. Although not appropriate for individuals suffering from dementia, it might be an option (at least temporarily) for some adventurous seniors.

Life-lease or life-contract facilities are another housing option. For a large initial investment and substantial monthly rental and service fees, older persons or couples are guaranteed a residence for life. Independent residents occupy apartment units, but extended-care units are either attached to this apartment complex or located nearby for residents who require skilled nursing services. If one spouse needs skilled care, the other may continue to live in the apartment and can easily visit the hospitalized loved one. When the occupants die, control



FIGURE 1-6 A living plan for CBRF with evacuation plan.

of the apartment reverts to the owners of the facility. The costs for this type of housing are high and may be out of the range of the average older adult. However, despite the costs, many find this option satisfactory because it meets their needs for independence, socialization, and services. Many find security in knowing that skilled care is easily available if needed.

Less-well-to-do people are more limited in their housing options. Some older adults qualify for **government-subsidized housing** if they meet certain financial standards and limits. Government-subsidized housing units may be simple apartments without any special services, or they may have limited services, such as access to nursing clinics and special transportation arrangements. Most communities are finding that the demand for these facilities exceeds the availability. Waiting lists and 1- to 2-year delays are common. Interpretation of government regulations is causing some concern with regard to senior citizen housing. Residences originally intended for older adults may be required to accept a

variety of medically disabled people, regardless of age. Some of these younger residents suffer from psychiatric or drug-related problems, and the presence of these individuals may leave older adult residents feeling threatened and fearful for their own safety and well-being.

Some older adults who are not related to each other are forming **group-housing plans**. In this type of arrangement, two or more unrelated people share a household in which they have private bedrooms but share the common recreational and leisure areas, as well as the tasks involved in home maintenance. Some communities offer services to help match people who are interested in this option. Roommates are selected so that the strengths of one individual compensate for the weaknesses of the other. In some cases, a large house may shelter 10 or more residents. Not all of these arrangements are limited to older adults. In some situations, younger adults who need reasonable housing may be included. By providing services for older adult

residents, the younger residents are able to reduce their rental costs. Both younger and older individuals who have chosen this option report benefits from the extended-family atmosphere.

A more formal type of group home called a **community-based residential facility (CBRF)** is available in some communities. For a monthly fee, this type of facility provides services such as room and board, help with activities of daily living, assistance with medications, yearly medical examinations, information and referrals, leisure activities, and recreational or therapeutic programs. Fees for this type of housing may be paid by the individual or may be provided by county or state agencies. Most of these facilities provide private or semiprivate rooms with community areas for dining and socialization.

The most dependent older adults require more extensive assistance, which is typically provided in **nursing homes** or **extended-care facilities**. Nursing homes provide room and board, personal care, and medical and nursing services. They are licensed by individual states and regulated by both federal and state laws. Three levels of care are provided by nursing homes.



Critical Thinking

Nursing Home Insurance

Medicare will pay for most of 100 days of nursing home care if admission follows a hospitalization and if long-term care placement is for the same reason as the person was hospitalized. After that time, the cost of nursing home care is usually the responsibility of the older person or his or her family, unless he or she qualifies for Medicaid. In light of this, do you think that people approaching retirement should purchase nursing home insurance? Why or why not?

Basic care facilities provide the level of care and supervision necessary to maintain the residents' safety and well-being. They provide assistance with activities of daily living, including hygiene, ambulation, nutrition, elimination, and other basic needs. This level of care is typically provided by nursing assistants and licensed vocational or practical nurses. *Skilled care facilities* provide skilled nursing care on a regular basis. Interventions, such as the administration of medication and skilled treatments or procedures that require the expertise of registered and practical nurses, are provided in this type of facility. Skilled care facilities also provide services performed by specially trained professionals such as speech, physical, occupational, and respiratory therapists. *Subacute care facilities* provide comprehensive inpatient care designed for individuals who have an acute illness, injury, or exacerbation of a disease process. Subacute care falls between the traditional care provided in an acute care facility and that provided in a skilled nursing home.

Specialty residences designed to meet the special need of people with Alzheimer's disease or other memory loss and their families are gaining in popularity around the country.

HEALTH CARE PROVISIONS

Health care is a major area of concern in the United States. Everyone wants the best and most comprehensive medical care for themselves and their loved ones. The costs incurred providing this level of care is the problem. At one time individuals were personally responsible for the payment of physician and hospital bills. Over time this changed, and health care insurance, either purchased by the individual or paid for by an employer, became the norm. Insurance companies paid the bills, and the individual became less aware and involved in the rising cost of health care.

Government played a minimal role until the establishment of Medicare in 1965's.

MEDICARE AND MEDICAID

Medicare is the government program that provides health care funding for older adults and those with disabilities. Medicare is a popular program, and most Americans believe that it must be preserved. This will be increasingly difficult when the Baby-Boom generation becomes eligible for coverage. In 2005, Medicare provided coverage for approximately 42.5 million citizens. By 2031, when all Baby Boomers are eligible for coverage, this number is expected to swell to 77 million citizens. Most Americans older than 65 years of age qualify for Medicare.

Medicare has four distinct programs, none of which pays all of the health care costs. Medicare **Part A** covers inpatient hospital care; extended care in a skilled nursing facility following hospitalization; some home health services such as visiting nurses and occupational, speech, or physical therapists; and hospice services, but only after the patient pays an initial deductible and any co-pay expenses. During the 1980s, Medicare instituted the **diagnosis-related group (DRG)** system in an attempt to contain hospital costs. Under this system, a hospital is paid a set amount based on the patient's admitting diagnosis. If the patient is discharged in fewer days than predicted, the hospital may keep the excess money. If the patient needs to stay longer than projected, the hospital must absorb the additional costs. Although DRGs have resulted in some cost reduction, they have also resulted in the quicker discharge of sicker people than in the past. Many older people are released from the hospital before they have actually recovered from their illnesses, placing an increased health care burden on families and home health agencies.

Medicare **Part B** is optional, but most people choose to obtain this coverage. This plan covers 80% of the

“customary and usual” rates charged by physicians after deductibles are met. In addition to physicians’ fees, services covered by Medicare Part B include medically necessary ambulance transport; physical, speech, and occupational therapy; home health services when medically necessary; medical supplies and equipment; and outpatient surgery or blood transfusions. The patient is responsible for the remaining 20% of the costs plus the difference between the actual fee and the government’s “customary and usual” rate. The actual costs of medical care often exceed the amount that the government pays. Many elderly pay for private supplemental health care insurance to cover these expenses rather than pay these costs out of pocket.

In 1997 optional Medicare Part C coverage was made available to individuals who are eligible for Part A and enrolled in Part B. Medicare Part C includes “Advantage” or “Choice” plans, which allow beneficiaries to receive Medicare benefits through private insurance companies that are able to demonstrate cost savings. These plans involve enrollment in a private plan offered by a health maintenance organization (HMO), preferred provider organization (PPO), provider sponsored organization (PSO), private fee for service (PFFS) organization, or medical savings account (MSA). These plans are designed to cover total costs so that supplemental insurance coverage is not necessary. They do, however, limit the pool of available health care providers, and premiums vary depending on the plan selected.

Medicare Part D, prescription drug coverage, went into effect during 2006. It is a voluntary plan available to anyone enrolled in Part A or B of Medicare. Under Part D, prescription drugs are distributed through local pharmacies and administered by a wide variety of private insurance plans. In many plans, there is a significant gap between the cost of the drugs and the benefits provided. Individuals will need to be cautious when selecting coverage to ensure that they select a plan that is most cost-effective for their specific situation and needs. Elderly people who have high medication costs may experience the “donut hole.” In 2010 an elderly person was expected to meet a deductible of \$310, then pay a 25% co-insurance of up to \$2,830. Once costs exceed that amount, the elder enters the “donut hole” and must pay the full cost of medication until out-of-pocket expenses reached \$4,550. Costs drop to a set fee for generic (\$2.50) and brand name (\$6.30), only after this large amount is reached in a single year.

Supplemental Medicaid (Title 19) assistance may be available for those older adults who meet certain financial need requirements. Many of those who have assets do not qualify; they are left with a Medicare gap (or “medigap”) that they must pay themselves. Many older people buy private medical insurance—often at unreasonable prices—to pay medical bills that are not covered by Medicare.

RISING COSTS AND LEGISLATIVE ACTIVITY

The costs of health care have increased dramatically in recent years. More money is spent on health care in the United States than in any other country in the world, yet health care is not provided for all U.S. citizens. Many other nations do a better job than the United States of meeting their citizens’ health care needs.

During 2009 the Centers for Medicare & Medicaid Services (CMS) reported that approximately \$2.5 trillion was spent on health care in the United States. This exceeds the amount spent on any other activity, including defense. This amount is expected to grow to \$4.3 trillion by 2018. A significant proportion (close to one-third) is spent on the 13% of the population that is older than 65 years of age. These costs are staggering considering how quickly the number of older adults is increasing. To contain health care costs, there has been an upsurge in initiatives such as managed care and insurance reform. If we expect to continue to provide adequate health care in the future, we can expect to see more changes in the way health care is financed and delivered. This is a major, and often divisive, political issue.

The cost of Medicare alone has grown dramatically from \$3 billion in 1967, the first year of funding, to \$52 billion in 1983; \$297 billion in 2004; \$425 billion in 2009; and \$528 billion in 2010. The Congressional Budget Office (CBO) projects it will reach \$735 billion in 2015 and \$1,038 billion (more than \$1 trillion) in 2020 (Figure 1-7).

In December 2009, under highly charged political controversy, the United States Congress passed The **Patient Protection and Affordable Care Act (PPACA)**. It was signed into law by President Barack Obama in 2010. The law includes numerous health-related provisions to take effect over several years. This 2,000-plus-pages legislative initiative includes major changes in health insurance, health care funding, student loans, and a wide range of spending considerations. The costs of these provisions are supposed to be offset by a variety of taxes, fees, and cost-saving measures.

There is a great deal of controversy because many specifics of the legislation and their ramifications are still unknown. Those in favor of the legislation cite expanded coverage, more competition among insurance companies, coverage of people with preexisting medical conditions and closure of the “donut hole” affecting senior citizens. Those opposed to the legislation cite cuts in Medicare funding, cuts to the Medicare Advantage program along with increases in the Medicare tax. They fear increased costs of health care, more taxes, decreased incentives to primary care physicians, and possible rationing of care as seen in single-payer plans such as those provided in Canada.

Legal challenges regarding the constitutionality of this bill were raised by several states. The legality of the bill may eventually require a ruling by the Supreme

Projected Medicare Spending in Billions of Dollars

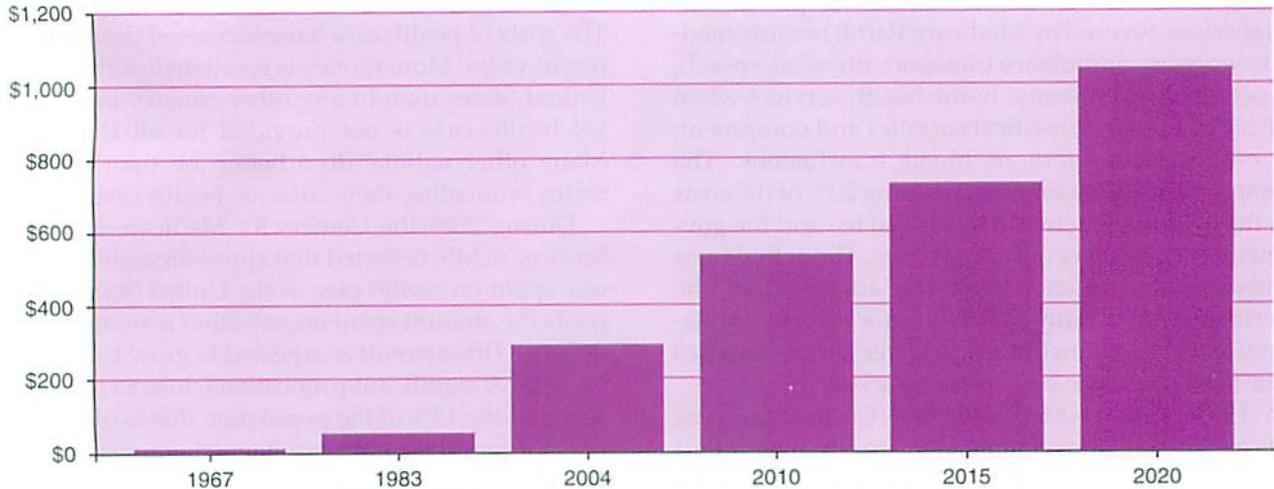


FIGURE 1-7 Projected Medicare spending in billions of dollars.

Court. This could be a drawn out process, and it remains to be seen what will happen in the interim. Health care providers should pay attention because this legislation is likely to have an impact on how health care is provided and funded.

COSTS AND END-OF-LIFE CARE

Not all older people use the available health care resources equally. Most health care services are consumed by the very ill or terminally ill minority, many of whom happen to be elderly. Studies by the Health Care Financing Administration indicate that 2% of the older-than-65 population receiving Medicare accounts for 34% of the costs. Overall, 72% of the total resources are used by only 10% of the aging population. More than 25% of the Medicare budget is used for terminally ill patients; 50% of all physicians' services, and 49% of all hospital days involve older Americans. Serious questions are being raised about the appropriateness of using intensive, expensive interventions to extend the lives of terminally ill older people.

Financial concerns are forcing health care providers and society to face ethical dilemmas regarding the allocation of limited health care resources. This is a highly emotional issue with no easy answers. Many people are alive today because of advances in medical technology. Some of those who benefit are young, whereas others are old. Some go on to lead lives of high quality; others never lead normal lives again. By virtue of their training, physicians are inclined to try to cure everyone. Most doctors do not feel comfortable allowing a patient to die, regardless of the person's age. Most doctors will use all available technology to save a life. Talking about death is not easy for anyone, including physicians. It is easier to avoid end-of-life issues than to take time for this difficult discussion. Many physicians are unwilling to take time away from other activities to have this discussion, particularly because they

can do only minimal billing for the time spent counseling the patient. In spite of these concerns, more physicians need to take time to have honest discussions with patients while they are competent to understand and make informed decisions.

Reputable authorities, ethicists, and politicians have widely differing points of view on this issue. Some believe that health care restrictions on older adults are the ultimate in age discrimination. Others argue that the benefits gained, which can usually be measured in months, do not outweigh the costs. Private citizens examining this dilemma are equally confused. Even those who believe that health care costs are excessive frequently want everything possible done to save their lives or those of their loved ones. This dilemma is moral, ethical, and legal, with no simple right answer. Part of the debate regarding health care reform involves differing viewpoints regarding end-of-life care. Perhaps this issue will encourage an honest national discussion among spouses, families, spiritual advisors, physicians, and other health care providers.

The Critical Thinking box is designed to increase your awareness and insight into these problems.

Critical Thinking

Your Understanding of the Health Care Dilemma

- Should an 80-year-old person have a coronary bypass surgery at a cost of approximately \$100,000?
- Should dialysis be provided to individuals older than 65? Older than 75? Older than 85?
- Should people older than 65 be candidates for organ transplants?
- Should a respirator be used on a terminally ill patient?
- Are feeding tubes a part of basic physical care, or are they extraordinary means?
- Should the individual, the family, or the physician decide the type and amount of medical intervention necessary?
- What should be the role of the government in health care?

ADVANCE DIRECTIVES

All adults who are 18 years of age or older and of sound mind have the right to make decisions regarding the amount and type of health care they desire. Because older adults are more likely to experience significant health problems, the question of what and how much medical care to administer must be addressed. Such important decisions are best made during a stress-free time when the individual is alert and experiencing no acute health problems. A person's wishes can best be communicated using advance directives, which are legally recognized, written documents that specify the types of care and treatment the individual desires when that individual cannot speak for himself or herself. Areas typically addressed in advance directives include (1) do not attempt to resuscitate (DNAR) orders, (2) directives related to mechanical ventilation, and (3) directives related to artificial nutrition and hydration.

Two formal types of advance directive are recognized in most states: (1) the durable power of attorney for health care and (2) the living will. Information about both of these is typically provided when a person enters the hospital. Each patient is expected to make a decision about the type and extent of care to be administered if his or her condition becomes terminal.

These written documents are designed to help guide the family and medical professionals in planning care. The family is often relieved to have this information when making difficult decisions during a stressful time. In general, advance directives are recognized and respected, but various agencies, individual physicians, or health care providers may have beliefs or policies that prohibit them from honoring certain advance directives. Individuals should discuss their wishes with their health care providers when these documents are written. Open communication reduces the chance of questions, conflict, or legal repercussions later. If irreconcilable differences exist between an individual and the care provider, changes in either the document or the care provider must be considered.

Durable power of attorney for health care transfers the authority to make health care decisions to another person, called the *health care agent*. The agent may act only in situations in which the person is unable to make decisions for himself or herself. Because the health care agent must be trusted to follow through with the older person's wishes, the agent specified in the document is usually a family member or friend. These wishes are specified in writing and usually witnessed by unrelated individuals to reduce the possibility of undue influence. Standardized legal forms are available to initiate a power of attorney for health care.

A living will informs the physician that the individual wishes to die naturally if he or she develops an

illness or receives an injury that cannot be cured. Living wills prohibit the use of life-prolonging measures and equipment when the individual is near death or in a persistent vegetative state. Living wills go into effect only when two physicians agree in writing that the necessary criteria are met.

Usually, either of these documents is adequate to communicate one's wishes; both are not needed. Those who choose to initiate both documents should ensure that there is no conflict between the directions provided in each document. Either document can be revoked at any time. Directions to accomplish this are usually provided on the specific forms. An advance directive should be stored in a safe place where it can be located easily if the need arises. A safe deposit box is not recommended for this purpose. Ideally, family members and the family lawyer should know the content of the document and its location. An advance directive should be provided to the physician so that it becomes part of the patient's permanent medical record. These documents are often required and kept available for emergency situations when an individual resides in an institutional setting such as an independent or assisted-living apartment, community-based residential facility, or a nursing home.

Laws and specifics differ from state to state. Nurses should be aware of the legal standing of such documents in the particular state where they practice and should understand any legal ramifications engendered by these documents.

Critical Thinking

Advance Directives

- How would you as a nurse approach a patient regarding initiation of an advance directive?
- Can a person who is diagnosed with Alzheimer's disease initiate a living will or durable power of attorney?
- What is the legal standing of these documents in your state?
- How do hospitals and extended care facilities identify a patient's advance directive?

IMPACT OF AGING MEMBERS IN THE FAMILY

The family is undergoing significant change in our society. Many factors, including increasing divorce rates, single parenting, and a mobile population, are creating a less stable, less predictable family structure. Blended families, extended families, and separated families all present challenges. In addition to these societal changes, the demographic changes discussed previously are having, and will continue to have, repercussions that we can only begin to appreciate (Box 1-4).

Families today face historically unprecedented situations. Because of the life span extension, it is not uncommon for four or five generations of a family to be

Box 1-4 Demographic Changes Affecting the Family

- Extended life spans are leading to more older family members.
- There are more people who are living with chronic conditions and who need some degree of care or assistance.
- The number of people in the younger generations is decreasing in proportion to the number of older members.
- There is an increasing number of widows who may be unprepared to provide for their own needs and who therefore need assistance.
- The role of women is changing. As women increasingly must work outside the home, many are attempting to meet the demands of their parents, home, children, and workplace.



FIGURE 1-8 Three generations.

alive at one time (Figure 1-8). Until recently, this was an unheard-of occurrence. Using 20 years as a typical generation, a family might resemble one such as that described in Table 1-3. If the generation time is less than 20 years, even more generations might be alive at the same time.

PERSONAL REFLECTION

Some years ago, as death was approaching for a 91-year-old gentleman, his family gathered at the hospital. His wife of 69 years asked that “the children” come into the room. This sounded rather strange because “the children” were all in their 60s, the grandchildren were all mature adults, and the great-grandchildren were fast approaching adulthood. It sounded even stranger to me, because this older man was my grandfather, and my father was “the baby” of the family.

Gloria Wold

It is estimated that 80% of older adults who need care will receive assistance from their families. The problems encountered in such situations can differ widely, depending on the respective ages of the family

Table 1-3 The Family

AGE (YEARS)	GENERATION
80+	Parents
60+	Children
40+	Grandchildren
20+	Great-grandchildren
Less than 20	Great-great-grandchildren

members. In some families, the “children” who are attempting to provide care for the oldest members are likely to be older than 65 themselves. They may have health problems of their own that make care giving difficult or impractical.

Middle-aged family members often become the caregivers. The generation in their forties and early fifties is often called the “sandwich” generation because its members are caught in the middle—trying to work, to raise their own dependent children, and often, to provide assistance to one or two generations of aging family members. In some cases, they are also trying to help raise grandchildren by giving financial or physical assistance or both.

Although the financial, psychological, and physical demands of assisting aging relatives affect all family members, women are likely to be the most affected. It is estimated that 72% of the caregivers in the United States are female. Regardless of whether this is fair, women are the primary caregivers in the family (Box 1-5). Typically, sons contribute financially, but the brunt of the emotional and physical care burden falls to the daughters. It is estimated that as the population ages, women will spend more time caring for their parents than they did caring for their children.

Families try to help aging family members in a variety of ways. If the aging family member is able to live alone, families may demonstrate concern by visiting frequently and assisting with transportation to shopping and doctor appointments. Some prepare meals, do the heavy housecleaning, and make major home repairs. Running between two households and trying to maintain both can be mentally and physically exhausting to younger family members, but many are willing to help their loved ones in any way they can.

Box 1-5 Caregivers in the United States

- Average caregiver age is 46.
- 30% of caregivers who provide 40 hours of care each week are 65 years or older.
- 73% of caregivers are female.
- Average woman spends 18 years helping an aging parent.
- More than half of caregivers work full-time.
- Average age of care recipient is 77 years.
 - 40% are older than 75.
 - 24% are older than 85.

A family crisis may occur when the aging person is no longer able to live alone. Important decisions must be made. Most families who try to do the right thing find that there is no perfect solution. The two most common options are bringing the aging parent into the home of one of the children or placing the parent in a long-term care facility. There are problems and concerns with both of these options. It is essential that the family making this difficult decision consider many factors. The amount of care needed by the parent; the availability of a willing and able family member; the amount of available space in the child's home; the added financial burden of an additional household member; the wishes of the parent, the child, and the child's family; and the interpersonal dynamics within the family must be considered before a decision is made.

Children often take older parents into their homes when the older parents can no longer maintain their own houses or apartments. Although this arrangement works well in some families, in others it is problematic for everyone involved. The familiar roles and responsibilities often reverse when children step in and attempt to take care of their parents. This places the aging person into the role of the child, which he or she usually resents strongly. "Don't tell your mother what to do!" or "I'm still your father!" is often heard in aging parent-child interactions.

Loss of independence is probably the most significant issue that aging parents and their children must face. The aging family members have spent 40, 50, 60, or even 70 years making their own decisions as adults. As independent adults, they could make their own choices about where to live, what to do, and when to do it. They chose what to eat, obtained their food, and prepared it without interference. They went to bed when and where they chose. They went to places they wanted to go without asking anyone's permission. They had control of their lives. Independence is what being an adult is about. Most independent adults do not want to ask anyone for help.

As physical changes or diseases affect older adults, some or all of their independent function may be lost. Aging persons find it difficult to accept that they can no longer do the things they once did. It is also distressing for the family to watch their loved ones change. While the aging person tries to cope with these changes, the family tries to determine how to respond to these changes. If "the right thing to do" is not known, all family members begin to have mixed feelings and confusion. Feelings of grief, anger, frustration, and loss are common in all affected individuals.

When an aging family member moves in with a child's family, the dynamics within the home are unavoidably changed. The ability of the family to adapt and cope with an additional member of the household varies greatly from situation to situation. If all parties are agreeable to the move, and if the older adult can be

given enough privacy to maintain independence, the blending of the older person into the child's home may be successful. Some families feel that a resident grandparent is rewarding and enriching. However, if the presence of the older person intrudes excessively on the family unit, the situation may be unpleasant for both the family and the older person.

If the older family member requires a substantial amount of physical care, the demands on family members can be intense. Regardless, many children feel duty-bound to care for their aging parents. This sense of obligation may be based on cultural, religious, or personal beliefs. If the children determine that they are unable to care for their parent and instead opt for nursing home placement, children often feel that they have failed in their responsibilities. This can lead to intense feelings of guilt, even if nursing home placement is the most realistic and reasonable option.

THE NURSE AND FAMILY INTERACTIONS

When we as nurses care for older adults, particularly in hospital or nursing home settings, we see the person only as he or she is now. We tend to forget that these people have not always been old. They lived, loved, worked, argued, and wept as each of us does. Often, the older adults we care for are very ill or infirm, and, as nurses, we tend to focus on their physical needs, cares, and treatments. In our preoccupation with our duties, we can easily lose our perspective of the older patient as both a person and a member of a family.

In hospitals and nursing homes, family members come and go. Some families show a great deal of interest and concern for their aging members, visiting regularly and interacting with the patient and the staff. This allows us to increase our understanding and appreciation of our patients as people. Other older individuals may never have family members visit them. They seem to be alone in the world, even though the charts list children and their telephone numbers for emergencies. Even in home settings, family attention and interaction vary greatly. In some households, a great deal of interest is given to each family member, whereas in others little or none is shown. Why do we see such a wide variation of family attention?

The answer often lies in family dynamics and processes that began long ago when the older adult was a young spouse and parent. Some families are very stable and cohesive. They are together often and share close, loving bonds. They have developed healthy methods for interacting, responding, and meeting each other's needs. Because of the strong bonds that have developed over many years, these families remain interested in and supportive of aging members.

Other families never develop the closeness that is ideal in a family. The family unit may have been disrupted by divorce, mental illness, or other serious problems. There may have been problems with **abuse**,

alcoholism, or drugs. In fact, many families today are troubled by these problems, which may have been caused by the behavior of younger family members or by the behavior of the older person. Long-term problems that have developed over time do not go away when a person gets old. When the family unit is weak, supportive behavior from family members is unlikely.

Most families we interact with fall somewhere between these extremes. Few families are perfect, and few are terrible. Families are made up of human beings who respond to stress in many different ways. Coping with the stresses related to aging is difficult for both the aging individual and for his or her family. The behavior we see at any given time is the best that the person is capable of at that time. That does not mean that it is the best that he or she will be capable of at some other time. We as nurses need to examine the stresses affecting the family so that we can best respond to the needs of all family members. The Critical Thinking box should help you determine your stress factors.



Critical Thinking

You and Your Family

Complete the following:

When my parents are unable to care for themselves, I will

_____.

If both my parents and grandparents were alive and in need of assistance, I would

_____.

If both my children and my parents needed help from me, I would

_____.

If my parents were in a nursing home, I would want the nurses to

_____.

When I grow old, I want my family to

_____.

SELF-NEGLECT

Abuse and **neglect** are usually something done to someone, but, unfortunately, self-neglect is a common problem in the older adult population. Self-neglect is more likely to be seen when an older person has few or no close family or friends, but it can occur despite their presence. Because our society has laws to protect the rights of adults, it may be difficult for concerned parties to intervene until a situation has reached critical or even life-threatening proportions.

Self-neglect is defined as the failure to provide for the self because of a lack of ability or lack of awareness. Indicators of self-neglect include the following:

1. The inability to maintain activities of daily living such as personal care, shopping, meal preparation, or other household tasks

2. The inability to obtain adequate food and fluid as indicated by malnutrition or dehydration
3. Poor hygiene practices as indicated by body odor, sores, rashes, or inadequate or soiled clothing
4. Changes in mental function such as confusion, inappropriate responses, disorientation, or incoherence
5. The inability to manage personal finances as indicated by the failure to pay bills or by hoarding, squandering, or giving away money inappropriately
6. Failure to keep important business or medical appointments
7. Life-threatening or suicidal acts such as wandering, isolation, or substance abuse

Self-neglect in the community is most likely to be recognized by neighbors and reported to the police, public health nurses, or social workers. It may also be suspected by emergency department nurses who see these individuals after they are found injured on the street, after a fire, or in some other state of distress.

Self-neglect is often connected with some form of mental illness or dementia. Once the problem is recognized, legal action through the courts may be needed to place the person in the custody of a family member or adult protective services.

ABUSE OR NEGLECT BY THE FAMILY

It is estimated that 10% of older adults will need some form of long-term care in the home. Attempts to meet these demands may be accompanied by high levels of stress for the caregivers. Increased demands on limited resources, physical exhaustion, or mental fatigue can result in deviant behaviors on the part of the caregiver. Inappropriate behavioral responses include abuse and neglect of the older family members. A Senate subcommittee that studied the problem of elder abuse estimated that as many as one million older Americans are being abused in some way by their families.

Intentional abuse occurs when any person deliberately plans to mistreat or harm another person. Abusive behavior cannot be justified at any time or in any way. Intentional abuse is most likely to occur in families with preexisting behavioral or social problems. High-risk families include those that have a history of family conflict and those with family members who have a history of violence or substance abuse, those with mental impairment of either the dependent person or caregiver (or both), and those with severe financial problems or unemployment.

Not all forms of abuse are intentional, but even unintentional abuse is devastating to older adults. Unintentional abuse or neglect is most likely to occur when the caregiver lacks the necessary knowledge, stamina, or resources needed to care for an older loved one. Often, the caregiver is an older spouse or an aging child who physically cannot meet the high-level care demands. Situations that trigger abuse are more likely

when the older person requiring care is confused or needs continual care.

Continuous demands on caregivers can virtually make them prisoners within their own homes. Stress builds, leaving the caregiver feeling trapped, frustrated, or angry. Unable to cope with the stress of these continual demands, caregivers may strike out at older adults, lock them in a room, restrain them in a chair, or leave them unattended. When stress is high and the coping ability is low, caregivers may not be able to identify any better options. They may not intend to hurt the older person or may rationalize that they are doing it to only “keep Dad from hurting himself,” but the end result is still abuse.

Abuse can be physical, financial, psychological, or emotional. Neglect and abandonment also constitute forms of abuse.

Physical Abuse

There are many types of physical abuse. Physical abuse is any action that causes physical pain or injury. Abuse may involve a physical attack upon a frail elderly person who is unable to defend himself or herself from younger, stronger family members. Older people may be locked in bedrooms, closets, or basements. Older women may be sexually abused or raped by caregivers or family members. Some older people are starved by family members or given food that is unsuitable or unfit for human consumption. Failure to provide adequate food or fluids also constitutes physical abuse. The inappropriate use of drugs, force-feeding, and the use of physical restraints or punishment of any kind are examples of physical abuse. Warning signs of physical abuse include bruising, lacerations, broken teeth, broken glasses, sprains, fractures, burn marks, wounds in various stages of healing, unexplained injuries, torn or bloody underwear, signs of vaginal trauma, delay in seeking medical treatment or history of “doctor shopping,” and refusal by the caregiver to let visitors see the elderly person.

Neglect

Physical abuse involves one or more actions that cause harm. Neglect is a passive form of abuse in which caregivers fail to provide for the needs of the older person under their care. Neglect, whether intentional or unintentional, accounts for almost half of the verified cases of elder abuse. Neglect includes situations in which caregivers fail to meet the hygiene or safety needs of the older adult. Examples include situations in which a bedridden person is left wet and soiled with body wastes for days at a time without care or in which an older person suffers from exposure because he or she lacks adequate clothing for protection from the elements. Failure to provide necessary medical care may constitute neglect because, with no means of going to the doctor or pharmacy, the older person may suffer or even die.

However, it is not considered neglect if the mentally competent older person refuses treatment. Neglect may be deliberate on the part of the caregiver, or it may result from lack of knowledge, inadequate financial resources, or an insufficient support system. Neglect is not uncommon in situations where one elderly spouse cares for the other. In spite of the best intentions, the caregiving spouse may be unable to provide adequately for the needs of the more dependent partner.

Emotional Abuse

Even when physical abuse is absent and adequate physical care is provided, emotional abuse may be present. Emotional abuse is more subtle and difficult to recognize than physical abuse or neglect. It often includes behaviors such as isolating, ignoring, or depersonalizing older adults. Emotional abusers may forbid visitors and isolate the older person from more responsible and sympathetic friends or family members. They may prohibit the use of the telephone or interfere with communication by mail.

Emotional abusers can use verbal or nonverbal means to inflict their damage. Verbal abuse includes shouting or voicing threats of punishment or confinement. Emotional abusers often threaten older adults with all manners of horrors if they tell anyone about their plight. Displeasure, disgust, frustration, or anger can be communicated nonverbally through sighing, head shaking, door slamming, or other negative body language. Repeatedly ignoring what the older person has to say and avoiding social interaction with the individual are subtle forms of emotional abuse. Signs of emotional abuse may include the lack of eye contact, trembling, agitation, evasiveness, or hypervigilance.

Negative communications are devastating because they can attack the older person’s mind and emotions. These messages can be so subtle and routine that people may not even recognize them as abusive. Emotional abuse is insidious in that it can damage the older adult’s sense of self-esteem and can even destroy the will to live without leaving any obvious signs.

Financial Abuse

Financial abuse exists when the resources of an older person are stolen or misused by a person whom the older adult trusts. Such incidents are reported frequently in the news. Children and grandchildren may take money from the older family member, rationalizing that money is owed to them for providing care or that it will eventually be theirs anyway. People who expect to benefit from the older person’s estate may be afraid that the needs of the older adult will consume all of the money and leave them with nothing, so they decide to take it while they can. Regardless of the caregivers’ rationalizations in these situations, it is financial abuse if the older person’s money is taken and spent by others for their own purposes. On the other

hand, it is not abusive to use the older adult's resources to provide for his or her personal needs.

Many older adults are overly trusting of family members, often refusing to believe that their children would steal from them. This state of denial often continues, despite clear evidence to the contrary. Often, all of the savings have been spent, the house has been sold, and any objects of value have disappeared before they will accept the truth. Even then, some older adults make excuses to try to cope with the harsh reality. Abusive caregivers often abandon the older person once all of his or her assets are gone. In such cases, older adults are left homeless, penniless, and in despair. Signs of financial abuse include unusual banking activity such as large or frequent withdrawals, missing bank statements, missing personal belongings, particularly those of value, and signatures on checks or documents that do not match the elderly person.

Some actions that senior citizens can take to protect their financial assets include (1) arranging for direct deposit of Social Security, pension, and any other benefit checks; (2) taking great care in the selection of anyone appointed as the power of attorney or giving advice regarding a will; (3) keeping ATM pin numbers secure—do not write them in a location where others may see them, and do not give the number to anyone; (4) having written agreements regarding expectations and fees for any services; (5) keeping valuables out of site in a secure location such as a safe deposit box; and (6) remembering that home helpers or attendants are employees not friends—pay the fair and agreed wage, and keep tips and gifts for special occasions.

Abandonment

Abandonment occurs when dependent older persons are deserted by the person or persons responsible for their custody or care under circumstances in which a reasonable person would continue to provide care. Abandonment usually leaves the older person physically, emotionally, and financially defenseless. Older adults who have been abandoned by their families usually become wards of the state.

Responses to Abuse

It is natural to think that an older person suffering from one or more forms of abuse would complain, but this is rarely the case. Fear of being treated even worse or fear of being institutionalized or abandoned may prevent the victim from seeking help.



Clinical Situation

Trends and Issues

An 84-year-old woman was admitted to the hospital for dehydration and malnutrition. Six months earlier, she had suffered a mild stroke. Since then, her 86-year-old husband had been caring for her at home. On admission, the woman weighed 91 pounds. Stage 2 pressure ulcers were present on both

buttocks. Her clothing and undergarments were soiled, and she was in serious need of a bath. She reported episodes of incontinence of bladder and bowel. Her only reported activity consisted of sitting in a lounge chair watching TV. She was wearing a wig, which covered hair that was matted tightly on her scalp. After several days of carefully combing out the snarls, the nurse realized the woman's shoulder-length hair had not been washed in months. The patient's husband explained, "I tried to do my best, but since she had always done all of the cooking, I didn't know what to do." He made sure she took her prescribed medicines, and he tried to see to it that she had enough to eat and drink, but he said that she was "picky." He also stated that he was unsure just how to take care of his wife's hygiene needs: "I tried to wash her up, but she said she wanted to be left alone." He explained that he shopped for groceries when she was asleep. He was afraid that if he called anyone for help, they would place his wife in an institution, and he could not cope with this idea. She had not complained to anyone for the same reason. Their children all lived out of state and had not visited since she had the stroke. The patient and her husband had assured their children by phone that everything was all right. It was only when she complained of chest pain that they sought medical attention.

Older people who manifest signs of abuse must be assessed carefully (Box 1-6). They may try to protect and defend the abuser, deny that abuse is occurring, or seem resigned to the situation, believing that there is no better alternative.

All questioning about and assessment of abuse must be done with great tact and sensitivity. It is best to question the elderly person alone so they can speak freely and without intimidation from the potential abuser. The rights of older people to determine their own affairs to the full extent of their abilities must be respected. Information obtained must be kept

Box 1-6 Signs That May Indicate Elder Abuse

- The older person demonstrates excessive agreement or compliance with the caregiver.
- The older person shows signs of poor hygiene such as body odor, uncleanliness, or soiled clothing or undergarments.
- The older person has malnutrition or dehydration.
- The older person has burns or pressure sores.
- The older person has bruises, particularly clustered on trunk or upper arms.
- The older person has bruises in various stages of healing that may indicate repeated injury.
- The older person lacks adequate clothing or footwear.
- The older person has had inadequate medical attention.
- The older person verbalizes a lack of food, medication, or care.
- The older person verbalizes being left alone or isolated in some way.
- The older person verbalizes fear of the caregiver.
- The older person verbalizes a lack of control in personal activities or finances.

confidential and shared only with agencies as authorized by the patient or necessitated by law. All observations, both objective and subjective, must be carefully documented in case legal action is required. Detailed records should be kept regardless of whether legal action is anticipated. Data may become significant only at a later date when they are impossible to reconstruct if not appropriately recorded. Photographs may be necessary to provide proof of neglect or abuse. These may include pictures of wounds, injuries, or living conditions. It is wise to avoid using the term *abuse* when working with older adults, because they may become defensive and will probably deny it. Using words such as *problems* or *concerns* is more likely to yield truthful information.

When there is any question of abuse, an experienced professional who is skilled in dealing with elder abuse should oversee the case. Physical abuse and financial abuse are criminal offenses. Nurses have a moral, legal, and ethical responsibility to report any suspected cases of abuse (see Critical Thinking box for more information). Nurses who provide care to at-risk groups, particularly the young and the older adult population, must be aware of their legal obligations with regard to suspected abuse. Nurses must know the state laws pertaining to abuse, as well as the proper authorities to contact and how to contact them. Once the responsible authorities are notified, they are obligated by law to investigate and pursue any legal action necessary to protect the safety of the abused and to protect them from further harm.

Critical Thinking

Your Knowledge of Elder Abuse

- Is elder abuse increasing today? If so, why?
- What would you do if you thought a close friend or relative was an elder abuser?
- What do you think is the best way to reduce the incidence of elder abuse? Why?
- What would you do if you suspected that a nursing assistant was abusing patients?
- What can you as a student nurse do to prevent elder abuse?
- What resources are available in your community to help prevent elder abuse?

ABUSE BY UNRELATED CAREGIVERS

Understandably, we would like to think that all persons seeking employment as caregivers to older adults are responsible, caring individuals, but, unfortunately, this is not the case. People who are hired to provide for the safety and well-being of older adults can sometimes become their greatest threat. Increased use of unrelated caregivers exposes older adults to additional risks.

As the number of older adults increases and as more frail older people remain in their homes, the demand for

nursing assistants, home health aides, and housekeepers increases. Most people who work as nursing assistants or housekeepers are decent, caring individuals who provide difficult services for little reward. The salaries paid to nursing assistants and housekeepers are generally low, the hours are long, and the work is emotionally and physically demanding. Under these conditions, it is difficult to find caring, responsible people who are willing to provide these types of services. When the demand for caregivers exceeds the supply of desirable workers, employers may be forced to hire people who are willing to take these jobs only because they cannot find other employment.



Coordinated Care

Collaboration

Elder Abuse in Institutions

Abuse in institutional settings is most likely to occur when the nursing assistants are forced to work under stressful conditions and have the poor ability to deal with that stress. The risk for abuse increases when caregivers perceive that they are not valued, supported, or acknowledged.

The following are ways that may help decrease stress and the likelihood of abuse:

- Improve staff training to identify and defuse potential abuse situations.
- Initiate a stress-reduction program, including staff support groups, a “time out” room for use when the staff’s stress level is high, and other stress-relieving interventions.
- Recognize the value of nursing assistants to the team’s effort by involving them in care planning and consulting with them regarding potential problems and possible solutions.
- Increase recognition of good, compassionate caregiving through verbal praise, employee-of-the-month recognition, bonuses, or other rewards.
- Provide an institutional mechanism for dealing with nursing assistants’ complaints and concerns in a proactive rather than punitive manner.

Specific federal and state laws designed to prevent undesirable persons from contact with vulnerable people, such as the young and the older adult population, are in force today; however, sometimes people with criminal records, inadequate training, or other serious shortcomings manage to gain employment, despite safeguards such as state registries, employment histories, and reference checks. Undesirable individuals may unwittingly be hired to provide care for older adults by families, home health agencies, and even health care institutions.

In home settings, unscrupulous caregivers have been known to take money and personal belongings from defenseless older people under their care. They may physically abuse older persons and threaten them with physical harm if the abuse is reported. They may threaten to quit, leaving the older person in fear of being placed in an institution. Using threats enables these

individuals to remain undetected until they have caused serious harm. When they are discovered, they often disappear, only to reappear somewhere else and repeat their pattern of abuse.

Even health care institutions are not immune to problems of elder abuse. Most people assume that because hospitals and nursing homes are licensed and regulated, this type of behavior does not occur. Unfortunately, this is wishful thinking. Many institutions have difficulty hiring enough people to meet the required staffing levels. Although most health care institutions and agencies screen applicants in an attempt to find the most qualified individuals and to avoid hiring anyone with a history of abusive or criminal behavior, some unscrupulous people manage to avoid detection and are employed as caregivers to older adults. These unsuitable caregivers may victimize older adults before they can be detected. Nurses who supervise other caregivers must constantly be on the lookout for abusive behaviors (Box 1-7). Any indication of abuse in an institutional setting must be reported as soon as it is suspected so that appropriate action can be taken and the abusive person removed. The importance of this nursing responsibility cannot be stressed enough.

To reduce abuse and to meet the emotional and physical needs of older adults and their caregivers, a wide variety of services have evolved. The types of services available vary from area to area, with some far-sighted cities offering many services. Nurses who

work with older adults should become knowledgeable about the services that are available in their communities. Resources may include education programs designed to improve an awareness of the problem of elder abuse, support groups for caregivers of older adults, **respite** care programs, and senior day care centers. Many hospitals and health care agencies (e.g., American Red Cross) provide educational programs in nutrition, medication administration, bedside care, and other aspects of caring for older adults. The need for these programs is growing as the older adult population increases.

SUPPORT GROUPS

Caregivers to older adults are often isolated from other people. The demands of providing care prevent them from getting the rest, encouragement, and support they need. Caregivers who want or need to share their experiences and frustrations have started forming support groups to help one another cope with stress. These support groups may be specialized (e.g., for caregivers of people with Alzheimer's disease) or more general in nature. Support groups allow caregivers to share their feelings and to learn new strategies for improving their coping skills. Some groups schedule speakers to discuss topics of common interest or offer social activities to promote stress reduction.

RESPITE CARE

Respite care allows the primary caregiver to have time away from the constant demands of caregiving, thereby decreasing caregiver stress and the risk for abuse. Many caregivers are unable to lead normal lives because they cannot leave their responsibilities for more than a few minutes without fear of some disaster occurring. Respite care gives the primary caregiver the opportunity to attend church, go shopping, conduct personal business, obtain medical care, and participate in other activities that most people take for granted. Respite care may be provided by family members, volunteers, or one of the many service agencies that have proliferated within the past few years. Caregivers may be reluctant to use respite care out of guilt, fear, or other misguided emotions. Nurses should encourage caregivers to protect their own health and well-being by regularly taking advantage of respite care.

Box 1-7 Abusive Behaviors in Health Care Settings

- Use of sedative or hypnotic drugs that are not medically necessary
- Use of restraints when they are not medically indicated
- Use of derogatory language, angry verbal interactions, or ethnic slurs
- Withholding of privileges such as snacks or cigarettes
- Excessive roughness in handling during care or during transfers
- Delay in taking a resident to the bathroom or allowing a resident to lie in body waste
- Consumption of a resident's food
- Theft of money or personal belongings
- Physical striking or any other assaultive behavior / toward a resident
- Violation of a resident's right to make decisions
- Failure to provide privacy