West Virginia 24-Hour License Renewal Package

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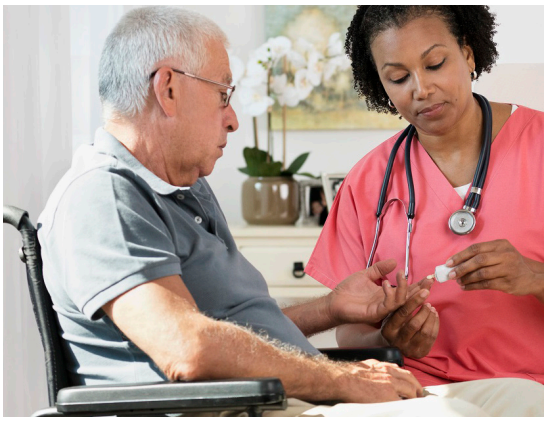
2022 West Virginia nursing continuing education requirements



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WHAT'S INSIDE

Drug Abuse Crisis for West Virginia Nurses (2021 Update) (Mandatory) 1

[3 contact hours] Despite individual and federal efforts to curb drug abuse, nurses care for patients who have drug problems every day. This course is designed to satisfy the West Virginia nursing continuing education requirement on the topic of substance abuse. The course presents information to help nurses in understanding an addict's problems and provides strategies to help nurses manage those problems. This course fulfills the West Virginia LPN requirement for 3 contact hours of Chemical Dependency/Substance Use Disorders.

West Virginia Mental Health Screening for Veterans (Mandatory) 19

[2 contact hours] It is imperative that nurses be able to screen veterans for such problems and intervene promptly and effectively. This course provides West Virginia nurses with information that increases their ability to screen veterans for mental health issues and intervene promptly and effectively as indicated. This course fulfills the West Virginia LPN, RN, and APRN requirement for 2 contact hours every renewal period of Mental Health Conditions Common to Veterans and Their Family Members.

An Overview of Dietary Supplements for Nurses 30

[3 contact hours] [3 pharmacology hours] Nurses in many practice settings are likely to encounter patients that are using dietary supplements – some appropriately – whereas in other instances, not. This course is designed to provide an overview of these products that will empower nurses to guide their usage safely and effectively. Dietary supplements of many types are widely used by Americans. As a result, it is likely that nurses, in a variety of settings, will encounter patients who use these products.

An Overview of Geriatric Care 43

[2 contact hours] This course presents common health conditions, care needs, and concerns associated with aging, including issues related to elder abuse, age-related memory changes and disease processes, and end-of-life issues.

Assessing and Preventing Falls 54

[2 contact hours] This course provides information that facilitates the development and initiation of a fall assessment program that includes preventive strategies to safeguard patients and others from the danger of falling.

COVID-19 Loss, Grief, and Bereavement 65

[2 contact hours] This course is for healthcare professionals who want to identify ways to support grieving individuals because of the coronavirus disease (COVID-19). Characteristics that influence COVID-19 grief, bereavement, and mourning are identified. Policies such as social distancing may mitigate the impact of contracting the virus but increase risk factors for mental health issues and complicated grief (prolonged grief disorder). The course presents major theories and models of mourning as they relate to coping with COVID-19 ambiguous loss and disenfranchised grief.

Hospice and Palliative Care for Healthcare Professionals 80

[5 contact hours] This course provides an overview of hospice and palliative care and describes care that meets the physical, psychological, social, and spiritual needs of suffering of patients and families. The goal of this course is to provide nurses and other clinicians information on how to care for their dying patients. The course will review theoretical models of the dying process, the psychological and physical symptoms as death approaches, and postmortem care. Lastly, misconceptions and barriers to providing end-of-life care are reviewed.

Managing Difficult Patients for Healthcare Professionals 101

[5 contact hours] Healthcare professionals will encounter difficult or hard to manage patients during their career. Examples of these difficult encounters include workplace violence, non-adherence to medical treatments, and manipulation of caregivers. This course explores how healthcare professionals can avoid potentially violent situations and work with difficult patients by being prepared and recognizing the signs and risk factors for these occurrences. De-escalation skills, diagnosis, preventative measures, training, and planning are all presented in this course to help healthcare professionals respond to difficult patients and ensure a healthy environment for everyone.

Course Participant Sheet 125

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FREQUENTLY ASKED QUESTIONS

What are the requirements for license renewal?

Licenses Expire	Contact Hours	Mandatory Subjects
LPNs renew licenses annually, but are required to complete CE by June 30 of the even year.	24 (All contact hours allowed through home-study)	2 hours of Mental Health Conditions Common to Veterans and Their Families 3 hours of Chemical Dependency/Substance Use Disorders One-time requirement of 2 hours in End-of-Life Care at initial renewal available at EliteLearning.com/Nursing

How much will it cost?

Course Title	Contact Hours	Price
Drug Abuse Crisis for West Virginia Nurses (2021 Update) (Mandatory)	3	$25.95
West Virginia Mental Health Screening for Veterans (Mandatory)	2	$20.95
An Overview of Dietary Supplements for Nurses	3	$28.95
An Overview of Geriatric Care	2	$18.95
Assessing and Preventing Falls	2	$18.95
COVID-19 Loss, Grief, and Bereavement	2	$18.95
Hospice and Palliative Care for Healthcare Professionals	5	$29.95
Managing Difficult Patients for Healthcare Professionals	5	$29.95
Best Value - Save $162.65 - All 24 Hours	**24**	**$29.95**

How do I complete this course and receive my certificate of completion?

See the following page for step by step instructions to complete and receive your certificate.

What information do I need to provide for course completion and certificate issuance?

Please provide your license number on the test sheet to receive course credit. Your state may require additional information such as date of birth and/or last 4 of Social Security number; please provide these, if applicable.

Are my credit hours reported to the West Virginia board?

Yes, the West Virginia Board of Examiners for Registered Professional Nurses uses CE Broker to track and verify your compliance. We report your hours electronically to the Board through CE Broker within one business day. Remember, do not forward your CE documentation to the board. Keep your certificate in a safe place for your records.

Is my information secure?

Yes! We use SSL encryption, and we never share your information with third-parties. We are also rated A+ by the National Better Business Bureau.

Are you a West Virginia board-approved provider?

Elite is approved by the State of West Virginia Board of Examiners for Registered Professional Nurses, Provider No. 50-4007

Are you approved by ANCC?

Yes. Elite is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation. West Virginia accepts courses offered by an ANCC provider.

Important information for licensees:

Always check your state's board website to determine the number of hours required for renewal, mandatory subjects (as these are subject to change), and the amount that may be completed through home-study. Also, make sure that you notify the board of any changes of address. It is important that your most current address is on file.

What if I still have questions? What are your business hours?

No problem, we have several options for you to choose from! Online at EliteLearning.com/Nursing you will see our robust FAQ section that answers many of your questions, simply click FAQs at the top of the page, e-mail us at office@elitelearning.com, or call us toll free at 1-866-344-0971, Monday - Friday 9:00 am - 6:00 pm, EST.

Licensing board contact information:

West Virginia State Board of Examiners for Licensed Practical Nurses
101 Dee Drive, Suite 100 | Charleston, WV 25311 | Phone (304) 558-3572 | Fax (304) 558-4367
Website: http://www.lpnboard.state.wv.us/

How to complete continuing education

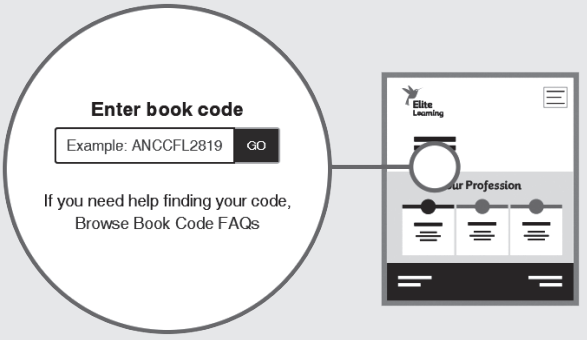
Please read these instructions before proceeding.

Read and study the enclosed courses and complete the self-assessment exercises. To receive credit for your courses, you must provide your customer information and complete the mandatory evaluation. We offer four ways for you to complete. Choose an option below to receive credit and your certificates of completion.

Fastest way to receive your certificate

Online

- Go to **EliteLearning.com/Book**. Use the book code **ANCCWV2422** and enter it in the example box then click **GO**.
- If you already have an account created, sign in to your account with your username and password. If you do not have an account already created, you will need to create one now.
- Follow the online instructions to affirm completion of your course. Complete the purchase process to receive course credit and your certificate of completion. Please remember to complete the online survey.



Mobile

- Read and study all course materials.
- Text **WVEVAL** to **386-245-9322**, then follow the link to complete affirmations.
- Use the book code **ANCCWV2422** and enter it in the example box then click **GO**.
- After completing affirmations, follow the link to get your certificate.

Per ANCC regulations, it is mandatory to complete a course evaluation for each course taken.

By mail

- Fill out the answer sheet and evaluation found in the back of this booklet. Please include a check or credit card information and e-mail address. Mail to Elite, **PO Box 37, Ormond Beach, FL 32175**.
- Completions will be processed within 2 business days from the date it is received and certificates will be e-mailed to the address provided.
- Submissions without a valid e-mail will be mailed to the address provided.

By fax

- Fill out the answer sheet and evaluation found in the back of this booklet. Please include credit card information and e-mail address. Fax to **(386) 673-3563**.
- All completions will be processed within 2 business days of receipt and certificates e-mailed to the address provided.
- Submissions without a valid e-mail will be mailed to the address provided.

Drug Abuse Crisis for West Virginia Nurses (2021 Update) (Mandatory)

3 Contact Hours

Release Date: March 12, 2021

Expiration Date: March 12, 2024

Faculty

Katie Blair, PharmD, RPh, is a pharmacist and freelance writer specializing in pharmacy education. She works as a consultant pharmacist in Vancouver, Washington, serving long-term care facilities in the area since 2016. Katie also has over 6 years of experience working as a staff pharmacist at a community pharmacy in Seattle, Washington. She graduated from Northeastern University in Boston in 2009 with a Doctor of Pharmacy degree. Dr. Blair has done freelance work writing and revising continuing education programs for pharmacists, pharmacy technicians, and nurses, as well as writing practice questions for various pharmacy technician exams.

Katie Blair has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Reviewer: Mary C. Ross, RN, PhD, Dr. Ross is an experienced nursing educator with extensive clinical experience including nursing management of a neuro-psychiatric unit. She is a retired Air Force flight nurse and previous chair of a national Veterans Administration advisory council. She has extensive experience in mental health nursing.

Mary C. Ross has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Reviewer: Shellie Hill, DNP, FNP-BC, currently serves full-time as the FNP Program Coordinator & Assistant Professor in the MSN-NP program at Saint Louis University. She has been a practicing Family Nurse Practitioner for 20 years and an RN for 27 years. Most of her clinical practice has been in primary care and she also has experience in urgent care and cardiology. Clinically, she works in corporate healthcare clinics part time, and she volunteers as an FNP in a clinic that manages underserved patients.

Shellie Hill has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

This course presents the severity of drug abuse issues in the United States and West Virginia in particular. The course meets the nurses' state requirements of three contact hours on the topic of substance abuse for every 2-year renewal period.

Learning objectives

Upon completion of the course, the learner will be able to:

- Describe the costs associated with substance abuse, including its psychosocial impact on children and their school performance.
- Review the most common street drugs, including their street names and health impacts.
- Explain how to use naloxone to reverse an opioid overdose, and the dos and don'ts of opioid overdose management.
- Differentiate between the three most frequently abused prescription drug types and provides examples of each type.
- Discuss the new emerging drugs of abuse.
- Describe the management of patients abusing street drugs as well as methods to ensure safe and effective controlled substance use.

How to receive credit

- Read the entire course online or in print which requires a 3-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

CE Broker reporting

Elite, provider # 50-4007, reports course completion results within 1 business day to CE Broker. If you are licensed in Arkansas, District of Columbia, Florida, Georgia, Kentucky, Mississippi, New Mexico, North Dakota, South Carolina, or West Virginia, your successful completion results will be automatically reported for you.

Accreditations and approvals

Elite is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Individual state nursing approvals

In addition to states that accept ANCC, Elite is an approved provider of continuing education in nursing by: Alabama, Provider #ABNP1418 (valid through February 5, 2025); California Board of Registered Nursing, Provider #CEP17480 (valid through January 31, 2024); California Board of Vocational Nursing and Psychiatric Technicians (LVN Provider #15058, PT Provider #15020) valid through December

31, 2023; District of Columbia Board of Nursing, Provider #50-4007; Florida Board of Nursing, Provider #50-4007; Georgia Board of Nursing, Provider #50-4007; Kentucky Board of Nursing, Provider #7-0076 (valid through December 31, 2023); Mississippi Board of Nursing, Provider #50-4007; and North Dakota Board of Nursing, Provider #50-4007. This CE program satisfies the Massachusetts Board's regulatory requirements as defined in 244 CMR 5.00: Continuing Education.

Activity director

Lisa Simani, MS, APRN, ACNP, Nurse Planner

Disclosures

Resolution of conflict of interest
In accordance with the ANCC Standards for Commercial Support for continuing education, Elite implemented mechanisms prior to the planning and implementation of the continuing education activity, to identify and resolve conflicts of interest for all individuals in a position to control content of the course activity.

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Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

INTRODUCTION

MDespite individual and federal efforts to curb drug abuse, nurses care for patients who have drug problems every day. This course, with a focus on West Virginia, offers facts that may help in understanding the addict's problems and provides strategies to help nurses deal with them.

OVERDOSE DRUG DEATHS

Deaths from drug use continue to contribute to mortality in the United States. The statistics tell the story. In 2018 (the latest year from which data are available), 67,367 people died of drug overdose. Opioids were the most common cause of overdose deaths, with 46,802 drug overdose deaths caused by opioids in 2018. Synthetic opioids, such as fentanyl, account for 67% of all drug overdose deaths. Synthetic opioid overdose deaths increased 10% from 2017 to 2018 (Centers for Disease Control [CDC], 2020a; Hedegaard et al., 2020).

Over the past 20 years, drug overdose deaths have been steadily increasing. In 1999, the age-adjusted rate of drug overdose deaths was 6.1 per 100,000 Americans; this increased to 21.7 deaths per 100,000 Americans in 2017. Between 2012 and 2018, the age-adjusted rate of cocaine overdose deaths more than tripled. The rate of deaths involving psychostimulants with abuse potential, such as methamphetamine, amphetamine, and methylphenidate, increased nearly five-fold. These trends of drug abuse and drug-related deaths are a national public health problem (CDC, 2020a; Hedegaard, 2020).

IN FOCUS: WEST VIRGINIA DRUG ABUSE

In 2018, West Virginia was the state with the highest age-adjusted drug overdose death rate: 51.5 drug overdose deaths per 100,000 people (CDC, 2020a). Opioids were responsible for 42.4 deaths per 100,000 people in 2018, a rate that declined for the first time in 10 years from 49.6 deaths per 100,000 people in 2017. The rate of deaths due to prescription opioids also decreased between 2017 and 2018, from 17.2 to 13.1 deaths per 100,000 people. While these declines in death rates are significant improvements, the overdose death rates remain nearly 400% higher when compared with data from 2005 (National Institute on Drug Abuse [NIDA], 2020a).

THE COST OF SUBSTANCE ABUSE ON SOCIETY

Children

The exact number of children exposed to parental substance abuse is unknown. A 2016 study estimated almost one in eight (11.9 percent) children under 18 years of age lived with at least one parent who was dependent upon alcohol or an illicit drug within the past year (Smith & Wilson, 2016).

According to Johnston and colleagues (2017) in the Monitoring the Future Report, drug use in eighth graders illustrates the nation's urgent need to continue addressing the substance abuse problems in today's youth. Eighth graders are more likely to carry forward behaviors and attitudes regarding substance use as they age; understanding their behaviors gives us a sense of the future substance use among young adults. Statistics among the eighth graders in 2017 included the following (Johnston et al., 2017):

- One in four (23%) report having tried alcohol.
- One in 11 (9%) report having been drunk at least once.
- One in 11 (9%) report having tried cigarettes, with one in 50 reporting they have smoked within the prior month.
- 62% recognize the risk of smoking one or more packs of cigarettes each day; however, for many it is too late, as they have already developed a smoking habit.
- 8% of males tried smokeless tobacco with 2.2% using in the past month and 0.5% using daily.

- One in 11 (9%) report trying inhalants, while one in 50 report using an inhalant within the prior month.
- One in seven (14%) report having tried marijuana, while 20% used in the prior month and 0.6% report daily use.
- 7% report trying prescription-type amphetamines without a prescription, while 1.7% report use within the prior month.
- Prevalence of using illicit drugs represents about one in every 30 students in the classroom. Twenty-three percent report having tried some illicit drug (including inhalants), while 9% have tried some illicit drug other than marijuana or inhalants.

Psychosocial Impact

Children in homes where substances are abused suffer from a disruption or lack of healthy family routines and rituals. A parent's substance abuse may affect their ability to prioritize their child's basic needs over their own addiction. Family income spent on substances also deprives children of resources and influences their perception of trustworthiness of the abuser. Children whose parents abuse substances commonly experience educational delays and inadequate dental and medical care. An estimated 25% of children whose mothers abuse substances do not receive routine child maintenance care in the first 2 years of life. Additionally, because of unnecessary parental conflict and stress, children generally lack the security associated with structure and stability typically provided by parents. Children of substance abusers are three times more likely to be either physically, emotionally, or sexually abused and are four times more likely to be emotionally or physically neglected. Children in rural populations have a higher rate of neglect than those in urban populations (Smith & Wilson, 2016).

In addition to affecting a child's psychosocial well-being, a substance abuser's home generally lacks appropriate childproofing measures. Open flames and lighters can lead to burns, fires, and explosions where children live. Children of substance abusers are at a greater risk of infectious disease because of the exposure to needles and drug paraphernalia. Children living in these environments tend to witness criminal behavior and interactions and, if they are subjected to sexual abuse or sex trafficking, the children are exposed to deplorable living conditions. Current data is lacking, but previous estimates from the U.S. Department of Health and Human Services (HHS) concluded that substance abuse by a parent is the contributing factor for one- to two-thirds of children who are involved in the child welfare system (Smith & Wilson, 2016).

Self-Assessment Quiz Question #1

Children of substance abusers are at a higher risk of which of the following?

a. Inadequate medical care.
b. Physical neglect.
c. Emotional abuse.
d. All of the above.

School Performance

Educational problems are common in children who have a parent dependent on a substance or who misuses substances. They may be secondary to perinatal substance exposure or external distraction from an unstructured or chaotic home environment. Children whose parents misuse a substance have a higher absenteeism rate and impaired attention in school. Their academic productivity is generally compromised. In addition, they are at a greater risk of expulsion and suspension from school. Children are generally distressed by their parent's abuse and may blame themselves for the abuse, conflicts in the home, parental acceptance of the abuse, or lack of home resources (Smith & Wilson, 2016).

College-age students who use non-medical prescription stimulant medications typically have lower grade-point averages and are more likely to be heavy drinkers and users of other illicit drugs (Arria, 2018). Use of prescription amphetamines such as Ritalin or Adderall within the past year was 8.1% in the college-age group compared to 5.9% in the non-college group in 2019. Heavy alcohol consumption also appears higher in college students than non-college peers. Binge drinking or having five or more drinks in a row in the past 2 weeks, was seen in approximately 33% of college-age young adults compared with 22% of their non-college peers (Schulenberg et al., 2020).

Marijuana use among full-time college students and non-college peers remains at the highest level since the early 1980s. In 2019 (latest data available), 5.9% of college-age students used marijuana nearly every day as compared to 15% of their peers who did not attend college. This highlights the issue that young adults, regardless of college status, are exposed to substance abuse, but the types of substance abuse can vary depending on whether they are college students (Schulenberg et al., 2020).

Evidence-based practice! A 2017 study found that as self-reported alcohol and drug use among college-age students increased, GPAs decreased. The researchers highlighted the importance of substance use prevention strategies to improve academic performance in college students (Bolin et al., 2017).

Economic costs

According to the latest available data, the economic cost of drug abuse in the U.S. was estimated at $1 trillion (Cidambi, 2017). This nation's epidemic equals 5% of the US gross domestic product. The value represents both the use of resources to address health and crime consequences, as well as the loss of potential productivity from disability, premature death, and withdrawal from the legitimate workforce. According to Cidambi, 50% of the costs tied to illicit drug use are directly related to the criminal justice system and incarceration. In contrast, the cost of addiction treatment only accounted for 6% of the total costs associated with drug use.

Addiction's financial toll focuses primarily on poverty. Individuals who abuse substances often do so with the heavy price tag of poverty both now and for their future generations. Addiction places a toll on the family's economics and can lead to unpaid debts, missed payments, late fees, and property foreclosure (American Addiction Centers, 2020a). Many other financial consequences that are often overlooked include a lack of dental care, poor home or car maintenance, lack of insurance, and depleted savings.

Evidence-based practice! According to Carpenter and colleagues (2017), there is a direct inverse relationship between a state's unemployment rates and substance use. For each percentage point increase in the state's unemployment rate, there is an estimated 6% increase in the likelihood of having a disorder involving the use of analgesics. There is also an 11% increase in the likelihood of having a disorder involving the use of hallucinogens. Specifically, this study identified that Caucasian men between the ages of 18 and 64 who are less educated are at the most significant risk of developing/having an analgesic and/or hallucinogenic disorder. Carpenter and colleagues (2017) support the postulation that economic conditions play a strong role in substance use disorders.

Addiction and treatment need

In 2019, 21.6 million people in the United States (one in 13) ages 12 and older needed treatment for substance use. Of these, only 2.6 million people actually received treatment at a specialty facility. Of the 18.9 million people who needed but did not receive substance use treatment, only about 4.2% felt that they needed treatment. About 40% of people who felt they needed treatment but did not receive any were not ready to stop using, and about 20% did not have healthcare coverage and could not afford the cost of treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020).

Drug abuse treatment doesn't only save lives – it can save billions of dollars. It is estimated that for every dollar spent on treatment, $4 is saved in healthcare costs and $7 is saved in law enforcement costs (American Addiction Centers, 2020a).

Acute and long-term health effects

There are numerous health effects that have been linked to substance use. Acute health risks are typically seen shortly after using a substance and can range from mild, such as drowsiness and confusion, to severe, such as tremors and loss of consciousness. Substance use can create altered states of perception, which can affect cognition. This can increase the risk of injuries as a result of many causes, such as traffic accidents, falls, and criminal activity. In addition, some immediate health risks can lead to the development of long-term health consequences; for example, sexual promiscuity can lead to sexually transmitted diseases and unwanted or high-risk pregnancies (American Addiction Centers, 2020b).

One of the most severe acute health risks – drug overdose – may look different depending on the type of drug involved in the overdose. Stimulant overdose can dangerously increase blood pressure and heart rate, while opioid overdose can slow breathing to dangerous levels. Some drugs can create significant physiological dependence, and when a user attempts to quit or decrease drug use, severe withdrawal symptoms can occur. Agitation, anxiety, and physical illness can make it difficult to maintain abstinence, as users may want to use again in order to make the discomfort stop. This creates a powerful cycle that can set a user up for a lifetime of substance abuse (American Addiction Centers, 2020b).

Substance abuse can put a user at a significantly higher risk of chronic medical conditions, as well as an increased risk of acute health issues as substance use continues. A 2017 study showed that patients with substance use disorders were at a higher risk of developing 19 common health conditions, including chronic pain, asthma, congestive heart failure, high blood pressure, stroke, and pneumonia. These patients also had an increased risk of dying at a young age when compared to those without a substance use disorder. In addition, drug use and drug-seeking behavior can result in a user neglecting their personal care and hygiene, leading to weight loss and dental health issues. Infectious disease risk can also increase, because of shared needles or unsafe sexual practices (American Addiction Centers, 2020b). Substance abusers also increase the risks to others for domestic violence, child neglect, and violent crime.

SUBSTANCE & DRUG TYPES

Drug addiction is a chronic, relapsing disease that causes compulsive drug-seeking and use, despite long-lasting changes in the brain and harmful consequences to the drug addict and those around them. Although it is true that, for most people, the initial decision to take drugs is voluntary, over time the changes in the brain caused by repeated drug use can affect the individual's self-control and ability to make sound decisions (NIDA, 2020a).

The two major drug categories discussed in this course are street drugs and prescription drugs.

Street drugs

Overview

Street drugs are a pharmacologically heterogeneous group of psychoactive compounds. Heroin, bath salts, cocaine, LSD, PCP, MDMA (ecstasy), marijuana, spice, and methamphetamine are some of the drugs in this group. The concept of street drugs is more dangerous than prescription drugs because there is no way of knowing how strong the drug actually is or what exactly is in the drug (NIDA, 2020a).

Heroin

Heroin (diacetylmorphine) is derived from the morphine alkaloid found in opium and is roughly two to three times more potent than morphine (NIDA, 2018b). As defined by the Drug Enforcement Agency (DEA), heroin is a Schedule I substance under the Controlled Substances Act, which means it has high potential for abuse, no accepted medical use for treatment in the United States and lacks accepted safety for use even under medical supervision (DEA, 2021).

In 2019, the National Survey on Drug Use and Health noted that about 50,000 people age 12 and older initiated heroin use, which resulted in an average of 140 people each day. About 745,000 people were noted to have used heroin in the past year, or approximately 0.3% of the population, as compared with 0.2% of the population in 2002 (SAMHSA, 2020).

Heroin: Common Street Names	
• Nose drops • Hell dust • Junk • Skag • Skunk • China white • Black pearl • Tar	• Dope • H or Big H • Horse • Smack • Thunder • Snow • Number 3, 4, or 8 • Brown sugar

Note. Adapted from "Commonly Used Drugs," 2020, National Institute on Drug Abuse (https://www.drugabuse.gov/sites/default/files/Commonly-Used-Drugs-Charts_final_June_2020_optimized.pdf). In the public domain.

Heroin is an opioid derived from the opium poppy flower that may be injected, inhaled, or smoked. Pure heroin is a white powder that primarily originates from South America and Southeast Asia. Highly pure heroin can be snorted or smoked and is appealing to new users as it eliminates the stigma of injecting heroin. "Black tar" heroin is black and sticky like roofing tar and is primarily produced in Mexico. The dark color is the result of crude processing methods that leave behind impurities; this type typically needs to be dissolved or diluted and injected into the veins, muscles, or under the skin (NIDA, 2018a).

New forms of heroin are now available and much cheaper. Cheese heroin is a combination of Mexican black tar heroin and cold medicine obtained over the counter. This highly addictive substance is very inexpensive, only a few dollars, so it is often targeted at young people. Children as young as nine have been identified in emergency rooms with addiction, overdose, and withdrawal from this form of heroin, which suppresses the central nervous system and causes breathing and heartbeat to slow or stop (Foundations for a Drug-Free World, 2021a).

Once ingested, heroin quickly binds to opioid receptors in the brain. This creates a surge of euphoria (the rush) accompanied by a warm flushing of the skin, a dry mouth, and a sensation of heavy extremities. Following the initial euphoria, the user may be drowsy for several hours. Breathing rate decreases, heart rate slows, and mental function is clouded. The slow breathing rate can lead to coma, permanent brain damage, and even death (NIDA, 2018a).

Nursing Consideration: Acute signs of a heroin overdose may include slow and shallow breathing, hypotension, muscle spasms, seizure, coma, and possible death (NIDA, 2018a).

Tolerance develops with regular heroin use and the abuser must use more of the drug to get the same effect or substance intensity. As higher doses are used over time, physical dependency and addiction develop. With physical dependence, the body adapts to the drug's presence and withdrawal symptoms may occur within a few hours of non-use.

Symptoms include feelings of drug craving, restlessness, muscle and bone pain, insomnia, diarrhea, and vomiting. Cold flashes and shivering may also occur. Major withdrawal symptoms may peak between 24 and 48 hours after the last dose is taken and may last up to 1 week. Sudden heroin withdrawal by heavy-user individuals can result in death (NIDA, 2018a).

Beyond the immediate withdrawal symptoms of heroin, there may be long-term consequences. Ongoing heroin use can lead to collapsed veins, gastrointestinal problems, liver disease, kidney disease, brain damage, and needle contamination diseases such as HIV. Heroin use during pregnancy may cause a spontaneous abortion or lead to premature birth, low birth weight, birth defects, or an opioid-addicted infant (NIDA, 2018a).

Self-Assessment Quiz Question #2

Heroin binds to which of the following receptors in the brain?

a. Opioid.
b. Serotonin.
c. Norepinephrine.
d. GABA.

Treating heroin and opioid overdose

Naloxone is the gold standard to reverse the effects of heroin overdose. Naloxone hydrochloride (Narcan) is a competitive opioid antagonist that reverses the effects of opioids. It can be administered via intranasal spray or by intramuscular, subcutaneous, or intravenous injection, and can be safely administered to children and pregnant patients. If the patient does not respond within 2 to 3 minutes after administration, a second dose should be administered. The duration of action of naloxone depends on the dose, route of administration, and drug overdose type. The fastest route of absorption is intravenous and the slowest absorption is intranasal. Patients who have overdosed on long-acting opioids (OxyContin, MS Contin, Kadian) typically require multiple doses or a continuous infusion of naloxone, since the opioid duration of action may be longer than the naloxone duration of action. The goal of naloxone therapy should be to restore adequate spontaneous breathing, not necessarily complete arousal (Fudin, 2018; SAMHSA, 2018).

Naloxone is a proven safe medication. When given to patients who are not opioid intoxicated or dependent, there are no clinical effects. Even though naloxone produces a rapid withdrawal in opioid-tolerant patients, it is not life threatening. These symptoms are unpleasant and some patients may become agitated and combative and require medication (e.g., benzodiazepine) to remain calm. Withdrawal symptoms include the following (SAMHSA, 2018):

- Body aches.
- Diarrhea.
- Tachycardia.
- Runny nose.
- Sneezing.
- Piloerection.
- Nausea.
- Vomiting.
- Restlessness.
- Agitation.
- Abdominal cramps.
- Increased blood pressure.

The Food and Drug Administration (FDA) has approved injectable naloxone, intranasal naloxone (Narcan nasal spray), and a naloxone autoinjector (Evzio) for the treatment of opioid overdose. Injectable naloxone can be administered intravenously, intramuscularly, or subcutaneously in healthcare settings at doses of 0.4 mg to 2 mg every 2 to 3 minutes until respiration is restored. The Narcan nasal spray is a prefilled, needle-free device that requires no assembly. It can deliver a single 4-mg dose of naloxone into one nostril. The Evzio autoinjector is injected into the anterolateral aspect of the thigh to deliver naloxone 2 mg / 0.4 mL in a prefilled autoinjector injected either intramuscularly or subcutaneously. Once Evzio is turned on, the device provides verbal and visual guidance to the user describing how to deliver the medication, similar to automated defibrillators, in a safe, confident manner. Both Narcan nasal spray and Evzio are packaged in a carton containing two doses to allow for repeat dosing if needed. Caregivers should be advised to repeat doses in 2 to 3 minutes if no response is seen or until emergency responders arrive (Dowell et al., 2016; FDA, 2016).

Evidence has shown that laypersons can learn to recognize the signs of an opiate overdose. They also can learn how to safely administer the antidote, naloxone. Naloxone kits provided to laypersons are safe and cost effective and reduce overdose deaths. Multiple health organizations recommend providing naloxone kits to laypersons who may witness an opioid overdose, to patients in substance abuse treatment programs, to persons leaving prison or jail, and as a component of responsible opioid prescribing (Dowell et al., 2016).

It is important to educate patients, family, and caregivers of the danger signs of respiratory depression and drug overdose. Everyone in the household should be advised to obtain immediate medical attention by calling 911 while administering naloxone intranasally, intramuscularly, subcutaneously, or intravenously if the person demonstrates any signs of overdose (Dowell et al., 2016; SAMHSA, 2018). Signs of Opioid-Induced Overdose include the following (SAMHSA, 2018):

- Breathing difficulties, slow and shallow or not present at all, or the presence of the "death rattle."
- Hard to arouse.
- Face is pale.
- Skin is clammy to the touch.
- Body is limp.
- Fingernails or lips are blue or purple.
- Person is vomiting or making gurgling noises.
- Person is unable to speak, is confused, or has slurred speech.
- Heartbeat is very slow or stopped.

Often laypersons attempt to help the overdose victim in ways that may harm the person more. The healthcare professional should educate the layperson on the appropriate way to respond to an opioid overdose (SAMHSA, 2018).

Dos and Don'ts in Responding to Opioid Overdose include the following (SAMHSA, 2018):

- **DO** support the person's breathing by performing rescue breathing.
- **DO** administer naloxone as prescribed in the kit.
- **DO** put the person in the recovery position (turn on the side) if they are breathing independently.
- **DO** stay with the person and keep them warm.
- **DON'T** slap or try to forcefully stimulate the person. This will only cause further injury. If you are unable to wake the person by shouting, rubbing your knuckles on the sternum, or lightly pinching them, they may be unconscious. If in any doubt, call 911 immediately.
- **DON'T** put the person into a cold bath or shower. This increases the risk of falling, drowning, or going into shock.
- **DON'T** inject the person with any substance (speed, saltwater, milk, heroin). The only safe treatment is naloxone.
- **DON'T** try to make the person vomit drugs that they may have swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.

Case study

Mr. Johnson, a 21-year-old male, has been admitted to a hospital medical floor for cellulitis and opioid withdrawal. He was admitted the previous day after being brought to the hospital by his roommate, who was concerned about a serious-looking infection on his arm. During shift change report, the oncoming nurse learns that the patient has a 4-year history of intravenous heroin abuse and that his use has escalated in the last few months, with higher doses needed to achieve a high. His medical history includes a condition causing chronic pain that was being treated with oxycodone. Several years ago, after a failed urine toxicology screen at his doctor's office because of recreational use of marijuana, he was no longer prescribed any opioid pain medications, so he started using heroin to alleviate his pain. Upon evaluation, he notes that he wants to cut down his use but has not been able to, and that he is in the process of getting a divorce because his wife cannot deal any longer with his continued drug use.

The nurse is processing the discharge paperwork for Mr. Johnson. Since he is at a high risk of relapsing in his opioid addiction, the nurse is reviewing overdose risk and response with the patient and his roommate.

Questions

1. If Mr. Johnson were to overdose on opioids, what symptoms could he experience?
2. What should be emphasized during patient education on signs of overdose?

Discussion

1. If he has an opioid overdose, Mr. Johnson may experience slow, shallow, or no breathing, clammy skin, or a slow or no heart rate. He may be difficult to arouse, limp, confused, unable to speak, or have slurred speech, because opioids are sedating and these effects are increased in an overdose situation. Blue or purple lips or fingernails may be seen, as this is a sign that he is not breathing enough to get adequate oxygenation to his lips and fingertips. His skin may be pale and clammy to the touch, and he could be vomiting or making gurgling noises as the body attempts to rid itself of the substance causing the overdose.
2. When educating a patient or significant other on signs of overdose, signs and symptoms of overdose should be reviewed, such as respiratory depression, cold and clammy skin, inability to stay alert or be aroused, blue or purple fingernails or lips, slow or no heartbeat, or slurred speech or inability to speak. Families and caregivers should be reminded that if breathing becomes shallow and the patient cannot be aroused, they should call 911 immediately. Patients and their families, friends, and caregivers should also be educated on how to use naloxone and what to do before emergency personnel arrive. CPR training should be completed by family and close associates.

Bath salts

Bath salts, or synthetic cathinones, are one of the newest fads landing patients in the emergency room. The drug consists of a synthetic powder that is sold legally online and in drug paraphernalia shops. Teens have been hospitalized because of confusing the actual bath salt (Epsom salts) with the illegal stimulant. The drug referred to as bath salts contains man-made stimulants called cathinones, which are related to a stimulant found in the khat plant. Because these substances are stimulants, they increase dopamine levels in the brain and create a sensation of euphoria. The substance comes as a powder and is typically swallowed, snorted, injected, or smoked. The drug is inexpensive and is easy to acquire (NIDA, 2020b). Common street names for Bath Salts include:

- Bliss
- Cloud Nine
- Vanilla Sky
- White Lightning
- Lunar Wave

Note: From "Synthetic Cathinones ('Bath Salts')," 2020, DrugFacts (https://www.drugabuse.gov/publications/drugfacts/synthetic-cathinones-bath-salts).

Individuals who consume synthetic cathinones may experience intense feelings of agitation, paranoia, hallucinations, increased sex drive, increased friendliness, panic attacks, and excited delirium. These drugs can increase heart rate and blood pressure and cause chest pain. People who experience delirium can suffer from dehydration, skeletal muscle breakdown, and kidney failure. Bath salts can trigger intense, uncontrollable urges to take the drug again. Withdrawal symptoms can include depression, anxiety, tremors, insomnia, and paranoia (NIDA, 2020b).

Nursing Consideration: Patients with an overdose of bath salts may require hospital admission, intravenous sedatives, and antipsychotics; restraints or other measures may be necessary to protect the patient and healthcare team.

Cocaine

Cocaine has been used since ancient times when Incas in the Andes chewed coca leaves to counter the effects of living in thin mountain air. Medically, it was first used in the 1880s; Sigmund Freud promoted the use of the drug as a tonic to cure depression and sexual impotence. Its use became more widespread when it was temporarily used as an ingredient in the soft drink Coca-Cola. As cocaine use increased, the dangers became more evident and the drug was officially banned in the United States in 1922 (Foundation for a Drug-Free World, 2021b).

The 2019 National Survey on Drug Use and Health (NSDUH) estimates that approximately 2% of Americans ages 12 or older used cocaine in the past year, which includes the use of crack cocaine. This number reflects a reduction from 2002 when a reported 2.5% of people ages 12 or older used cocaine. Approximately 0.4% of Americans aged 12 and older were diagnosed with a cocaine use disorder in 2019, a decline of 0.2% since 2002 (SAMHSA, 2020).

Cocaine is made from the leaves of the coca plant, which is native to South America, and is a powerfully addictive stimulant. As a street drug, cocaine is typically a fine, white crystal powder. It can be snorted, rubbed into the gums, or injected. When snorted, cocaine powder is inhaled through the nose and absorbed into the bloodstream through the nasal tissues. When injected, it is released directly into the bloodstream. All of these methods pose great risks to the user (NIDA, 2018a).

Crack is a cocaine base that has not been neutralized by an acid to make the hydrochloride salt. This form of cocaine comes in a rock crystal that is heated to produce vapors that are then smoked and absorbed into the bloodstream through the lungs. The term "crack" refers to the crackling sound produced by the rock as it is heated (NIDA, 2018a). Common street names for Cocaine include:

- Blow
- Rock
- Coke
- Crack
- Snow

Note. Adapted from "Prescription Stimulants," 2018, National Institute on Drug Abuse (https://www.drugabuse.gov/publications/drugfacts/prescription-stimulants).

Cocaine is highly addictive. It triggers the brain to release dopamine and creates a euphoric feeling – a "high" – that is intense, but short-lived. This leads individuals to continue using the drug repeatedly. The duration of cocaine's immediate euphoric effects depends upon the route of administration. The faster the absorption, the higher the intensity. Also, the faster the absorption, the shorter the duration of action. The high from snorting is relatively slow in its onset and may last 15 to 30 minutes; the high from smoking may last 5 to 10 minutes (NIDA, 2018a). Table 1 includes the clinical signs of a person abusing cocaine.

Table 1. Cocaine Abuse: Clinical Signs

Short-term	Short-term Continued Use	Long-Term
• Narrowed blood vessels. • Tachycardia. • Hypertension. • Hyperthermia. • Gastric pain/ nausea. • Loss of appetite. • Dilated pupils.	• Restlessness. • Malnourishment. • Cardiac dysrhythmias. • Stroke. • Loss of smell. • Seizure. • Coma. • Sudden death.	• Poor nutrition. • Weight loss. • Increased infection risk. • If snorted: loss of smell, nosebleeds, problems swallowing. • If smoked: cough, respiratory issues, lung infections. • If injected: bloodborne infections, skin infections, collapsed veins.

Note. Adapted from "Cocaine," 2018, National Institute on Drug Abuse (https://www.drugabuse.gov/publications/drugfacts/cocaine).

The drug user may develop a tolerance to the cocaine high. Many addicts report that they fail to achieve as much pleasure from their subsequent cocaine use as they did from their first cocaine exposure. Some users will increase their dose in an attempt to intensify and prolong the euphoria. This can also increase the risk of adverse psychological or physiological effects and overdose (NIDA, 2018e).

Evidence-based practice! The full extent of cocaine's effect on an unborn or newborn child is not fully known. Studies have shown that infants born to women who use cocaine during pregnancy may be delivered prematurely, have low birth rates, and may be shorter in length at birth, while the mothers have an increased risk of placental abruption. Women who abuse cocaine may have other addictive habits, such as nicotine and alcohol use. The amount of prenatal care, exposure to sexually transmitted diseases, and socioeconomic factors may also affect infant outcomes. Research shows that the fetal exposure to cocaine in utero may also lead to deficits in cognitive abilities, information processing, and the ability to complete tasks in childhood (NIDA, 2016).

Hallucinogens: LSD

Hallucinogenic substances are characterized by their ability to cause changes in a person's perception of reality. Persons using hallucinogenic drugs often report seeing images, hearing sounds, and feeling sensations that seem real but do not exist (see Table 2). LSD (D-lysergic acid diethylamide) is one of the major drugs in the hallucinogen class and one of the most powerful mind-altering chemicals. It was first synthesized in 1938 from ergot, a fungus that grows on rye and other grains (NIDA, 2019a).

LSD is produced in crystalline form. It is then mixed with excipients or is diluted as a liquid for production in ingestible forms. It is odorless, colorless, and has a slightly bitter taste. LSD is most commonly sold as blotter paper, which are sheets of absorbent paper soaked in or impregnated with LSD, covered with colorful designs or artwork, and perforated into individual dosage units. It can also be found in tablet form (usually small tablets known as microdots), in thin squares of gelatin (commonly referred to as windowpanes), on sugar cubes, or in pure liquid form (Anderson, 2021c).

The effects of LSD are unpredictable. When taken by mouth, the first effects of the drug are felt 30 to 45 minutes after taking it, peak at 2 to 4 hours, and may last 12 hours or longer. A wide variety of physical and behavioral effects may result (Anderson, 2021; NIDA 2019).

LSD produces tolerance, so some who use the drug repeatedly must take progressively higher doses to achieve the state of intoxication that they had previously achieved. This is an extremely dangerous practice given the unpredictability of the drug (Anderson, 2021a).

Table 2. LSD Abuse: Clinical Signs

Short-term	Long-term
• Distortion of ability to think rationally. • Hallucinations. • Distorted perception of shapes and colors. • Altered sounds. • Anxiety, depression. • Hypertension. • Tachycardia. • Dry mouth. • Insomnia. • Dizziness. • Insomnia. • Dilated pupils. • Hyperthermia. • Sweating. • Nausea. • Loss of appetite. • Tremors. • Perception of hearing colors and seeing sounds. • Increased blood sugar.	• Frightening flashbacks. • Ongoing visual disturbances. • Longer lasting psychoses. • Disorganized thinking. • Panic feeling. • Paranoia. • Mood swings. • Fear of insanity and death.

Note. Adapted from "LSD" by L. Anderson, 2021 (https://www.drugs.com/illicit/lsd.html).

Phencyclidine (PCP)

PCP was developed in the 1950s as an intravenous anesthetic. Its use in humans was discontinued in 1965 because patients often became agitated, delusional, and irrational as they recovered from its anesthetic effects. PCP is now illegally manufactured in laboratories (Anderson, 2021b; NIDA, 2019).

Phencyclidine, the main ingredient in PCP, is a powerful mind-altering dissociative drug, leading to distortion of sights, colors, sounds, self, and one's environment. In its pure form, it is a white crystalline powder that is readily soluble in water or alcohol. It has a distinctive, bitter chemical taste. PCP can be easily mixed with dyes and turns up on the illicit drug market in a variety of tablets, capsules, and colored powders. These are either taken orally or by the intranasal route ("snorted"). It can also be smoked or injected. For smoking, PCP is often applied to a leafy material such as mint, parsley, oregano, or marijuana. On the illicit drug market, it can contain a number of contaminants. This causes the color to range from a light to darker brown, and its consistency can range from a powdery substance to a gummy mass. The liquid form of PCP is actually PCP base dissolved most often in ether – a highly flammable solvent (Anderson, 2021b). Common street names of PCP include:

- Angel dust
- Boat
- Hog
- Love boat
- Rocket fuel
- Wack
- Ozone
- Dust
- Embalming liquid

Note. Adapted from "PCP," by L. Anderson, 2021, Drugs.com (https://www.drugs.com/illicit/pcp.html).

The effects of PCP use are unpredictable; they can be felt within minutes of ingestion and can last for many hours. When taken in a moderate amount, PCP causes the user to feel distracted, distant, and estranged from their surroundings. The user may be observed with a blank stare, rapid and involuntary eye movement, an exaggerated gait, slurred speech, and loss of coordination (see Table 3). As the dosage is increased, the individual's behavior may escalate to acute anxiety, feelings of impending doom, violent hostility, and even psychosis (Anderson, 2021b).

Table 3. PCP Abuse: Clinical Signs

Short-term – low dose	Short-term – high dose	Long-term – high dose
• Tachypnea. • Hypertension (early). • Tachycardia. • Hypoventilation. • Flushing or profuse sweating.	• Hypotension (late). • Nausea. • Vomiting. • Drooling. • Loss of balance. • Violence. • Suicidal thoughts.	• Delusions. • Hallucinations. • Seizure. • Coma. • Death.

Note. Adapted from "PCP," by L. Anderson, 2021, Drugs.com (https://www.drugs.com/illicit/pcp.html).

Many users of PCP are brought to hospital emergency rooms because of unpleasant psychological effects or overdoses. They may become violent or suicidal and can be very dangerous to themselves and others. They should be kept in a calm setting and not left alone (Anderson, 2021b).

MDMA (Ecstasy or Molly)

MDMA was first used in the 1970s – not as a recreational drug, but as an aid in psychotherapy. In 1985, the DEA labeled MDMA a Schedule I substance, or a drug with a high abuse potential and no recognized medical use in the US. However, researchers remain interested in its value in psychotherapy when given under carefully controlled conditions for the treatment of PTSD, anxiety in terminally ill patients, and for social anxiety in autistic adults (NIDA, 2020d).

MDMA is a synthetic psychoactive drug that has similarities to both the stimulant amphetamine and the hallucinogen mescaline. It produces feelings of increased energy, euphoria, emotional warmth, and empathy toward others. It also produces distortions in sensory and time perception. As a street drug, MDMA was initially popular among white adolescents and young adults in nightclub scenes or at "raves" (long dance parties), but the drug is now used among a broader range of users and ethnicities (NIDA, 2020d).

MDMA is typically taken orally as a capsule or tablet, though the powder can also be snorted. The popular term Molly (slang for "molecular") refers to the pure crystalline powder form of MDMA that is usually sold in capsules, although it may be mixed or "cut" with other substances. The drug's effects last approximately 3 to 6 hours; users often take a second dose of the drug as the effects of the first dose begin to fade. It is commonly taken in combination with other drugs, such as alcohol and marijuana or the erectile-dysfunction drug sildenafil (Viagra; NIDA, 2020d).

MDMA impacts the brain by creating a surge of several neurotransmitters. It increases dopamine, which results in increased energy and activity, and reinforces behaviors by acting in the reward system. It also stimulates the release of large amounts of serotonin, which affects mood, appetite, and sleep, as well as affecting sexual arousal, trust, and emotional closeness (see Table 3). Norepinephrine is also increased, which increases heart rate and blood pressure; these effects can be particularly risky in people with pre-existing heart and blood vessel problems (NIDA, 2020d). Table 4 includes the clinical signs of a person abusing MDMA.

Table 4. MDMA Abuse: Clinical Signs

During Use	Within a Week After Use
• Lowered inhibition. • Increased energy. • Euphoria. • Emotional warmth. • Empathy toward others. • Anxiety. • Nausea. • Blurred vision. • Muscle cramping. • Chills. • Sweating. • Involuntary teeth clenching. • Increased body temperature.	• Irritability. • Depression. • Sleep problems. • Drug cravings. • Memory and attention problems. • Impulsiveness. • Aggression. • Decreased appetite. • Anxiety. • Decreased interest in or pleasure from sex. • Sleep disturbances.

Note. Adapted from "MDMA (Ecstasy/Molly) DrugFacts," 2020, National Institute on Drug Abuse (https://www.drugabuse.gov/publications/drugfacts/mdma-ecstasymolly).

Pills, capsules, and powders sold as Ecstasy and Molly may contain other drugs instead of, or in addition to, MDMA. Many police seizures of Molly contain additives including ketamine, methamphetamine, over-the-counter cough medications, cocaine, and synthetic cathinones. These combinations can be very dangerous, particularly when the user does not know what they are taking or when combined with other substances, such as alcohol, marijuana, or prescribed medications they may be taking (NIDA, 2020d).

Marijuana

Marijuana refers to dried leaves, stems, seeds, and flowers of the hemp plant (Cannabis sativa or Cannabis indica). The Cannabis plant contains the chemical THC (delta-9-tetrahydrocannabinol), which is responsible for the mind-altering properties of marijuana. Marijuana is commonly smoked as a cigarette (called a "joint") or in a pipe or bong. In recent years it has become available in vaping devices that pull the active ingredients of marijuana from the plant for the user to inhale. Marijuana has also appeared in blunts, which are cigars that have been emptied of tobacco and refilled with marijuana, sometimes in combination with another drug, such as crack. It can also be mixed into foods or used to brew a tea (NIDA, 2019b).

Marijuana is the most frequently used psychotropic drug in the United States. In 2019, 48 million Americans ages 12 and over reported using marijuana in the past year, an increase of 6.5% from 2002 (SAMHSA, 2020). Use of marijuana is widespread among young people. Rates of past year marijuana use have remained steady, but the number of teenagers who say that they use it daily has increased. The popularity of vaping devices is thought to be a contributor; nearly 4% of 12th graders say they vape THC daily. A declining number of young people believe regular marijuana use is risky (NIDA, 2019b). Thirty-eight percent of teens report using marijuana (CDC, 2017 https://www.cdc.gov/marijuana/factsheets/teens.htm).

Common effects of marijuana use include pleasure, relaxation, and impaired coordination and memory. The use of marijuana can produce adverse physical, mental, emotional, and behavioral effects. It can impair short-term memory and judgment and distort perception. Because marijuana affects brain systems that are still maturing through young adulthood, heavy use by teens may have a negative effect on their development. Studies have shown that people who started smoking marijuana heavily in their teens and who had an ongoing marijuana use disorder lost an average of 8 IQ points between ages 13 and 38. These lost mental abilities did not fully return in adults who quit use. People who started smoking marijuana as adults did not show notable declines in IQ. Studies have additionally shown an association between chronic marijuana use and increased rates of anxiety, depression, suicidal thoughts, and schizophrenia (NIDA, 2019b).

Contrary to popular belief, marijuana can be addictive. Marijuana addiction is also linked to a withdrawal syndrome similar to that of nicotine withdrawal, which can make it difficult to quit. People trying to quit report irritability, sleeping difficulties, craving, and anxiety (see Table 5). Studies have shown that between 9 and 30 percent of people who use marijuana may develop some degree of marijuana use disorder. People who start using marijuana before age 18 are 4 to 7 times more likely than adults to develop a marijuana use disorder (NIDA, 2019b).

While marijuana has a reputation for being a gateway drug, studies have shown that the majority of people who use marijuana do not go on to use other "harder" drugs. Table 6 includes common street names for marijuana. The use of alcohol, tobacco, and marijuana are likely to come before the use of other drugs, but a number of other factors are also involved in a person's risk of drug use and addiction, such as their social environment (NIDA, 2019b).

Table 5. Marijuana Abuse: Clinical Signs

During Use	Long-Term
• Enhanced sensory perception. • Euphoria. • Tachycardia. • Increased appetite. • Drowsiness/relaxation. • Slowed reaction time. • Problems with balance and coordination. • Problems with learning. • Problems with memory.	• Mental health problems. • Chronic cough. • Frequent respiratory infections.

Note. Adapted from "Marijuana," 2021, National Institute on Drug Abuse, 2021 (https://www.drugabuse.gov/publications/drugfacts/marijuana).

Table 6. Marijuana: Common Street Names

• Grass. • Chronic. • Pot. • Weed. • Hash. • Flower. • Skunk. • Hay. • Blaze.	• Bud. • Dope. • Ganja. • Herb. • Mary Jane. • Skunk. • Boom. • Reefer. • Rope.

Note. Adapted from "Marijuana Street Names, nicknames, and Slang Terms," 2021, Vertava Health (https://vertavahealth.com/blog/marijuana-street-names/).

Methamphetamine

Methamphetamine is a highly addictive central nervous system stimulant. It is chemically similar to amphetamines, used in the treatment of attention-deficit hyperactivity disorder (ADHD). It increases the amount of dopamine in the brain; the rapid release of dopamine in reward areas of the brain strongly reinforces a user's drug-taking behavior. Methamphetamine is found as a white powder or in crystal form, which looks similar to glass fragments or shiny blue-white rocks. Medically, the drug has limited uses for the treatment of narcolepsy, attention-deficit disorders, and obesity (NIDA, 2019c).

Methamphetamine can be injected, snorted, smoked, or ingested orally. Methamphetamine users feel a short, yet intense, "rush" when the drug is initially administered. The high from methamphetamine starts and fades quickly, so users often take repeated doses in a "binge and crash" pattern; binges can last for several days with users taking the drug every few hours. The immediate effects of methamphetamine include increased activity and decreased appetite (NIDA, 2019c).

The majority of methamphetamine in the United States is produced by criminal organizations in Mexico. The ease of clandestine synthesis, combined with tremendous profits, has resulted in significant availability of illicit methamphetamine. It can also be easily made in small laboratories with inexpensive over-the-counter ingredients such as pseudoephedrine, an ingredient in cold medications. Pharmacies are now required to keep a record of pseudoephedrine purchases and take steps to limit sales in order to decrease methamphetamine production. Toxic chemicals are involved in the process of making methamphetamine, which can linger in the environment long after a lab has been shut down, causing a range of health problems (NIDA, 2019c).

Methamphetamines: Common Street Names
• Crystal meth • Meth • Ice • Blue • Speed • Crystal • Glass

Note. Adapted from "Methamphetamine," 2019, National Institute on Drug Abuse (https://www.drugabuse.gov/publications/drugfacts/methamphetamine).

Methamphetamine is a powerful stimulant that increases alertness, decreases appetite, and gives the individual a sense of euphoria or pleasure (see Table 7). Withdrawal can lead to anxiety, fatigue, depression, psychosis, and severe drug cravings (NIDA, 2019c).

Table 7. Methamphetamine Abuse: Clinical Signs	
Short-term	Long-term
• Increased alertness. • Increased physical activity. • Decreased appetite. • Tachypnea. • Mood disturbances. • Increased body temperature. • Tachycardia. • Anxiety. • Insomnia. • Irregular heart rate.	• Changes in brain structure and function. • Weight loss. • Severe dental problems (meth mouth). • Psychotic signs. • Violent behavior. • Confusion. • Memory loss. • Insomnia. • Paranoia. • Delusions (such as sensation of bugs crawling under skin). • Intense itching.

Note. From "Methamphetamine," 2019, National Institute on Drug Abuse (https://www.drugabuse.gov/publications/drugfacts /methamphetamine). In the public domain.

Methamphetamine was involved in about 15 percent of all drug overdose deaths in 2017. High doses of methamphetamine can increase heart rate and blood pressure, so an overdose often leads to heart attack, stroke, or organ failure (NIDA, 2019c). Home meth labs have also caused explosions and fires resulting in the loss of lives.

Self-Assessment Quiz Question #3

Which of the following drug categories describes methamphetamine?

a. Depressant.
b. Hallucinogen.
c. Stimulant.
d. Muscle relaxant.

PRESCRIPTION DRUGS

The non-medical use or abuse of prescription drugs in the United States is a major drug problem. The 2019 NSDUH showed that 5.9% of Americans misused prescription drugs in the past year, accounting for nearly 16.3 million people. Of the prescription drugs reported, nearly 9.7 million people misused prescription pain relievers, while about 4.9 million people misused prescription stimulants and 4.8 million people misused benzodiazepines (SAMHSA, 2020). The CDC estimates that about 41 people die each day because of prescription opioid overdose (CDC, 2020b).

In focus: West Virginia

West Virginia reported 13.1 per 100,000 people died because of a prescription opioid overdose in 2018, the highest rate in the nation. This is despite a decrease of 4.1 per 100,000 people from 2017 (CDC, 2020b). According to the report by the Trust for America's Health (TFAH), in West Virginia, prescription drug abuse has quickly become a top public health concern. With the rise of heroin, fentanyl, and carfentanil use, the nation is rapidly at risk of reaching 100 drug-related deaths per 100,000 people by 2025 (TFAH, 2018).

In focus: United States

Misuse and abuse of prescription painkillers costs the country an estimated $78 billion a year in lost productivity, medical costs, and criminal justice costs (NIDA, 2018c). The NSDUH noted that 21.6 million Americans needed substance use treatment, but only 4.2 million received any treatment (SAMHSA, 2020). In 2014, Americans filled 245 million prescriptions for opioid pain relievers, making them the most prescribed medication in the United States (NIDA, 2017). The hidden cost of domestic violence, child abuse, accidents, and crime are difficult to measure, but can impact many lives and degrade neighborhoods.

Women are at an increasing risk for prescription drug overdose. According to the CDC (2018), about 18 women die every day because of prescription painkiller overdoses. This type of overdose death has risen sharply among women, with an increase of 400% since 1999 in women as compared with 265% in men. For every woman who dies of a prescription pain killer overdose, 30 visit the emergency department for painkiller misuse or abuse (CDC, 2018).

Prescription drug abuse poses a unique challenge because of the need to balance prevention, education, and enforcement with the need for legitimate access to controlled substance prescription drugs (CDC, 2018b). Providers have been encouraged to prescribe only a limited number of doses and to explore non-pharmacological treatments for pain control. Insurance limitations for physical therapy, massage, acupuncture, and other treatments has limited access to these approaches for pain management.

According to the NIDA (2020e) research report, Prescription Drugs: Abuse and Addiction, three classes of prescription drugs are most commonly abused: opioids or pain killers, central nervous system depressants or tranquillizers, and stimulants. The problem that most often occurs with prescription drug abuse is that the individual does not just take one substance. As dependency increases, more pills or substances are needed to create the same effect. Then, when increased usage of various substances does not create the desired sensation, the individual may begin mixing substances and adding alcohol or other illegal substances. According to NIDA (2017c), 60% of patients using prescription opioids are also taking other prescription drugs; more than 29% were prescribed benzodiazepines; 28% were prescribed muscle relaxants; and 8% were prescribed all three medications concurrently, placing them at a significant risk of overdosing. Misuse of prescription opioids is a risk factor for heroin use. Eighty percent of heroin users report misusing prescription opioids before using heroin (NIDA, 2017c). In addition, some prescriptions are sold on the street to children or substance abusers.

Opioids

Many Americans benefit from the appropriate use of prescription painkillers, but when abused, they can be as addictive and as dangerous as illegal drugs. Pain is a complex topic and adequate pain control may enhance the quality of life for people who suffer from chronic pain. Short-term opioid use under a provider's cautious supervision rarely leads to addiction or dependence (see Table 8). However, when used long-term, opioids may lead to drug abuse and physical dependence and/or addiction (NIDA, 2020b).

Table 8. Opioids				
Generic Name	Brand Names	Street Names	Common Forms	Common Ways Taken
Codeine	Varies.	• Captain Cody. • Cody. • Lean. • Schoolboy. • Sizzurp. • Purple Drank. • Doors & Fours. • Loads. • Pancakes & Syrup.	• Tablet. • Capsule. • Liquid.	• Injected. • Swallowed (often mixed with soda and flavorings).
Fentanyl	• Actiq. • Duragesic. • Sublimaze.	• Apache. • Blonde. • Blue. • Diamond. • Snowflake. • Humid. • Jackpot. • Murder 8. • Tango and Cash. • TNT. • White Ladies.	Lozenge. • Sublingual tablet. • Film. • Buccal tablet.	• Injected. • Smoked. • Snorted.
Hydrocodone or Dihydrocodeinone	• Lorcet. • Lortab. • Norco. • Vicodin.	• Vikes. • Veeks. • Idiot Pills. • Scratch. • 357s. • Lemonade. • Bananas. • Lorries.	• Capsule. • Liquid. • Tablet.	• Swallowed. • Snorted. • Injected.
Hydromorphone	Dilaudid.	• D. • Dillies. • K4. • Needle Candy.	• Liquid. • Suppository.	• Injected. • Rectal.
Meperidine	Demerol.	• Demmies. • Pain Killer.	• Tablet. • Liquid.	• Swallowed. • Snorted. • Injected.
Methadone	• Dolophine. • Methadose.	• Amidone. • Biscuits. • Fizzies. • Jungle Juice. • Maria. • Wafer. • With MDMA: ○ Chocolate Chip Cookies.	• Tablet. • Dispersible tablet. • Liquid.	• Swallowed. • Injected.
Morphine	• Duramorph. • MS Contin.	• Dreamer. • First Line. • Joy Juice. • Morpho. • Miss Emma. • Monkey. • White Stuff. • Mister Blue. • Unkie.	• Tablet. • Liquid. • Capsule. • Suppository.	• Injected. • Swallowed. • Smoked.
Oxycodone	• OxyContin. • Percodan. • Percocet. • Roxicodone.	• 30s, 40s, 512s. • Oxy. • Beans. • Blues. • Buttons • Cotton. • Hillbilly. • Heroin. • Kickers. • Killers. • Percs. • Roxy.	• Capsule. • Liquid. • Tablet.	• Swallowed. • Snorted. • Injected.
Oxymorphone	Opana.	• Biscuits. • Blue Heaven. • Blues. • Mrs. O. • Bomb. • Octagons. • Stop Signs.	Tablet.	• Swallowed. • Snorted. • Injected.

Note. From "Commonly Used Drugs," 2020, National Institute on Drug Abuse (https://www.drugabuse.gov/sites/default/files/Commonly-Used-Drugs-Charts_final_June_2020_optimized.pdf). In the public domain.

Opioids can be life threatening in an overdose (see Table 9). The threat is enhanced when the opioids are taken with alcohol or with central nervous system depressants. Because the drugs may not offer an immediate effect, additional substances may often be taken with the hopes of enhancing the feelings of euphoria. If the dosage and mixture of systems is significant, the individual may slip into a drug overdose situation with central nervous system depression and other life-threatening signs (NIDA, 2020f).

Nursing Consideration: Individuals trying to withdraw from chronic opioid drug use should be carefully monitored for restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with shivering, severe cravings, and irregular leg movements (NIDA, 2020f).

Table 9. Clinical Signs of Abuse or Overdose

Short-term	Longer-term or High Dose	High or Lethal Dose
• Feelings of euphoria. • Pain relief. • Drowsiness. • Nausea. • Constipation. • Confusion.	• Respiratory depression. • Central nervous system. • Depression.	• Loss of consciousness. • Permanent brain damage. • Death.

Note. From "Prescription Opioids DrugFacts," 2020, National Institute on Drug Abuse (https://www.drugabuse.gov/publications/drugfacts/prescription-opioids). In the public domain.

Benzodiazepines and barbiturates: Central nervous system depressants

Benzodiazepines depress the central nervous system (CNS). Millions of people in the United States use benzodiazepines to treat anxiety and sleep disorders, including insomnia (see Table 10). Barbiturates are commonly used for anesthesia and are prescribed to treat seizures and occasional insomnia or anxiety (NIDA, 2018d).

Table 10. Central Nervous System Depressants

Generic name	Brand Names	Street Names	Common Forms	Common Ways Taken
Benzodiazepines				
Alprazolam	Xanax	• Benzos. • Downers. • Poles. • Tranks. • Totem. • Z-Bars. • Yellow/Blue • Zs. • Zannies.	• Pill. • Capsule. • Liquid.	• Swallowed. • Injected.
Chlorodiazepoxide	Limbitrol			
Diazepam	Valium			
Lorazepam	Ativan			
Triazolam	Halcion			
Barbiturates				
Pentobarbital	Nembutal	• Barbs. • Dolls. • Phennies. • Red/Blue • Birds. • Tooies. • Yellow jackets. • Yellows.	• Pill. • Capsule. • Liquid.	• Swallowed. • Snorted.
Phenobarbital	Luminal			
Sleep Medications				
Eszopiclone	Lunesta	• Forget-me Pill. • Looney Bar. • Mexican Valium. • R2. • Roche. • Tic-Tacs. • Sleepeasy. • Symphony. • Zombie flip.	• Pill. • Capsule. • Liquid.	• Swallowed. • Snorted.
Zalepion	Sonata			
Zolpidem	Ambien			

Note. From "Commonly Used Drugs," 2020, National Institute on Drug Abuse (https://www.drugabuse.gov/sites/default/files/Commonly-Used-Drugs-Charts_final_June_2020_optimized.pdf). In the public domain.

Taking CNS depressants for a few days to a few weeks may help to calm nerves or enhance sleep. After a while, however, larger doses may be needed to get the same calm or sleepy feeling. Like opioids, the individual may overdose if the substances are taken in large amounts and mixed with opioids, other substances, and/or alcohol (NIDA, 2018d).

Clinical Signs of Abuse or Overdose

• Drowsiness. • Slurred speech. • Poor concentration. • Confusion. • Dizziness. • Problems with movement and memory.	• Dry mouth. • Lowered blood pressure. • Respiratory depression. • Decreased heart rate.

Note. From "Prescription CNS Depressants DrugFacts," 2018, National Institute on Drug Abuse (https://www.drugabuse.gov/publications/drugfacts/prescription-cns-depressants). In the public domain.

Patients addicted to barbiturates or benzodiazepines should not attempt to stop taking the drugs on their own. Withdrawal from these drugs can be problematic and, in the case of certain CNS depressants, is potentially life threatening. Patients addicted to these medications should undergo medically supervised detoxification because the treatment dose must be gradually tapered off. Inpatient or outpatient counseling can help the individual during this process. Cognitive-behavioral therapy has also been successful in helping individuals adapt to no longer using benzodiazepines (NIDA, 2018d).

Nursing Consideration: Older adults are at a higher risk for unintentional misuse or abuse because many have multiple prescriptions and may not remember when they took their last dose. This increases the risk of drug-to-drug interactions. Also, many older adults are treated with opioids for chronic pain. Careful monitoring is critical (NIDA, 2020f).

Self-Assessment Quiz Question #4

Benzodiazepines are most commonly used to treat which of the following medical conditions?

a. ADHD.
b. Anxiety.
c. Pain.
d. Narcolepsy.

Prescription stimulants

Prescription stimulants have often been used therapeutically for weight loss, attention-deficit disorders, and narcolepsy (see Table 11). Stimulants impact the body with a fast jumpstart, causing a great increase in alertness, energy, and attention (NIDA, 2018e).

Table 11. Stimulants

Generic name	Brand Names	Street Names	Common Forms	Common Ways Taken
Amphetamine	Adderall	Addys, Bennies, Beans, Black Beauties, Crosses, Hearts, Ivy League Drug, Pep Pills, Speed, Truck Drivers, Uppers.	• Tablet. • Capsule.	• Swallowed. • Snorted. • Smoked. • Injected.
Methylphenidate	• Concerta. • Daytrana. • Methylin. • Ritalin.	Diet Coke, JIF, Kiddie Coke, MPH, R-ball, R-Pop, Skippy, Study Buddies, the Smart Drug, Vitamin R.	• Liquid. • Tablet. • Chewable • tablet. • Capsule.	• Swallowed. • Snorted. • Smoked. • Injected. • Chewed.

Note. From "Commonly Used Drugs," 2020, National Institute on Drug Abuse (https://www.drugabuse.gov/sites/default/files/Commonly-Used-Drugs-Charts_final_June_2020_optimized.pdf). In the public domain.

Withdrawal symptoms can occur in regular users who suddenly stop using prescription stimulants. Symptoms can include fatigue, depression, and sleep issues (see Table 12). Treatment of an addiction to prescription stimulants is based on behavioral therapies used in treating cocaine and methamphetamine addiction. At this time, there are no medications that are FDA-approved for treating stimulant addiction (NIDA, 2018e).

Table 12. Clinical Signs of Abuse or Overdose

Short-term	Long-term; high dose
• Increased alertness. • Energy. • Increased body temperature. • Increased blood sugar. • Tachycardia. • Hypertension. • Constriction of blood vessels. • Irregular heartbeat.	• Anger. • Seizure. • Dangerously high body temperature. • Cardiovascular system failure. • Psychosis. • Paranoia.

Note. From "Prescription Stimulants," 2018, National Institute on Drug Abuse (https://www.drugabuse.gov/publications/drugfacts/prescription-stimulants). In the public domain.

EMERGING SUBSTANCES OF ABUSE

New drug and drug use trends emerge quickly, are transient, and are difficult to track. Outbreaks of new psychoactive substances are significant public health issues. It is important to be aware of emerging substances of abuse in order to properly treat users (see Table 13). The following substances have been identified as emerging drug abuse substances (American Medical Association [AMA], 2017).

Table 13. Emerging Substances of Abuse

Substance	Emerging Drug Abuse Substances
Fentanyl	There is a recent surge in overdose deaths related to the opioid fentanyl. Fentanyl-related overdose deaths more than doubled between 2010 and 2015. There have been some reported cases when the individual thought they were taking heroin but, in fact, the substance was fentanyl. An overdose of fentanyl can be reversed with naloxone (Narcan). Fentanyl has been found laced in heroin and in counterfeit pill forms made to look like prescription pain relievers and sedatives (AMA, 2017).
Counterfeit prescription narcotics	Counterfeit tablets of various prescription narcotics, such as Norco, have shown up on the market. Some have been made with the highly potent opioids fentanyl and carfentanil, resulting in unintentional drug overdoses (AMA, 2017).
Synthetic cannabinoids	Synthetic cannabinoids are chemically related to THC, the active ingredient in marijuana. They are sometimes called “synthetic marijuana” or “legal marijuana,” but the effects can be considerably more powerful and more dangerous than marijuana. This category represents the largest category of emerging substances of abuse, with a wide variety of compounds available for sale in stores across the nation, including gas stations and adult stores. Synthetic cannabinoids can cause the user to experience anxiety and agitation, nausea and vomiting, high blood pressure, shaking and seizures, hallucinations and paranoia, and violent outbursts (AMA, 2017).
Carfentanil	This potent opioid is one of the strongest available. Carfentanil, a fentanyl analog, has a potency approximately 10,000 times greater than morphine. The drug has been linked to a significant number of overdoses. It has been found to be added to heroin, cocaine, counterfeit prescription medications, and other street drugs. The high potency of carfentanil may require higher doses of naloxone or more frequent administration in order to reverse an overdose (AMA, 2017).
Flakka (alpha-PVP)	Alpha-PVP is chemically similar to other synthetic cathinone drugs popularly called "bath salts." It takes the form of a white or pink foul-smelling crystal that can be eaten, snorted, injected, or vaporized in an e-cigarette or similar device. Vaporizing, which administers the drug very quickly into the bloodstream, may make it particularly easy to overdose. Like other drugs of this type, alpha-PVP can cause a condition called "excited delirium" that involves hyper stimulation, paranoia, and hallucinations, and can lead to violent aggression and self-injury. The drug has been linked to deaths by suicide as well as heart attacks. It can also dangerously raise body temperature and lead to kidney damage or failure (Hudson, 2020).
Caffeine Powder	Bulk bags of pure caffeine powder are readily available online. These products may be attractive to young people looking for added caffeine stimulation or for help losing weight. But they are extremely dangerous: Just a teaspoon of pure caffeine powder contains approximately 3200 mg of caffeine, the equivalent of 20 to 28 cups of coffee – a potentially lethal amount. In addition to death, a severe caffeine overdose can cause a fast and erratic heartbeat, seizures, vomiting, diarrhea, and disorientation – symptoms that are much more extreme than those from drinking too much coffee or tea or consuming too many sodas or energy drinks (FDA, 2018).
E-Cigarettes	E-cigarettes are increasingly popular battery-operated devices marketed as a safer alternative to smoking conventional cigarettes. They produce a flavored nicotine aerosol that looks and feels like tobacco smoke, but without the tar or other chemicals produced by burning tobacco leaves. However, while e-cigarettes do not produce tobacco smoke, it is still unclear how safe they are. They still deliver nicotine, which is a highly addictive drug. Also, vapor from some e-cigarette products has been found to contain known carcinogens and toxic chemicals. Due to the widespread use of e-cigarettes among teenagers, the government raised the federal minimum age for purchasing tobacco products, including cigarettes, cigars, and e-cigarettes, to 21 years of age (FDA, 2020).
N-Bomb	“N-bomb” refers to any of three closely related synthetic hallucinogens: 25I-NBOMe, 25C-NBOMe, and 25B-NBOMe. They are sold as substitutes for LSD. Also called “smiles” or “25I” they are generally found as powders, liquids, soaked into blotter paper (like LSD), or laced within something edible. They have a strong, bitter, metallic taste. These chemicals act on serotonin receptors in the brain, like other hallucinogens, but they are considerably more powerful – even more powerful than LSD. Extremely small amounts can cause seizures, heart attack or arrested breathing, and death (Foundation for a Drug-Free World, 2021c).
“Syrup” “Purple Drank” “Sizzurp” “Lean”	Refers to drinking prescription-strength cough syrup containing codeine and promethazine, mixed with soda or alcohol. Codeine and other opioids present a high risk of fatal overdose because of their effect of depressing the central nervous system, which can slow or stop the heart and lungs. Mixing with alcohol greatly increases this risk (Bezrutczyk, 2020).

Note. Adapted from “Emerging Drugs of Abuse Are a Public Health Threat,” 2017, American Medical Association (https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-science-public-health/a17-csaph-2.pdf); “Flakka Addiction and Abuse,” by H. Hudson, 2020 (https://www.addictioncenter.com/drugs/flakka-addiction-abuse/); “FDA Takes Step to Protect Consumers Against Dietary Supplements Containing Dangerously High Levels of Extremely Concentrated or Pure Caffeine,” 2018, Food and Drug Administration (https://www.fda.gov/news-events/press-announcements/fda-takes-step-protect-consumers-against-dietary-supplements-containing-dangerously-high-levels); “Vaporizers, E-Cigarettes, and Other Electronic Nicotine Delivery Systems (ENDS),” 2020, Food and Drug Administration (https://www.fda.gov/tobacco-products/products-ingredients-components/vaporizers-e-cigarettes-and-other-electronic-nicotine-delivery-systems-ends); “What Is ‘N-Bomb’?” 2021c, Foundation for a Drug-Free World (https://www.drugfreeworld.org/drugfacts/synthetic/what-is-n-bomb.html); “Lean Addiction and Abuse,” by D. Bezrutczyk, 2020, Addiction Center (https://www.addictioncenter.com/opiates/codeine/lean-addiction-abuse/); A

DRUG ABUSE NURSING ASSESSMENT AND CARE: IDENTIFICATION AND SCREENING

Screening and assessment tools can help stratify patients according to risk level. Placing patients in a risk level helps guide the degree of structure and monitoring needed in the treatment plan. Even though multiple tools are available, clinical studies have shown insufficient evidence in the accuracy of these tools to categorize patients at a low or high risk of abuse or misuse. Clinicians should not overestimate the ability of risk assessment tools to rule out risks of long-term opioid treatment and should use these tools in conjunction with their own clinical judgment (Dowell et al., 2016).

The CAGE substance abuse screening tool is a simple line of questions to help identify if substance abuse exists. It was developed in 1984 by John Ewing for assessing alcohol problems. CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, Eye-opener.

The CAGE-AID uses the same questions but adds the phrase drug use in each question. The normal cutoff for the CAGE is two positive questions. However, some clinicians recommend lowering the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders (National Institute on Alcohol Abuse and Alcoholism, 2021).

The CAGE Questionnaire

1. Have you ever felt you ought to Cut down on your drug use (or drinking)?
2. Have people Annoyed you by criticizing your drug use (or drinking)?
3. Have you ever felt bad or Guilty about your drug use (or drinking)?
4. Have you ever used drugs (or had a drink) first thing in the morning (Eye-opener) to steady your nerves to get the day started (or get rid of a hangover)?

Brief assessment, identification, and care

Healthcare providers are often surprised to have an individual suddenly appear who is having an acute drug-related crisis. Regardless of whether the substance is an illegal street drug or a prescription medication, the initial assessment and care is the same. It is important for the healthcare provider to gather as much information as possible, keep the patient and staff safe, and provide intervention and supportive care to ensure that the patient receives the help necessary to deal with the drug problem, while protecting themselves and others (Donroe & Tetrault, 2017).

Initial observation and history:

- Who brought the individual in for care?
- What is the story that is being shared? Time sequence of substance or drug ingestion?
- Were designer drugs involved? Get as many details as possible.
- Were substances or drugs mixed?
- Do they have any of the substance, drug, or evidence of the substance on them? Get a sample if possible.
- Is the patient awake/alert? Do they have reduced consciousness? Is the individual acting out or violent?
- Overall observation of person, place, and time.

Information about the form of the drug, amount, and route of administration, if possible, may indicate the anticipated peak of symptoms. Alcohol use around the time of drug use may indicate possible potentiating effects. It is important to determine what substance or substances may have been consumed. The individual often may have taken more than one substance type or mixed the substances with alcohol. If street drugs were consumed, they might have been tainted with unknown chemicals that may create a totally unanticipated patient response. It may be possible to gather this information from the patient, the person who brought them in, or a laboratory test (Donroe & Tetrault, 2017).

Brief Assessment:

- Conscious?
- A-B-C assessment?
- Vital signs? Stable or unstable?
- Track marks or skin lesions?
- Ensure safety for individual, family, and staff.

Clinical Care:

- Safety for patient, family, and staff is the first priority.
- Provide supportive care, as indicated.
- Notify law enforcement or safety officers as appropriate.
- Where appropriate, help to ensure that individual has long-term help as needed.

(Donroe & Tetrault, 2017)

Self-Assessment Quiz Question #5

Which of the following is the first priority when treating patients who are experiencing an acute drug crisis?

a. Safety for the patient, family, and staff.
b. Notifying law enforcement.
c. Figuring out what substance the patient took.
d. Drawing blood for lab tests.

ENSURING SAFE AND EFFECTIVE CONTROLLED SUBSTANCE USE

Despite their high risk of addiction, controlled substances are often a critical component to optimal patient care. Healthcare providers must remember that patient safety is always the primary goal. The following steps can help to ensure safe and effective patient care in those patients that require controlled substance treatment (Brummond et al., 2017; DiPiro et al., 2019; Munzing, 2017):

- Assess and document the patient's comprehensive history, including medical history, psychiatric and psychosocial history, current medications, and substance abuse history.
- Ensure a diagnosis and medical necessity are established before starting or continuing controlled substance therapy.
- Ensure functional goals are established and reviewed regularly for patients requiring the use of controlled substances.
- Use the state's prescription monitoring program to assess patterns of controlled substance prescription use.
- Consider potential contraindications to the use of controlled substances before initiation, such as acute psychiatric instability and concurrent use of similar controlled substances.
- Use imaging tests, screening tools, and other evaluations appropriately.
- Use written agreements and informed consent for prescribing pain medications and, as appropriate, for other controlled substances.
- Ensure the patient understands the risks and benefits of controlled substances.
- Ensure that controlled substance dosages start low and are titrated up with caution only if appropriate in patients with a low concern of overdose and misuse.
- Long-acting and high-dose controlled substances should be reserved for patients who cannot be adequately managed with short-acting medications.
- Consider consultation with specialists for treating patients with complex conditions; those who require high-dose therapy; and patients at high risk of abuse, misuse, or diversion.
- Ideally, only one prescriber should be prescribing controlled substances for a patient.
- Controlled substances should be prescribed at the lowest effective dose in appropriate quantities. Follow-up appointments should be used to continue any needed doses.
- Periodically review the patients' condition and treatment effectiveness to ensure they are progressing toward their goals.
- Individualize treatment plans based on prior successes and failures, adverse events, and response to treatment.
- Monitor for possible abuse, misuse, and diversion.

- Recommend discontinuation of controlled substances in patients who frequently engage in suspicious drug-related behaviors, those experiencing significant side effects, and those who are not progressing toward their established goals. Appropriate tapering should be used if needed.
- Maintain accurate records.
- Ensure compliance with all state and federal controlled substance laws and regulations.

PROFESSIONAL DOCUMENTATION OF TREATMENT

Written documentation of all aspects of a patient's care – including assessments, informed consent, treatment plans, and provider-patient agreements – are a vital part of controlled substance best practices. Such documentation provides a transparent and enduring record of a clinician's rationale for a particular treatment; a basis for ongoing monitoring; and, if needed, modifications of a treatment plan. Healthcare providers must decide for themselves how thoroughly and how frequently their documentation of a patient's treatment should be. Regardless of the approach, records should document patient pain and function using objective measures. Furthermore, a number of key components should be considered for documentation (Brummond et al., 2017; DiPiro et al., 2019; Munzing, 2017):

- Histories demonstrating consistent improvements in symptoms and function offer a solid rationale for increases in controlled substance doses.
- All histories of substance abuse must be recorded, including past treatment successes and failures.
- Documentation of collaboration with a substance abuse professional is recommended for any patients with ongoing substance abuse issues who are receiving controlled substances.
- All prescriptions, especially psychoactive drugs and drugs with the potential for abuse, must be documented.
- The medical necessity of multiple controlled substances used, such as benzodiazepines with oxycodone and carisoprodol, must be clearly recorded.
- Every prescription written must include the dose, and the number dispensed must be charted.
- Prescriptions should be written with the objective of avoiding the necessity to refill prescriptions outside a clinic visit.
- Notes should have documentation of screening for depression, for example, "In the past month have you felt overwhelmed?"
- All side effects must be documented, especially in patients receiving high-dose narcotics.
- Documented histories of constipation, worsening sleep apnea, impairment of operation of equipment or vehicles.
- Complete documentation of red flags such as early refills, self-dose escalation, "lost" scripts, missed appointments, signs of substance abuse, and violated past care agreements.
- Documentation of urine toxicology screens.

Before issuing any controlled medications, healthcare providers should clearly outline treatment expectations in a treatment plan (frequency of visits, who can prescribe). Furthermore, the consequences of violating the treatment plan need to be prospectively determined. Following are best practice elements for pain treatment agreements (Brummond et al., 2017; DiPiro et al., 2019; Munzing, 2017):

- Medications will not be refilled early.
- Refills require a clinic visit, by appointment.
- No urgent requests; appointments for refills must be requested at least 2 days in advance.
- Lost or stolen prescriptions or medications cannot be refilled.
- Failure to follow these policies may result in discontinuation of pain medications.
- Regularly scheduled urine toxicology screens should occur often, for example, at the first visit and then at random intervals two or three times a year or more if the patient has a history of substance abuse.

Nursing Consideration: Documentation is one of the most important steps in prescribing controlled substances. Always remember: if it is not documented, it did not happen.

RESOURCES AND EDUCATION

While providing education during an acute care situation may not be appropriate, it is important to know the resources available in the local community to help those who have addiction or abuse problems. Nationally, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides a treatment location service that offers behavioral health help in the individual's local community. The agency national helpline is 1-800-662-HELP. The agency's primary website offers more information (http://www.samhsa.gov/find-help). From this resource, there is the capability to enter a local address, city, or zip code to find local or state help.

Nursing Consideration: During an encounter where drug abuse is identified and the individual is ready for help, the most important part the health provider can play is to ensure that a multidisciplinary team is involved and that the individual has a concrete plan and a next step for evaluation and care. It is not helpful to simply provide a pamphlet, a phone number, or list a website. Recidivism is characteristic of substance abuse, so a follow-up and compliance monitoring are essential to rehabilitation.

NATIONAL DRUG CONTROL STRATEGY

The 2020 National Drug Control Strategy in America focuses on three target areas. First, the strategy aims to prevent drug use through education and evidence-based prevention programs. It also aims to reduce barriers to treatment services and improve access to long-term recovery. Lastly, it seeks to reduce availability of illicit drugs through law enforcement and cooperation with international partners, eliminating the negative effects of drug trafficking on American communities (Office of National Drug Control Policy, 2020).

The National Drug Control Strategy reflects a comprehensive approach to reducing drug use and its consequences. Endorsing a balance of prevention, treatment, and law enforcement, the strategy set nine measurable goals to be achieved by 2022. These include the following (Office of National Drug Control Policy, 2020):

- A 15% reduction in the rate of youth drug use over 2 years, and a 15% reduction in opioid use.
- Reduce overdose deaths by 15%.
- Improve access to medication-assisted addiction treatment nationwide, double the number of specialty addiction treatment facilities providing medication-assisted treatment, and increase the number of providers certified to prescribe and administer buprenorphine for opioid use disorder to 10%.
- Increase the number of federal prescribers who have completed continuing education on opioid prescribing by 50%.
- Decrease opioid prescriptions filled by 1/3 and maintain that reduction.
- Increase the number of states integrating electronic health records with their prescription drug monitoring programs to 30 states.
- Significantly reduce the availability of illicit drugs by preventing their production outside of the United States.
- Significantly reduce the availability of illicit drugs by disrupting their sale over the Internet and stopping mail and express courier shipments across borders.
- Ensure measures increase the per gram cost of illicit drugs, which reflects decreased drug availability.

Conclusion

Drug abuse in America is a public health problem of great proportion. It is the responsibility of each healthcare professional to know the facts, know the laws, understand screening, provide the best care, and take an active role in preventing, reporting, and caring for individuals who need help kicking the problem.

It is the responsibility of all healthcare professionals to advocate for their patients and promote access to healthcare for everyone. The disease of drug addiction impacts all ages in all communities, so health professionals today must work to bring drug addiction out of the shadows. They must educate others to remove the stigma and address drug addiction as a brain disease that can affect anyone. As with many diseases, such as HIV/AIDS, drug addiction causes fear and is widely misunderstood in the community. Scientists and researchers are collaborating on better screening, treatment, and prevention techniques; health professionals and the public should be educated about what they can do in their daily lives to prevent drug addiction from spreading. This course points to the need for a multiple disciplinary approach that must start early in life to address the complex factors that lead to at-risk behaviors that may result in drug experimentation. Factors that contribute to addiction have been identified and discussions related to economic and psychosocial effects on youth and college-age individuals have been explicated. These factors are critical in developing effective treatment and prevention programs. Addressing these factors among youth at an early age may be the only way to control the epidemic, while law enforcement tries to eradicate the sources of the drugs. Schools have recently included how to make choices in their curriculum to help instill healthy decision making.

Prevention begins by educating parents, teachers, and healthcare staff about early identification of risk factors in childhood, as well as the early signs and symptoms of drug use. Healthcare professionals, school staff, and community resource agencies can identify and refer at-risk individuals and struggling families to social services for prevention and treatment programs. Once identified, these families can benefit from early intervention programs, including healthcare, counseling, assistance with parenting, and discipline to support healthy family interaction. Healthcare professionals must participate in prevention and treatment programs in the community through fundraising activities, lobbying local officials and state legislators, conducting community outreach activities to identify and offer services to young people and adults at risk, educating the public about the disease, and working with the media to develop effective campaigns to combat negative cultural influences.

By moving forward through a multidisciplinary approach, healthcare professionals can close the drug treatment gap and increase prevention efforts. As advocates, health professionals, government agencies, and politicians must collaborate to write policies and increase funding for heroin addiction prevention and treatment to stop the escalating cycle of addiction and relapse. NIDA research has demonstrated that prevention is cost effective in lowering expenditure in areas such as residential treatment, hospital and healthcare, incarceration, crime, and the justice system. Funds are necessary to increase the accessibility and ease of treatment to encourage families and individuals to seek help to stop the cycle of addiction and prevent it in the future. There is no way to put a price on the mounting death toll from this epidemic, and healthcare professionals are the front line of defense. The epidemic of drug addiction is a massive problem that requires effort on the part of every healthcare professional to identify what they can do today to break the cycle of addiction in their community

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DRUG ABUSE CRISIS FOR WEST VIRGINIA NURSES (2021 UPDATE) (MANDATORY)

Self-Assessment Answers and Rationales

1. The correct answer is D.

Rationale: Children of substance abusers are at a higher risk of emotional abuse, physical neglect, and inadequate medical care, since their parents are often preoccupied with the process of obtaining, taking, and withdrawing from drug use.

2. The correct answer is A.

Rationale: Heroin binds to the opioid receptors in the brain.

3. The correct answer is C.

Rationale: Methamphetamine is a stimulant.

4. The correct answer is B.

Rationale: Benzodiazepines are used therapeutically to treat anxiety disorders.

5. The correct answer is A.

Rationale: Safety for the patient, family, and staff is the first priority when caring for patients experiencing an acute drug crisis.

Course Code: ANCCWV03DA

West Virginia Mental Health Screening for Veterans (Mandatory)

2 Contact Hours

Release Date: June 4, 2020

Expiration Date: June 4, 2023

Faculty

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Reviewer

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Course overview

A significant number of veterans are dealing with problems related to mental health disorders. An estimated 30% of active-duty and reserve military personnel deployed in Iraq and Afghanistan have a mental health disorder that requires treatment (National Council for Behavioral Health, 2020). It is imperative that nurses be able to screen veterans for such problems and intervene promptly and effectively. The purpose of this education program is to offer West Virginia nurses information that increases their ability to screen veterans for mental health issues and intervene promptly and effectively as indicated.

Learning objectives

Upon completion of this course, the learner will be able to:

- Discuss relevant statistical data that pertain to the mental health of veterans.
- Explain how homelessness impacts veterans.
- Discuss why veterans may be reluctant to seek help for mental health issues.
- Describe the clinical presentation of post-traumatic stress disorder (PTSD) in veterans.
- Explain treatment initiatives for PTSD.
- Discuss statistics pertaining to major depressive disorder and suicide in veterans.
- Explain the screening process for depression.
- Assist in facilitating treatment for veterans suffering from depression.
- Discuss nursing interventions and intent to change practice.

How to receive credit

- Read the entire course online or in print which requires a 2-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- Provide required personal information and payment information.
- Complete the MANDATORY Self-Assessment and Course Evaluation.
- Print your Certificate of Completion.

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Activity director

June D. Thompson, DrPH, MSN, RN, FAEN, Lead Nurse Planner

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Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

INTRODUCTION

A significant number of veterans are dealing with problems related to mental health disorders, which are intertwined with the problems of homelessness, substance use/abuse, and suicide. It is imperative that nurses be able to screen veterans for such problems and intervene promptly and effectively to help decrease the effects of these critical healthcare issues.

GENERAL STATISTICAL DATA PERTAINING TO THE MENTAL HEALTH OF VETERANS

About 30% of active-duty and reserve military personnel deployed in Iraq and Afghanistan have a mental health disorder that necessitates treatment. This percentage represents approximately 730,000 men and women, many of whom experience post-traumatic stress disorder (PTSD) and major depression (National Council for Behavioral Health, 2020).

Less than 50% of returning veterans who need mental health treatment receive it. The Veterans Administration reports that about 22 veterans die by suicide every day (National Council for Behavioral Health, 2020).

According to the 2018 State of West Virginia Department of Veterans Assistance Annual Report, there are 147,869 veterans living in West Virginia; 137,874 are male and 9,995 are female. Veterans make up about 10% of the state's population. Additional information from the report includes the following:

- Age distribution: 18–29 (4%); 30–49 (21%); 50–69 (40%); 70 or more (35%).
- Period of service: 4% served in WWII; 10% in the Korean War; 30% in the Gulf War; and 35% in the Vietnam Conflict.
- Unemployment rate for West Virginia veterans is 7.6%.
- About 8% of veterans live in poverty.

Self-assessment quiz question 1

Carl is a veteran of the Gulf War. He is an RN who lives and works in West Virginia. He is discussing the mental health of veterans with his colleagues and tells them that:

a. The largest group of veterans to serve in West Virginia participated in the Vietnam conflict.
b. Veterans make up about five percent of the West Virginia population.
c. An estimated 20% of West Virginia veterans live in poverty.
d. The unemployment rate for West Virginia veterans is less than 5%.

THE PROBLEM OF HOMELESSNESS AMONG VETERANS

Mental health issues can also contribute to the problem of homelessness among veterans. Because of the transient nature of homelessness, it is difficult to obtain an accurate count of the number of homeless veterans. It is estimated that 40,056 veterans are homeless on any given night (National Coalition for Homeless Veterans, 2017).

Mental illness compounds the homelessness problem for veterans. Mental illnesses such as PTSD and depression can interfere with the ability of affected persons to hold jobs, attend school, maintain good interpersonal relationships, and/or ultimately function effectively in society. These kinds of problems can also interfere with a person's

ability to accrue adequate financial means to maintain a home (National Coalition for Homeless Veterans, 2017).

Characteristics of the homeless veteran population include the following (National Coalition for Homeless Veterans, 2017):

- The majority of the nation's homeless veterans are male with roughly 9% being female.
- Most homeless veterans are single and live in urban areas.
- The majority of homeless veterans suffer from mental illness, alcohol and/or substance abuse, or co-occurring disorders.
- About 9% of the total adult homeless population are veterans.
- About 45% of all homeless veterans are African-American or Hispanic, despite the fact that these groups account for only 10.4% and 3.4% of the US veteran population, respectively.
- Nearly half of the homeless veterans served during the Vietnam era.
- Homeless veterans are younger on average than the total veteran population. About 9% are between the ages of 18 and 30, and 41% are between the ages of 31 and 50.

Nursing consideration: Risk factors for homelessness among veterans include poverty, lack of support networks, and dismal living conditions in overcrowded or substandard housing (National Coalition for Homeless Veterans, 2017). Nurses must support efforts to reduce these risk factors and work to reduce the problem of homelessness.

Nursing interventions and intent to change practice

It is imperative that nurses know about the homeless population of veterans. Nurses should assist in community efforts to identify this population and promote interventions such as mental health screening, referring clients to homeless shelters, and referrals to employment and financial counselors. Practice should be changed to include assessing clients for homelessness and providing appropriate referrals.

Self-assessment quiz question 2

Homelessness is a considerable problem among veterans. According to the characteristics of the homeless veteran population, which of the following persons is most likely to be or to become homeless?

a. A married female with two children.
b. A single African American male.
c. A veteran who served in the Korean War.
d. A 65-year-old female living in a rural area.

REASONS VETERANS DO NOT SEEK HELP FOR MENTAL HEALTH PROBLEMS

Despite the impact of mental health problems, many veterans do not seek help for mental health problems. Considering the sobering statistics pertaining to the impact of stressors experienced by veterans, as well as the consequences of such stress (e.g., mental illness and homelessness), it is critical that the healthcare community facilitate appropriate screening and treatment for veterans. Even if services are available, healthcare professionals must ask themselves, "Why don't veterans seek the help they need?"

Nursing consideration: Compounding the problem of mental illness in veterans is that they sometimes have specific reasons for not seeking help. Nurses and other healthcare professionals must not only be aware of such reasons but remain objective as they work to get veterans the help needed.

Reasons some veterans give for not seeking help for mental health problems include the following (National Veterans Foundation, 2016; Veterans Families United, 2020):

- Personal embarrassment about service-related mental disorders.
- Long wait times to seek and receive mental health treatment.
- Shame over needing to seek mental health treatment.
- Fear of being perceived as weak.
- Stigma that may be associated with mental health issues.
- Lack of understanding or lack of awareness about mental health disorders and their treatments.
- Logistical issues such as distance of mental health treatment facilities.
- Concerns about veteran mental health treatment options offered by the VA.
- Belief that comrades who were killed or badly injured suffered more than they are suffering.

Mental illness can be cyclical in nature. It is not generally something that has a definitive ending like strep throat, for example. Strep throat is treated with appropriate antibiotics and the problem is resolved. Mental illnesses such as PTSD and depression can be treated, but still may be ongoing or have symptoms that wax and wane. Additionally, there is still a stigma about mental illness, especially in the military. Veterans may also be reluctant to seek help for mental health problems for fear of discrimination, loss of job, or fear that a diagnosis or treatment may compromise interpersonal relationships (Jordan, 2020; Veterans Families United, 2020).

There are also aspects of military culture that can interfere with a veteran's ability to seek help for mental health issues. Veterans may believe that they must be strong and cope with all manner of stress since they had dealt with life-threatening conditions for considerable periods of time. They may also believe that, having seen comrades killed or wounded, they should consider themselves fortunate to be alive and not allow themselves to feel frightened, helpless, or unable to cope with life upon returning home. Veterans who have sustained injury have additional physical problems that may coexist with mental health issues (Jordan, 2020); Veterans Families United, 2020).

Nursing interventions and intent to change practice

It is not enough to screen and assess veterans in healthcare settings since many veterans are reluctant to seek help. Nurses need to promote such screening and assessments during all healthcare visits. Healthcare professionals must take the initiative to identify clients with mental health problems.

Evidence-based practice! Research shows that a number of factors may interfere with a veteran's willingness to seek help for mental health problems (Jordan, 2018; Veterans Families United, 2020). It is critical that nurses are able to identify these factors in order to help veterans obtain the mental health services that they need.

Self-assessment quiz question 3

A nurse practitioner is screening an Iraq war veteran for mental health disorders. He is accompanied by his wife. She is the person who insisted that he seek help. During the screening the nurse talks with the client about his reluctance to seek help for mental health disorders. The NP knows that veterans may give all of the following reasons for not seeking help EXCEPT:

a. Fear of being perceived as weak.
b. Adequate knowledge of how mental illness impacts veterans and their families.
c. Mental health services are located too far away.
d. Belief that veterans who are treated for mental illness are an embarrassment to the military.

PTSD is defined as a "a disturbing pattern of behavior demonstrated by someone who has experienced, witnessed, or been confronted with a traumatic event such as a natural disaster, combat, or an assault. A client with PTSD was exposed to an event that posed actual or threatened death or serious injury and responded with intense fear, helplessness, or terror" (Videbeck, 2020). These feelings of intense fear, helplessness, or terror can cause severe disruptions in daily life.

Historically, PTSD in veterans was referred to as "soldier's heart," "shell shock," or combat fatigue. Today, however, such reactions are referred to as a distinct medical condition, PTSD. In veterans, PTSD is most often associated with combat-related trauma. Military sexual assault or harassment can also cause PTSD (US Department of Veterans Affairs, 2018a).

Nursing consideration: About half of those who initially experience PTSD recover within relatively short periods of time with or without treatment. However, about one-third of people who have initial symptoms of PTSD continue to have persistent symptoms (Veteransandptsd.com, 2015a; Veteransandptsd.com., 2015b). Nurses must remain alert to signs and symptoms of PTSD during the assessment process, even if considerable time has gone by since the veteran experienced traumatic events.

Statistics related to veterans and PTSD

PTSD statistics have been described as "moving targets." When researching the effects of this disorder, investigators must try to determine at what point data should be gathered. Should veterans be assessed within one year of return from battle? Within five years? Some veterans may go undiagnosed for as long as 30 years. Should they be included in current research studies (Veteransandptsd.com., 2015a)?

Should all incidences of PTSD be studied, or should they be studied only if they cause specific effects, such as interfering with return to combat situations, holding a post-military job, or maintaining important interpersonal relationships (Veteransandptsd.com., 2015a)?

There are no simple answers to these kinds of questions. Generally agreed upon facts are that PTSD is a significant problem among veterans, is diagnosed at widely varying points in the veterans' lives and can cause chronic difficulties for veterans and their families (Veteransandptsd.com., 2015a; Veteransandptsd.com., 2015b).

The US Department of Veterans Affairs National Center for PTSD (2018b) provides the following statistical information on PTSD:

- The number of Veterans with PTSD varies by service era:
  - Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF): About 11–20 out of every 100 veterans (11%–12%) who served in these wars have PTSD in a given year.
  - Gulf War (Desert Storm): About 12 out of every 100 Gulf War veterans (12%) have PTSD in a given year.
  - Vietnam War: About 15 out of every 100 Vietnam veterans (15%) were currently diagnosed with PTSD at the time of the most recent study.
- In addition to combat situations, the political issues surrounding the war, where the war was fought, and the type of enemy faced can influence the development of PTSD.
- Another cause of PTSD in veterans is military sexual trauma (MST). This is any sexual harassment or sexual assault that occurs while clients are in the military. MST affects both men and women and can occur during peacetime, training, or war. Among veterans who use VA healthcare, the following have reported MST:
  - 23 out of 100 women (23%) reported sexual assault while in the military.
  - 55 out of 100 women (55%) and 38 out of 100 men (38%) have experienced sexual harassment while in the military.

Evidence-based practice! Research shows that PTSD affects a significant portion of the general population as well as veterans (Gersch et al., 2016). This means it is probable that nurses will encounter a client suffering from PTSD at some point. Therefore, they must be able to recognize the disorder, facilitate treatment, and provide appropriate nursing care.

Self-assessment quiz question 4

Monica is a nurse practitioner who has served in the military for 15 years. She is conducting research on veterans and the occurrence of PTSD. Monica knows that, according to the US Department of Veterans Affairs National Center for PTSD:

a. Sexual harassment in military men is not an issue.
b. The location of the war that veterans fought in has not been shown to affect the development of PTSD.
c. Political issues typically do not influence the occurrence of PTSD.
d. 12% of veterans who fought in the Gulf War are likely to develop PTSD.

PTSD and traumatic brain injury

An estimated 22% of all combat casualties from the conflicts in Iraq and Afghanistan and 12% from Vietnam have traumatic brain injuries (TBIs; National Veterans Foundation, 2016; US Department of Veterans Affairs, 2019a).

The primary cause of TBI in Veterans of Iraq and Afghanistan are blasts, blast plus motor vehicle accidents (MVAs), MVAs alone, and gunshot wounds. Research shows that exposure to blasts is unlike other causes of military TBI and it may cause different symptoms. For example, veterans seem to experience post-concussive symptoms for longer than the civilian population experiencing TBI. In fact, some studies show that most veterans continue to have residual symptoms 18–24 months after the injury. Compounding the effects of military TBI is the problem that many veterans have multiple medical problems, including PTSD, chronic pain, and substance use/abuse. Clients with TBI frequently meet the criteria for PTSD on screening instruments for TBI and vice versa (US Department of Veterans Affairs, 2019a; U.S. Department of Veterans Affairs, 2019b). Therefore, it is imperative that nurses as well as other healthcare professionals screen for both problems when working with veterans.

PTSD and substance abuse

It is not uncommon for persons with PTSD to develop unhealthy coping mechanisms in order to deal with the symptoms of the disorder, such as drinking excessively, using drugs, or smoking heavily. Having PTSD increases the risk that the affected person will develop a drinking or drug problem. Abuse of these substances can lead to substance use disorder (SUD), which must be treated in conjunction with PTSD (US Department of Veterans Affairs, 2015).

There is a strong link between PTSD and SUD in the entire population. Statistics specific to veterans include the following (US Department of Veterans Affairs, 2015).

- Veterans with both PTSD and alcohol abuse problems tend to be binge drinkers, which may be a response to bad memories of combat trauma.
- More than two of ten veterans with PTSD also have SUD.
- Almost one out of every three veterans seeking treatment for SUD also has PTSD.
- The number of veterans who use nicotine products is almost double for those who have PTSD compared to those who do not.
- About one in 10 soldiers returning from the wars in Iraq and Afghanistan who are seen in a VA setting have a problem with alcohol or other drugs.

Risk factors for PTSD in veterans

Some factors can increase the risk of PTSD in not only veterans, but in people of all ages and walks of life. Such general factors include the following (Mayo Clinic, 2018):

- Experiencing intense or long-lasting trauma.
- Having a job that increases risk of exposure to traumatic events.
- Having other mental health issues, such as anxiety or depression.
- Having problems with substance misuse.
- Lacking a good support system.
- Having blood relatives with mental health problems, including anxiety or depression.

Pre-trauma risk factors associated with veterans include the following (American Addiction Centers, 2020):

- Being female.
- Being nonwhite.
- Family problems.
- Low level of education.
- Being non-officers.
- Experiencing more deployments or having a longer cumulative length of deployment.
- Veterans who served in the Marines, Air Force, Navy, or Coast Guard have a lower risk of PTSD than those who served in the Army.
- Adverse life events, such as early childhood trauma or sexual abuse, appear to increase the risk of PTSD.

Risk factors during and after trauma in veterans include (American Addiction Centers, 2020):

- Exposure to combat.
- Worry about family.
- Discharging a weapon.
- Witnessing an injury or death during deployment.
- Being attacked, fired at, or handling human remains.
- Lack of post-deployment support.
- Subsequent life stress.
- Comorbid mental health disorders.

Signs and symptoms of PTSD

Veterans with PTSD generally report that symptoms began immediately or soon after the traumatic triggering event(s), although they may not become evident for months or years later. PTSD symptoms can be grouped into four main subcategories (Mayo Clinic, 2018; Shalev & Marmar, 2017; Videbeck, 2020):

1. Reliving the trauma (intrusive memories): This involves having memories of the traumatic event(s) that triggered the disorder that can return at any time. Veterans may have nightmares or feel as though they are living through the trauma again. These feelings are referred to as flashbacks. Clients may dream about the trauma, have recurrent and intrusive thoughts, or be on guard.
2. Avoiding situations that remind veterans of the event (avoidance): Veterans may go to considerable effort to avoid situations or people that bring back memories of the event. For example, hot weather and tall grass may trigger flashbacks of traumatic events for Vietnam veterans, making them avoid living or visiting areas with hot climates. Avoidance of situations that trigger memories may reach phobic proportions, with veterans taking extreme measures to avoid them.
3. Negative changes in thinking and mood: These changes involve negative thoughts about themselves, hopelessness, memory problems, problems maintaining interpersonal relationships, feeling detached from loved ones, difficulty experiencing positive emotions, feeling emotionally numb, and lack of interest in formerly pleasurable activities.
4. Hyperarousal: This involves feeling anxious and jittery and always being on the lookout for danger in environments. Veterans may abruptly become angry or irritable for reasons unknown to others.

Additional symptoms include the following (Borchers, 2015; Mayo Clinic, 2018):

- Trouble falling or staying asleep.
- Aggressive outbursts upon awakening.
- Survivor's guilt (feeling guilty or believing they have done something wrong by surviving a traumatic event such as combat when others did not).
- Chronic anxiety.
- Panic attacks (sudden feelings of extreme fear and anxiety. The heart pounds and there may be difficulty in breathing. They may feel as if they are dying or losing their minds).
- Depression.
- Suicidal thoughts.

Self-assessment quiz question 5

Anthony is a nurse practitioner whose specialty is mental health nursing. A number of his clients are veterans who fought in various wars. Anthony knows that all of the following characteristics are related to higher risk of PTSD development EXCEPT:

a. Having a low level of education.
b. Being nonwhite.
c. Being male.
d. Being a non-officer.

Diagnosis

Diagnosis depends on a thorough physical and mental health assessment. However, as previously noted, veterans are often reluctant to seek help for mental health issues. This makes veteran/family education particularly important. Veterans, families, and colleagues may believe that certain behaviors are a normal part of readjusting to life at home. Some, including veterans themselves, may believe that seeking help is a sign of weakness or that nothing, including medical treatment, can help them. Therefore, veterans and families should be taught about the signs and symptoms of PTSD and that there is effective treatment available.

Nursing consideration: Whenever veterans seek medical attention they should also be evaluated for signs and symptoms of PTSD and other mental health problems. Such problems may be identified when veterans are seeking help for other reasons or even when they are accompanying family members to medical office visits. As PTSD can manifest days to years after the event, the screening should be ongoing throughout the veteran's life. It is absolutely essential that health care professionals maintain a supportive, objective attitude. Judging, coercing, or belittling concerns and feelings of veterans and their families will significantly interfere with, and perhaps even permanently prohibit, veterans seeking the help needed (Gersch et al., 2016; Videbeck, 2020).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013), diagnostic criteria for PTSD for adults, adolescents, and children older than 6 years of age are listed as follows:

Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:

- Directly experiencing the traumatic event or events.
- Witnessing the event(s) as occurring to others.
- Learning that the traumatic event(s) occurred to a close family member or close friend. Note that in cases of actual or threatened death, the death must have been violent or accidental.
- Experiencing repeated or extreme exposure to details of the traumatic events.

Presence of one or more of the following intrusion symptoms associated with the traumatic event(s) that began after the event(s) occurred:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
- Recurrent distressing dreams in which the content is related to the traumatic event(s).
- Flashbacks (referred to as dissociative reactions) in which the veteran feels or acts as if the traumatic event(s) were recurring.

- Intense or prolonged psychological distress when exposed to internal or external cues that are symbolic of or resemble an aspect of the traumatic event(s).
- Marked physiological reactions to internal or external cues that are symbolic of or resemble an aspect of the traumatic event(s).

Persistent avoidance of stimuli associated with the traumatic event(s) that starts after the event has occurred and is evident by one or both of the following symptoms:

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about the traumatic event(s).
- Avoidance of or efforts to avoid external reminders (such as people, places, or activities) that arouse distressing memories, thoughts, or feelings associated with the traumatic event(s).

Negative alterations in cognitions and mood associated with the traumatic event(s) that begin or worsen after the occurrence of the traumatic event(s), as evidenced by one or more of the following:

- Inability to remember an important aspect of the traumatic event(s), usually because of dissociative amnesia and not other reasons, such as head injury, alcohol, or drugs.
- Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world in general.
- Persistent distorted beliefs about the cause or consequences of the traumatic event(s). Such beliefs could cause the person to blame themself or others for the occurrence of the traumatic event(s).
- Significantly reduced interest or participation in significant activities.
- Persistent negative emotional feelings (e.g., anger, guilt, shame, fear).
- Feelings of detachment or estrangement from other people.
- Persistent inability to experience positive emotions.

Marked alterations in arousal and reactions associated with the traumatic event(s) that began or worsened after the occurrence of the event(s), as evidenced by two or more of the following:

- Irritability and angry outbursts with little or no cause, usually expressed as verbal or physical aggression toward people or objects.
- Recklessness or behavior that is self-destructive.
- Hypervigilance. (Being abnormally aware of the environment, accompanied by intensity of behaviors that are designed to detect threats.)
- An exaggerated startle response.
- Difficulty concentrating.
- Sleep disturbances such as trouble falling or staying asleep.

The length of the disturbance is more than one month.

The disturbance causes distress or impairment that is clinically significant in social, occupational, or other important areas of functioning.

The disturbance is not attributable to the physiological effects of a substance (such as alcohol) or another medical condition.

For detailed diagnostic information consult the DSM-5.

Self-assessment quiz question 6

Nicole is screening a veteran for signs and symptoms of PTSD. She knows that signs and symptoms of PTSD include all of the following EXCEPT:

a. Reliving the event.
b. Feeling lethargic and unaware of their environment.
c. Negative feelings about themselves.
d. Survivor's guilt.

Suicide

Since PTSD is associated with suicidal thoughts and suicide attempts, it is imperative that nurses teach veterans and their families how to monitor for suicidal thoughts and actions and what action to take if such thoughts or actions occur. According to the Centers for Disease Control and Prevention (CDC) suicide was the 10th leading cause of death for all ages in the US There were 44,193 suicides in the US in 2015—121 suicides each day. In 2014, about 18% of those who died by suicide were veterans (US Department of Veterans Affairs, 2019b).

US veterans with PTSD are more likely than the average American to die of suicide and accidental injuries according to a recent study (Forehand, et al., 2019).

Researchers reviewed data on about 491,000 veterans who initiated treatment for PTSD between 2008 and 2013. In the first year following the initiation of treatment, just over 5,200 or 1.1% of the veterans died, a mortality rate five percent higher than the general population of the same age and sex. Veterans were more than twice as likely to die by suicide or accidental injures than people of the general population (Forehand, et al., 2019).

Nurses must include assessment for suicidal ideation in their clients. Clients and their families must be taught about the possibility of suicide, how to monitor for it, and the importance of treatment options for mental health issues that increase the likelihood of death by suicide.

Treatment

PTSD treatment goals focus on reducing symptoms, preventing chronic disability, and promoting social and occupational rehabilitation. Several types of interventions, including psychotherapy and medication, are used as part of the treatment process.

Cognitive Processing Theory (CPT)

CPT is an evidence-based treatment protocol that has been effective for the treatment of PTSD. It focuses on helping veterans understand how to cope with distressing thoughts, behaviors, and other symptoms. In CPT, the veterans learn how the traumatic event(s) changed the way they view the world, themselves, their friends, families, and colleagues, and how their behaviors have changed in response to these traumatic event(s) (Galovski, Norman, & Hamblen, 2019; Videbeck, 2020).

CPT can be conducted in both individual and group settings. It generally consists of four main components (Galovski, et al., 2019; Videbeck, 2020):

1. Teaching veterans about their PTSD symptoms and how treatment can help.
2. Helping veterans to become aware of how their thoughts, feelings, and behaviors are related to their efforts to cope with the traumatic event(s) they have experienced. This involves processing the trauma by identifying and allowing for the dissipation of the normal emotions related to the trauma, as well as identifying those thoughts and behaviors that are preventing recovery. Such inappropriate thoughts and behaviors are referred to as "stuck points" because they tend to keep persons stuck in PTSD.
3. Teaching veterans skills to cope with intrusive thoughts and feelings and inappropriate behaviors. This could involve focusing on thoughts and feelings of guilt and self-blame, such as "If I had only done … then my friend would not have been killed," and restructuring such thoughts to the point of alleviating guilt and self-blame. This is referred to as cognitive restructuring.
4. Veterans are then helped to make plans for the future that include avoiding relapse and utilizing coping skills in their everyday lives.

Prolonged Exposure Therapy (PE)

PE is based in emotional processing theory, which proposes that PTSD symptoms occur as a result of cognitive and behavioral avoidance of trauma-related thoughts, reminders, activities, and situations. PE is designed to help veterans interrupt and reverse these factors by stopping (referred to as blocking) cognitive and behavioral avoidance and introducing corrective actions (Center for Deployment Psychology, n.d.).

The goals of PE are to help the client to learn coping skills (McSweeney, et al., 2019):

- Memories and reminders of the trauma are not dangerous and can be experienced without significant distress.
- Distress does not last forever.
- Emotional responses gradually reduce with time, even without doing anything.
- Responses (such as heart racing) are not dangerous.
- Clients can handle negative effects.

PE is typically delivered in eight to fifteen, 90-minute sessions. Sessions are usually delivered on a weekly basis. The key components of PE are (McSweeney, et al., 2019):

- Education about treatment, common reactions to trauma, and breathing retraining.
- Imaginal exposure, which requires repeatedly retelling the trauma memory out loud, in present tense, and with eyes closed. The client listens to an audio recording of the session between treatment sessions.
- In-vivo exposure to places, things, and situations that are being avoided because they evoke distress and anxiety.
- Emotional processing that focuses on reviewing the experience of exposure and its impact on thoughts related to the self, the world, and the trauma.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is a fairly new clinical treatment that has been evaluated primarily as a technique used to help trauma survivors. In EMDR, a qualified therapist guides the veterans to vividly recall distressing past experiences (desensitization) in a safe setting while gaining new insight (reprocessing) into the events and how they respond physically and emotionally to these distressing events. The eye movement component of EMDR involves the veterans moving their eyes in a back and forth manner while recalling the traumatic event(s) (Psychcentral.com., 2020).

EMDR is generally administered weekly, with up to 90-minute sessions over the course of about three months. The length of treatment varies depending on the client, with both shorter and longer lengths of treatment possible (Beauvais, et al., 2019).

Treatment generally consists of the following components (Beauvais, et al., 2019):

- Assessment phase: During the assessment phase, a thorough history is obtained and the process of EMDR is explained. A target image, taken from the most distressing images of a traumatic memory, is identified, accompanied by a negative feeling the image triggers. Clients rate the distress caused by the image and what physical and emotional feelings are produced by the distress.
- Desensitization phase: During the desensitization phase, clients identify what positive feelings they would prefer to have. The therapist leads clients through bilateral stimulation sets (20–40 rapid eye movements).
- Continuation: During the continuation phase, clients notice and incorporate new insights and sensations until the distress related to the traumatic is significantly reduced and more positive feelings exist. After this distress is alleviated, clients and therapists can decide to move on to another distressing memory.

Adaptive Disclosure

Adaptive disclosure was developed by the military to offer an intense, specific, and short-term therapy for active-duty military personnel with PTSD. It includes exposure therapy and the "empty chair" technique. With the empty chair technique, the clients say whatever they need to say to anyone, alive or dead. Adaptive disclosure generally consists of six sessions and is usually well-tolerated and effective in reducing symptoms of PTSD (Videbeck, 2020).

Pharmacology

First-line medications for treating PTSD are SSRIs and SNRIs. Two SSRIs, paroxetine (Paxil) and sertraline (Zoloft) are approved by the Food and Drug Administration (FDA) for the treatment of PTSD (Gersch et al., 2016).

Side effects associated with these medications include the following (Comerford & Durkin, 2020):

- Decreased sexual desire and/or erectile dysfunction in males.
- Dizziness.
- Drowsiness.
- Dry mouth.
- Insomnia.
- Nausea, vomiting, and diarrhea.
- Nervousness, agitation, and restlessness.
- Weight gain or loss.

The FDA requires that all antidepressants carry black box warnings for an increase in suicidal ideation, especially in children, teenagers, and young adults under 25 (Comerford & Durkin, 2020).

Other SSRIs and SNRIs are often used off-label in the treatment of PTSD. Examples of these drugs include (Comerford & Durkin, 2020; Gersch et al., 2016).

- Fluoxetine (Prozac).
- Citalopram (Celexa).
- Fluvoxamine (Luvox).
- Escitalopram (Lexapro).

Second-line medications used off-label to treat PTSD include tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), and anxiolytic benzodiazepines. It is important to use caution with benzodiazepines since these medications are quite addictive, and a high comorbidity between PTSD and substance use disorders already exists (Comerford & Durkin, 2020; Gersch et al., 2016).

Nursing consideration: It is essential that nurses provide detailed client/family education regarding medications. Nurses must assess whether or not clients and family members have acquired the necessary knowledge to safely administer their medications. For example, avoid asking "yes" or "no" questions such as "Do you know what side effects your medication may cause?" Instead, say, "Please tell me what side effects your medication might cause and what you should do if they happen." Asking clients and families to actually explain what side effects might occur and what they should do if they occur allows the nurse to assess the extent of their knowledge.

Additional Nursing Interventions and Intent to Change Practice

Promoting client safety is a priority. Nurses must assess veterans for suicidal ideation or any type of self-injury and initiate appropriate interventions. Nurses can help veterans learn to go to a safe place at home, work, etc., where they can calm down, stop self-destructive thoughts, and regain control of themselves (Videbeck, 2020).

Other interventions to help clients cope with stress include the following (Gersch et al., 2016; Videbeck, 2020):

- Validate the veteran's feelings of fear but promote contact with reality.
- During flashbacks, help veterans change body positions as needed but do not grab or attempt to force them to stand up or move.
- Encourage the use of deep breathing and relaxation techniques.
- Facilitate the use of distraction techniques such as physical exercise, listening to music, talking to others, or participating in hobbies or activities that are positive. Recommend strategies to cope with substance abuse such as joining Alcoholics Anonymous or other appropriate support groups and therapies.

Nurses must be aware that long-term identified goals may take years to achieve. Veterans can learn to manage their thoughts, feelings, and behaviors, but the effects of the traumatic event(s) can last a lifetime. Participation in ongoing community support groups may be helpful (Videbeck, 2020).

No matter how long it has been since the traumatic event(s) occurred, there is considerable reason to believe that symptoms can be reduced and quality of life improved. Veterans who have lived with PTSD for many years may believe that there is nothing that can help them. It is important to teach veterans and their families that therapy can work even after considerable time has passed (Gersch et al., 2016; Videbeck, 2020).

Self-assessment quiz question 7

As nurses facilitate PTSD treatment, they need to be aware that:

a. Cognitive processing therapy changes the details of the traumatic event(s).
b. Prolonged exposure therapy includes listening to audio recordings of sessions.
c. EMDR focuses on avoiding the recall of distressing past experiences.
d. Zoloft is contraindicated in the treatment of PTSD in veterans.

Veterans, depression, and suicide

Depression and PTSD are the most common mental health problems faced by returning troops. Depression is common in the general population as well as in veterans. In any given year, nearly one in 10 adult Americans has some type of depression. Depression and PTSD often occur together. Research results indicate that depression is nearly three to five times more likely to occur in persons with PTSD than in persons without PTSD (US Department of Veterans Affairs, 2019c).

Evidence-based practice! Since research shows that depression and PTSD often coexist, nurses must be sure to screen for both depression and PTSD when assessing veterans' health.

Veterans with depression and PTSD can be at risk for suicide for several reasons. These include the following (US Department of Veterans Affairs, 2018c):

- Coping with aging.
- Stress.
- Lingering effects of their military service that have never been addressed.
- Underlying mental health disorders.
- Substance use disorders.
- Difficulty with interpersonal relationships.
- Transitioning back to civilian life.

An updated analysis of veteran suicide issued in 2016 includes data from 1979 to 2014, from every state in the US. Key findings include the following (US Department of Veterans Affairs, 2018c):

- **65% of veterans who died by suicide were 50 years of age or older.**
- Veterans accounted for 18% of all deaths from suicide among US adults. This is a decrease from 22% in 2010.
- Since 2001, US adult civilian suicides have increased 23%. Veterans' suicides increased by 32% in the same period. After statistical adjustments for age and gender, the risk of suicide is 21% greater for veterans.
- Since 2001, the rate of suicide among US veterans who used VA services has increased by nearly 9%. The rate of suicide among veterans who did not use VA services has increased by almost 39%.

Dr. Tom Berger, executive director of the Vietnam Veterans of America (VVA) Veterans Health Council, proposes that although older veterans share many of the risk factors of younger veterans, including depression, PTSD, and combat experience, other factors may influence the decision to commit suicide in this age group. Recent research suggests the following factors specific to older veterans play a role in suicide among this population (Jordan, 2020):

- Older veterans have reached an age where the structure of their lives is changing. After returning from combat, many veterans deal with their stressors by hard work and focusing on their families. As they reach retirement age and children leave home, the work and people they have focused on are no longer present in the same way, but the stressors and memories of the traumatic event(s) remain.
- Korean War veterans may have even more intense problems since they would have reached their 40s before PTSD was acknowledged as a significant problem for veterans.
- Injuries to limbs, migraine headaches, or other conditions that cause chronic pain all increase the risk of suicide if depression is also present.
- As veterans age, they may become more representative of the general population. In the general population, older people account for a higher percentage of suicides.

Nursing consideration: Critical to the treatment of depression and PTSD is recognizing that service members and veterans represent a subgroup within the general population. Treatment needs to factor in the military culture and experiences specific to veterans (Jordan, 2020).

Self-assessment quiz question 8

The nursing research council at a VA hospital is developing a research project concerning suicide risk in veterans. From research issued in 2016, the council found all of the following EXCEPT:

a. Since 2001, veterans' suicides decreased by 20%.
b. Research issued in 2016 showed that 65% of veterans who died from suicide were 50 years of age or older.
c. Veterans accounted for 18% of all deaths from suicide among US adults.
d. The rate of suicide among veterans who do not use VA services increased by almost 39%.

Definition of major depressive disorder

Major depressive disorder generally involves two or more weeks of a sad mood or lack of interest in normal life activities accompanied by at least four other symptoms, such as the following (American Psychiatric Association, 2013; Videbeck, 2020):

- Weight changes.
- Changes in sleep patterns.
- Lack of energy.
- Trouble concentrating.
- Difficulty making decisions.
- Decreased self-esteem.

Nursing consideration: At some point in their lives, about 22% of women and 16% of men in the US experience a major depressive disorder. Nurses need to be meticulous in assessing for depression in all clients (Gersch et al., 2016).

There are several forms of depression in addition to major depressive disorder that may affect veterans. These include the following (Goldberg, 2018; National Institute of Mental Health [NIH], 2018; Videbeck, 2020):

- Persistent depressive disorder: This is a depressed mood that lasts for at least two years. To be diagnosed with persistent depressive disorder, the person must have episodes of major depression along with periods of less severe symptoms. However, symptoms must last for at least two years.
- Psychotic depression: Psychotic depression occurs when a person is affected by severe depression plus some form of psychosis, such as delusions or hallucinations.
- Postpartum depression: About 10% to 15% of women experience postpartum depression, which is a serious form of depression that develops after a woman gives birth. Hormonal and physical changes combined with the responsibilities of caring for a newborn can be overwhelming, thus triggering depression that can interfere with her ability to care for her baby, her interpersonal relationships, and her ability to function effectively at home and/or at work.
- Seasonal affective disorder (SAD): SAD is characterized by the onset of depression during winter months when there is less natural light. This type of depression usually lifts during spring and summer months.

A milder, chronic form of depression is referred to as dysthymic disorder. This disorder is characterized by a chronic dysphoric mood that has persisted for at least two years in adults and one year in children and adolescents. Affected persons may also experience fatigue, lack of energy, difficulty concentrating, insomnia, lack of appetite or overeating, feelings of hopelessness, difficulty making decisions, and low self-esteem. Dysthymic disorder is diagnosed when the client exhibits at least two of the preceding symptoms lasting no more than two months during a two-year period. The disorder usually begins in childhood, adolescence, or early adulthood, and it is more common in women in adulthood, and equally common in both sexes in childhood and adolescence. Dysthymic disorder causes no more than mild social or occupational problems (NIH, 2018; Videbeck, 2020).

Depression and suicide

Suicide is the most serious consequence of depression. Feelings of guilt, worthlessness, and hopelessness are so overpowering that affected persons feel life is no longer worth living and/or the only way to stop these overwhelming feelings is to take one's life (UC Santa Cruz, 2018; Videbeck, 2020).

In the US, men compose about 72% of the people who die by suicide, which is about three times the rate of women. However, women are four times more likely than men to attempt suicide. The higher death by suicide rates in men are associated with the method of suicide chosen. In men, these methods are often shooting, hanging, and jumping from a considerable height, which are more likely to cause mortality. Women are more likely to attempt to die by suicide by overdosing on medication (Videbeck, 2020).

Nursing consideration: All persons who suffer from depression should be assessed for suicidal ideation. Nurses must be sure to include such evaluation during the assessment process.

Risk factors for depression

A number of risk factors are associated with the development of depression. These include the following (Bhandari, 2019; Gersch et al., 2016):

- Family history of depression.
- Excessive stress.
- History of abuse or neglect.
- Physical trauma.
- Emotional trauma.
- Loss of a parent.
- Loss of an interpersonal relationship.
- Presence of other mental health disorders.
- Chronic medical illness(es).
- Developmental, learning, or conduct disorders.

Signs and symptoms

Persons who are depressed may say that they find it hard to get out of bed in the morning, have trouble falling asleep or staying awake, and/or have no interest in activities that were once important to them (Gersch et al., 2016; NIH, 2018; Videbeck, 2020).

People with depression do not all experience the same symptoms. The number, frequency, and duration of symptoms varies depending on the person. The primary symptoms of major depression are a predominantly sad mood and a loss of interest in daily activities, or the inability to experience pleasure in them (Gersch et al., 2016; Videbeck, 2020).

Other signs and symptoms include the following (Gersch et al., 2016; National Institute of Mental Health, 2018; Videbeck, 2020):

- Aches, pains, and headaches that do not improve even with treatment.
- Difficulty concentrating.
- Digestive problems that do not decrease with treatment.
- Fatigue and lack of energy.
- Feelings of guilt, helplessness, or worthlessness.
- Feelings of hopelessness or pessimism.
- Irritability.
- Loss of appetite or overeating.
- Loss of interest in once enjoyable activities.
- Loss of interest in sex.
- Persistent feelings of anxiety, sadness, or emptiness.
- Restlessness.
- Signs of agitation such as hand wringing.
- Suicidal ideation.

Diagnosis

To confirm a diagnosis of major depression, veterans and other clients must fulfill the criteria as published in the DSM-5. A summary of these criteria includes the following information (American Psychiatric Association, 2013).

The client must experience five or more of the following symptoms during the same two-week period and be indicative of a change from previous functioning. At least one of the symptoms must be either a depressed mood or loss of interest or pleasure.

- Depressed mood most of the day, almost every day, as evident by subjective reporting of feelings of sadness, emptiness, or hopelessness, or observations made by others.
- Significant diminished interest or pleasure in all, or nearly all, activities most of the day, nearly every day.
- Significant weight loss when not dieting, or weight gain, or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation almost every day.
- Fatigue or loss of energy almost every day.
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
- Diminished ability to think or concentrate or indecisiveness, nearly every day.
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide.

The symptoms that the client is experiencing cause significant distress or impairment in social, occupational, or other important areas of functioning.

The episode (major depression episode) is not due to the physiological effects of a substance or to another medical condition.

Additional restrictions related to a diagnosis of major depression include the following (American Psychiatric Association, 2013):

- The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- There has never been a manic episode or hypomanic episode.

Self-assessment quiz question 9

Jennifer is being evaluated for major depressive disorder. Her symptoms include a weight loss of about five pounds (with dieting), an excessive amount of energy, and a depressed mood in the mornings about three times a week. Based on these symptoms, does Jennifer have major depressive disorder?

a. These symptoms are indicative of major depressive disorder.
b. Deliberate dieting meets the criteria for major depressive disorder.
c. Excessive energy can be an early warning sign of impending depression.
d. To meet the criteria for depression, the depressed mood must last all day on most days.

Treatment

The most common treatments for depression are medication and psychotherapy (Comerford & Durkin, 2020; Gersch et al, 2016; National Institute of Mental Health, 2018; Videbeck, 2020).

Medication

SSRIs

SSRIs are the most frequently prescribed antidepressants. The action of SSRIs is believed to be linked to their inhibition of central nervous system (CNS) neuronal uptake of serotonin. This class of antidepressant is generally considered safe, but can interact with some commonly prescribed medications, especially those that also block serotonin reuptake, including, but not limited to some pain medications, anti-Parkinson's medications, other antidepressants, and some anti-nausea medications. The use of more than one medication that acts on or affects the amount of available serotonin in the system can lead to serotonin syndrome, which is an excess of serotonin that can lead to extreme nerve cell activity. Signs of this syndrome include confusion, agitation, headache, tachycardia, tremors, loss of muscle control, hypertension, hallucinations, and nausea, vomiting, and diarrhea. Commonly prescribed SSRIs include Prozac (fluoxetine), Zoloft (sertraline), Lexapro (escitalopram), Paxil (paroxetine), and Celexa (citalopram). Common side effects of these drugs include headaches, nausea, restlessness, insomnia, and sexual problems (Comerford & Durkin, 2020; Gersch et al., 2016; Videbeck, 2020).

Nursing consideration: It can take weeks or even months for significant improvement in symptoms to occur after beginning antidepressant medications. Clients and their families should be taught that they should not expect immediate improvement of symptoms (Comerford & Durkin, 2020; Videbeck, 2020).

Tricyclics

Tricyclics are older antidepressants that are powerful but not often used in current practice because their side effects have the potential to be more serious than SSRIs. Tricyclics can affect cardiac status in people who have heart conditions. They can also cause dizziness, drowsiness, dry mouth, and weight gain. Examples of tricyclics include Tofranil (imipramine) and Pamelor (nortriptyline; Comerford & Durkin, 2020; Gersch et al., 2016: Videbeck, 2020).

MAOIs

MAOIs (monoamine oxidase inhibitors) are the oldest class of antidepressants but are used infrequently because of potentially fatal side effects and possibly dangerous interactions with other drugs (including prescription and over-the-counter [OTC]) and certain foods. The most serious side effect is hypertensive crisis, a life-threatening event that occurs when someone who is taking an MAOI eats foods, such as cheese and red wine that contain tyramine, and/or takes medications, such as certain types of oral contraceptives, prescription pain relievers, cold and allergy medications, and herbal supplements. MAOIs can also adversely interact with SSRIs to cause serotonin syndrome, which can lead to confusion, hallucinations, diaphoresis, seizures, muscle stiffness, and adverse changes in blood pressure or heart rhythm. MAOIs and SSRIs should never be taken together (Comerford & Durkin, 2020; Gersch et al., 2016; Videbeck, 2020).

Nursing consideration: The Food and Drug Administration (FDA) has issued a black box warning label on all antidepressants to alert prescribers and consumers to the potential for increased risk of suicidal ideation in children, adolescents, and young adults taking these medications. Clients and families must be made aware of this warning and taught how to respond to an increase in suicidal ideation (Comerford & Durkin, 2020; Gersch et al., 2016; Videbeck, 2020).

Psychotherapy

Psychotherapy and medications, used concurrently, are considered to be the most effective treatment for depressive disorders. Some types of psychotherapy include (Gersch et al., 2016; Videbeck, 2020):

- Cognitive Behavioral Therapy (CBT): CBT focuses on how a person thinks about themselves, others, and the future. It also helps people focus on how they interpret their experiences. In the case of veterans returning home, CBT can help them focus on how they interpret traumatic events. Qualified therapists can help veterans recognize how their beliefs, feelings, interpretations, and behaviors may contribute to their depression, and how to change them so they can interact with their environments in positive and realistic ways.
- Interpersonal Therapy (IPT): IPT focuses on problems in interpersonal relationships. This form of therapy helps veterans understand and work through troubled relationships that may contribute to their depression and to work on improving interpersonal relationships.
- Behavioral Therapy: This therapy focuses on increasing the frequency of positive interactions with the clients' environments and decreasing negative interactions. Therapists can also help clients work on improving social skills.

Electroconvulsive Therapy (ECT)

ECT is used by psychiatrists to treat clients who do not respond to medication and/or psychotherapy. Formerly known as shock therapy, ECT once had very negative connotations, and experts still remain divided about its effectiveness. In recent years, however, the administration of ECT has improved significantly and can provide relief for clients with severe depression who have not been helped by other types of treatments. Clients who are actively suicidal may also be given ECT if there is concern for their safety while waiting for the effects of antidepressant medications to be felt (Videbeck, 2020).

Electrodes are applied to the head of the client to deliver an electrical impulse to the brain, which causes a seizure. It is believed that the shock delivered via ECT stimulates the brain to correct the chemical imbalance of depression (Videbeck, 2020). Clients are to eat nothing by mouth after midnight the night before the procedure, to remove fingernail polish, and to void immediately before the procedure. An intravenous line is inserted and the client is given a short-acting anesthetic so that they are not awake during the procedure itself. Then, a muscle relaxant is administered to reduce the outward signs of seizure. Electrodes are applied to the head so that brain activity is monitored as the electrical stimulation is delivered. After the ECT treatment, the client is very tired, usually has a headache, and is slightly confused or briefly disoriented (Gersch et al., 2016; Videbeck, 2020).

Clients usually receive a series of 6 to 15 treatments commonly scheduled three times a week. In addition to ECT, most clients take antidepressants (Gersch et al., 2016; Videbeck, 2020).

Nursing consideration: Some people, including some healthcare professionals, may have negative opinions about ECT. It is important that nurses know the current therapeutic uses for ECT and how to teach clients and families about its use as a treatment.

Self-assessment quiz question 10

A nurse is teaching clients about the various types of treatment for depression. It is appropriate for the nurse to tell clients that:

a. MAOIs are the first-line treatment for depression.
b. ECT is generally contraindicated for the treatment of depression.
c. Sertraline is a commonly prescribed SSRI.
d. IPT focuses on increasing the frequency of positive interactions with the client's environments.

Additional nursing interventions and intent to change practice

- Maintain an objective, supportive environment.
- Teach the veteran and their family about the signs and symptoms of depression as well as to be on the alert for suicidal ideation. Take all mention of suicide seriously!
- Teach clients and families about any medications being taken. Explain that the veteran's health care provider must be aware of all medications they are taking, including prescription, OTC drugs, vitamins, minerals, supplements, and any herbal preparations. Note if the client is drinking alcohol and, if so, how often and how much. It should also be determined if any illegal and/or recreational drugs are being used.

Conclusion

Veterans are at significant risk for PTSD and depression, as well as for suicidal ideation and suicide attempts. Veterans of all ages are at risk. It is important that nurses and other healthcare professionals tell veterans and their loved ones that, even if many years have passed since experiencing traumatic events, treatment can still be effective and help significantly improve quality of life.

Veterans have expressed a number of reasons why they do not seek help for their mental health problems. These include believing that nothing can help them, guilt, and feeling that seeking assistance for mental health issues is a sign of weakness. Nurses should do their best to encourage veterans to seek help and point out that treatment can and does work.

Arguably the most important issue facing nurses when facilitating mental illness treatment is recognizing, and helping veterans and their families to recognize, the signs and symptoms of mental health problems. Recent publicity about veterans and PTSD, depression, and suicide has helped bring attention to these devastating problems. But it is not enough to just call attention to the problem—the healthcare community must act to assess and intervene to help veterans deal with the signs and symptoms of mental health disorders and to obtain necessary, even life-saving treatment.

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WEST VIRGINIA MENTAL HEALTH SCREENING FOR VETERANS (MANDATORY)

Self-Assessment Answers and Rationales

1. The correct answer is A.
Rationale: 35% of West Virginia veterans served in the Vietnam conflict.

2. The correct answer is B.
Rationale: Most homeless veterans are single and live in urban areas. Nearly half of the homeless veterans served during the Vietnam era. About 45% of all homeless veterans are African American or Hispanic.

3. The correct answer is B.
Rationale: Most homeless veterans are single and live in urban areas. Nearly half of the homeless veterans served during the Vietnam era. About 45% of all homeless veterans are African American or Hispanic.

4. The correct answer is D.
Rationale: In the Gulf War (Desert Storm) about 12% have PTSD in a given year.

5. The correct answer is C.
Rationale: Being female increases the risk of PTSD.

6. The correct answer is B.
Rationale: One of the signs and symptoms of PTSD is hypervigilance, which means being abnormally aware of the environment, accompanied by intensity of behaviors that are designed to detect threats.

7. The correct answer is B.
Rationale: Prolonged exposure therapy includes listening to audio recordings of sessions between appointments.

8. The correct answer is A.
Rationale: Since 2001, veterans' suicides increased by 32%.

9. The correct answer is D.
Rationale: Depressed mood must occur most of the day, almost every day, as evident by subjective reporting of sadness, emptiness, or hopelessness, or observations made by others.

10. The correct answer is C.
Rationale: Commonly prescribed SSRIs include Prozac (fluoxetine), Zoloft (sertraline), Lexapro (escitalopram), Paxil (paroxetine), and Celexa (citalopram).

An Overview of Dietary Supplements for Nurses

3 Contact Hours

Release Date: January 11, 2021

Expiration Date: January 11, 2024

Faculty

Bradley Gillespie, PharmD, is a clinical pharmacist. He has practiced in an industrial setting for the past 25+ years. His initial role was as a clinical pharmacology and biopharmaceutics reviewer at FDA, followed by 20 years of leading early development programs in the pharma/biotech/nutritional industries. In addition to his industrial focus, he remains a registered pharmacist and enjoys mentoring drug development scientists and health professionals, leading workshops, and developing continuing education programs for pharmacists, nurses, and other medical professionals.

Bradley Gillespie has disclosed that he has no significant financial or other conflicts of interest pertaining to this course.

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Shellie Hill has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

Nurses in many practice settings are likely to encounter patients that are using dietary supplements – some appropriately – whereas in other instances, not. This course is designed to provide an overview of these products that will empower nurses to guide their usage safely and effectively. Dietary supplements of many types are widely used by Americans. As a result, it is likely that nurses, in a variety of settings, will encounter patients who use these products.

This educational program is designed to provide an overview of the following:

- The regulation of nutritional supplements.
- Main categories of nutritional supplements, their potential activity, and safety concerns.
- Resources available to provide additional information.

Learning objectives

Upon completion of the course, the learner should be able to do the following:

- Detail two key events responsible for the regulation of dietary supplements.
- Describe one sign associated with vitamin deficiency.
- Name one benefit of vitamin C that has support in the scientific literature.
- Explain why supratherapeutic doses of water-soluble and fat-soluble vitamins can have different consequences.
- Discuss the difference between macrominerals and microminerals.
- Develop an awareness of "miracle" supplements.
- Identify two body systems that may be susceptible to adverse events when using St. John's wort.
- State one potential drug interaction associated with the use of St. John's wort.
- Provide a potential use for fish oil that is well supported by the scientific literature.

How to receive credit

- Read the entire course online or in print which requires a 3-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

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Activity director

Lisa Simani, MS, APRN, ACNP, Nurse Planner

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Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

INTRODUCTION

Most Americans consume at least one product defined as a dietary supplement each day; others may use them on a more irregular basis. Although products categorized as dietary supplements can include a variety of preparations, this educational program will consider common dietary supplements identified by the National Institutes of Health's (NIH) Office of Dietary Supplements as vitamins, minerals, herbs, botanicals, amino acids, probiotics, and fish oils. Dietary supplements can be ingested using a variety of formulations. Examples include tablets, capsules, powders, drinks, and energy bars. Supplements that are commonly consumed contain vitamins, minerals, herbs, fish oil, and probiotics (NIH, 2020b).

The Federal Food, Drug, and Cosmetic Act defines dietary supplements similarly to the NIH but adds that these substances are used to increase total dietary intake. Further, the U.S. Food & Drug Administration (FDA) states that dietary supplements are not intended to treat, diagnose, prevent, or cure diseases. As such, drug-like marketing claims such as "pain reducer" or "treatment of heart disease" are prohibited (FDA, 2020).

HISTORY

Contemporary thinking may assume that the nutrient depletion that some Americans suffer as a result of processed food consumption is a recent problem. Nonetheless, a review of nutritional history suggests that we have faced this problem for over 100 years. In actual fact, today's most popular dietary supplement, the multivitamin, was developed in the early 1900s. Before inventing this critical supplement, though, scientists first needed to acknowledge and understand the existence and need for substances now known as vitamins. Before this era nutrients were roughly categorized into three food groups: proteins, carbohydrates, and fats. Contemporary thinking of the time also blamed poor sanitation and hygiene deficiencies as the source of all disease. In response to this concern, food was often sterilized to remove germs and toxic substances. Grains were milled to remove their husks, and rice grains were polished (this is how brown rice is modified to become white rice). These efforts succeeded in extending food longevity but also led to unknown and sometimes harmful consequences (Tweed, 2017).

For example, well-intentioned grain processing decimated critical B vitamins, resulting in an increased incidence of two diseases common to the time: pellagra – niacin deficiency resulting in a variety of sores and sometimes delusions; and beriberi – thiamine (vitamin B1) deficiency, which can lead to nerve damage, sometimes to the extent of paralysis. Further, the practice of milk sterilization destroyed its vitamin C resulting in an increased incidence of scurvy. Interestingly, scurvy commonly occurred in affluent families, those able to afford the so-called "best food." These maladies were quite mysterious and not understood (Tweed, 2017).

The practice of rice polishing resulted in a hotbed of scientific interest around the turn of the 20th century. Many scientists in Europe and Asia realized the nutritional value of rice polishing (the substance removed from brown rice during its refinement) and endeavored to identify what part of it was important. Some of the more industrious investigators even tried to synthesize this material. One example of such a trailblazer was Casimir Funk, a Polish biochemist. In 1910 he reported that he had isolated the active factor in rice polishing. Though history would show that his findings were faulty, he did go on to make a critical contribution to the science, suggesting that his isolate belonged to the chemical class of amines. Further to that, he hypothesized that all of the organic trace nutrients linked to preventing disease belonged to that same class of chemicals. He then created the term "vitamin," to describe all of these *vital amines*. In a few years, Funk's hypotheses were disproven; not all of the chemicals in this category were amines. Nevertheless, the nomenclature was slightly shortened to vitamin, and it stuck (Carpenter, 2020).

For at least 14 years before 1926, intermittent nominations had been submitted for the Nobel Prize in Physiology or Medicine on the basis of vitamins. Although it is unknown why vitamin work never rose to the level of receiving this valued award, it may have been a result of skeptics who declared these substances to be only hypothetical; it was true that, up until this time, no one had ever seen a vitamin. This all changed in 1926 when a pair of Dutch scientists, Jansen and Doanth, produced pure crystals extracted from rice polishing. Only one-hundredth of a milligram of their extract, administered daily, was required to cure vitamin-deficient pigeons. By 1929 the award committee decided that it was time to honor the work of the vitamin pioneers.

The problem was that so many had contributed to this developing science, whose work should be honored. Ultimately, the prize was jointly awarded to Christiaan Eijkman and Sir Frederick Hopkins. Eijkman's work centered around his study of beriberi in the Dutch East

Indies. He noted that some of the chickens in his laboratory developed symptoms of beriberi after the cook refused to allow the birds to be fed leftover rice. When rice was procured from an alternative source, the animals quickly recovered, leading him to believe that something in the rice was responsible for preventing this disorder. Hopkins was an influential advocate for the importance of vitamins. As a result of these efforts, in 1929 the award was granted to these two men, cementing the importance of vitamins (Carpenter, 2020).

Over time, as the body of research developed, it became evident that vitamins were critical to supporting growth and function. It is now established that there are a total of 13 vitamins: vitamins A, C, D, E, K and the B vitamins (thiamine, riboflavin, niacin, pantothenic acid, biotin, B6, B12, and folate). Each of these diverse substances has different roles – some help to avoid infection or promote nerve health; others assist in the extraction of energy from food or serve as critical factors required for proper blood coagulation. Generally, if individuals follow proper dietary guidelines, they can consume the majority of the vitamins that they need from the food that they eat (National Institute on Aging [NIA], 2019).

In addition to vitamins to promote proper function, the body also relies on a number of minerals. Although most minerals, such as iodine and fluoride, are required in only small quantities, greater quantities of others are needed. Examples of minerals with larger requirements are calcium, magnesium, and potassium. The good news is that, like vitamins, a varied and balanced diet is typically adequate to supply enough of most minerals needed to support good health (NIA, 2019).

In summary, Funk's declaration that vitamins are vital is as true today as it was when he first suggested it over 100 years ago. Without them, horrible things will happen to the body. This well-accepted truth makes it very easy to market and sell vitamins as well as other substances purported to promote health. This is evidenced by a current explosion of start-up organizations stating that their products work for almost everyone. The Internet is packed with examples of sometimes expensive vitamin concoctions claiming to be essential for good living, many for seemingly exorbitant prices. Some marketers take it a step further by offering online personal surveys allowing consumers to create personalized supplement blends – in essence a multivitamin engineered to meet each individual's needs. A wise consumer may acknowledge that, though vitamins are important and worthwhile, perhaps not all available supplement regimens are worth their lofty prices (Palus, 2019).

REGULATION

Even though FDA-regulated products account for over 20% of consumer expenditures (Abram, 2017), the agency is not responsible for regulating harmful dietary supplements until a tainted or mislabeled product is sold. Further, the agency has no responsibility for ensuring the effectiveness of supplements. Nonetheless, FDA is planning to modernize and strengthen its oversight of dietary supplements. To this end it has listed a number of steps designed to improve the safe and effective use of dietary supplements, with a primary goal of preserving access while protecting consumers from dangerous products (Norman, 2019).

In spite of FDA's intention to modernize the regulation of dietary supplements, any useful modifications to law are not yet in place. Organizations manufacturing nutritional and dietary supplements are well aligned with Congress, which typically endorses industry-friendly regulations that support the concept of self-regulation (Brown, 2019). Nevertheless, hundreds of laws have been enacted to provide oversight of these diverse product lines. Over the history of FDA, many significant events have been recorded.

Seven key events are responsible for the regulation of the dietary supplement industry today. Taken together, these laws effectively provide a working definition of a dietary supplement.

1. *The 1938 Food, Drug, and Cosmetic Act*: In 1938 the Federal Food, Drug, and Cosmetic (FD&C) Act was passed in response to a legally marketed toxic elixir that killed 107 people, including a number of children. The FD&C Act led to a complete overhaul of the public health system, featuring an authorization of FDA to demand solid evidence of safety and proper labeling for new drugs, sanctioning factory inspections, and adding new enforcement tools (FDA, 2018).
2. *Nutrition Labeling and Education Act of 1990 (NLEA)*: Although the NLEA of 1990 was geared mainly toward food labels, certain aspects of this mandate were relevant to the regulation of dietary supplements. The nutritional labeling guidelines described in this legislation were designed to work in tandem with previously established requirements for statements of identity, net contents, ingredient lists, and the name and place of the manufacturer/distributor. Of interest, NLEA regulated health claims that could be made on behalf of a supplement. NLEA provisions were issued in January 1993 and applied to all supplements except those that were eligible for exemption. In the case of some small businesses or where labeling was impractical or not feasible, manufacturers could apply for such exemptions (GovTrack, n.d.b.).
3. *The Dietary Supplement Health and Education Act of 1994 (DSHEA)*: DSHEA was unanimously passed by Congress based on a number of findings that emphasized the need to communicate information to the public regarding the potential risks and benefits of dietary supplements. DSHEA was intended to protect the rights of consumers to continue to access safe supplements as a means to promote wellness. DSHEA provided FDA with the regulatory authority and enforcement mechanisms to allow the access of supplements to consumers while providing some level of protection. DSHEA specifically defined dietary supplements as a category of food, while making it clear that supplements would not be regulated as food additives. Further, DSHEA mandated that dietary supplements must be produced in compliance with current good manufacturing practices (cGMP). It is critical to note that the enhanced enforcement capabilities laid out in DSHEA gave FDA the authority to remove unsafe products from the market (Council for Responsible Nutrition [CRN], n.d.a.).
4. *New dietary ingredient (NDI) notifications*: As part of DSHEA, it was established that dietary supplements that were in commerce before 1994 could be considered safe based on their history of use and can remain on the market without additional evidence of safety. All other dietary ingredients will be considered "new" and will require that a formal notice is provided to FDA with evidence that it is reasonably expected to be safe (NDI notification). If FDA has reason to suspect that the NDI is unsafe, it has the authority to request additional information (FDA, 2019b).
5. *Good manufacturing practices (GMP)*: This is a specific set of rules and documentation that governs the manufacture of dietary supplements. These guidelines, finalized in 2007, mandate high standards intended to ensure the consistent manufacture of dietary supplements. Dietary supplement GMP include guidelines stating that all ingredients are thoroughly tested for identity and purity, as well as requiring products to meet prospectively determined quality specifications. Dietary supplement manufacturers are accountable to FDA to show proper documentation of all ingredients and processes. GMP documentation also covers sanitation, batch records, training of employees, process validation, and release testing to document conformance to the product label (CRN, n.d.b.).
6. *Dietary Supplement and Nonprescription Drug Consumer Protection Act (2006)*: This amendment to the FD&C Act requires the manufacturer, packer, or distributor whose name appears on the label of a dietary supplement to report within 15 days to the secretary of health and human services any serious adverse event associated with the use of its product. Further, this act requires that all related records are maintained for a period of 6 years and that they will allow inspection of these documents (GovTrack, n.d.a.).
7. *The Food Safety & Modernization Act (2011)*: This provision granted FDA the authority to issue a mandatory recall in the event that the manufacturer or distributor fails to enact a voluntary recall of a dietary supplement after being requested by FDA (CRN, n.d.b.).

This current characterization states that a dietary supplement is a product that meets the following requirements (NIH, 2020b):

- It is designed to supplement the diet.
- It is intended to be taken orally, formulated as a capsule, tablet, liquid, gel cap, or soft gel.
- It contains one or more dietary ingredient: vitamins, minerals, herbs, botanicals, amino acids, or other specific substances.
- It has proper labeling identifying it as a dietary supplement.

Nursing consideration: Although the regulation of dietary supplements is not as rigorous as for prescription or over-the-counter medications, certain requirements must be met to legally market these products in the United States. When completing medication histories, nurses and nurse practitioners should ensure that the supplements used by their patients meet all applicable regulatory requirements. Further, patients may benefit from discussing their therapeutic objectives and available supportive data.

FDA has proposed that a listing be created describing all products marketed as dietary supplements. Although FDA has the authority to act against noncompliant products, there is currently a problem with identifying all available products. Such a registry would allow FDA to know when new products enter the marketplace and provide the agency the tools needed to quickly identify and act against dangerous products (Mister, 2020).

The 2015 Dietary Guidelines Advisory Committee (DGAC) was formed as a joint effort of the U.S. Department of Health and Human Services (HHS) and the United States Department of Agriculture (USDA) to evaluate dietary guidelines and identify critical new research. An overarching objective was to develop food-based recommendations that were critical to good health. In a 2015 publication, these agencies noted that approximately 50% of American adults suffered from a preventable chronic disease. Further, they stated that about two of every three Americans were either overweight or obese. Although the causes of these issues were multifactorial, poor dietary patterns were at least partly to blame, with the potential for positive changes to diet capable of influencing them (USDA, 2015).

A national survey showed that more than 30% of adult Americans and about 12% of children employ healthcare approaches that are outside of traditional Western medical practice. When such a nonmainstream practice is used together with conventional medicine, it is termed "complementary healthcare." This combined and coordinated practice is known as "integrative health" (NIH, 2018).

Complementary health approaches are often used to try to promote overall well-being rather than to try to manage the symptoms of a health problem. Although nutritional supplement use is a mainstay of complementary health, many people find that combining it with other approaches, such as yoga, is helpful. The state of wellness is multidimensional to include emotional welfare (coping and the creation of satisfying relationships) and physical well-being (the recognition of need for healthy food, sleep, and physical activity). The National Center for Complementary and Integrative Health has conducted research that suggests that people who employ complementary approaches with an aim towards wellness have better overall health than people who use complementary approaches to manage an existing health problem (NIH, 2020g). These findings support the concept that supplements may be best suited for prevention of disease, in line with FDA regulations stating that dietary supplements are not intended to treat, diagnose, prevent, or cure diseases.

NUTRIENT RECOMMENDATIONS: DIETARY REFERENCE INTAKES (DRI)

The Food and Nutrition Board is a component of the National Academies of Sciences, Engineering, and Medicine (NASEM). As part of its task of ensuring nutritional well-being for all Americans, it provides policy guidance designed to use nutrition and food science to enhance the health of Americans. Since its establishment in 1940, the Food and Nutrition Board has been evaluating myriad issues relevant to the adequacy and safety of the US food supply. As a component of this nutritional study, it has provided authoritative perspectives on the complicated relationships and the dependencies of food intake, health maintenance, nutrition, and the prevention of disease (NASEM, 2018).

Dietary reference intake (DRI) is a generalized term that describes the reference values for nutrient intakes in healthy individuals. In addition to their usefulness in assessing nutrient intakes, they can also be employed to plan diets and supplementation strategies. It is critical to note that these values, in some cases, vary by sex and age. Multiple values are subsequently derived from DRI, including the following (NIH, n.d.):

- *Recommended dietary allowance (RDA)*: RDA is estimated to be an average level of a nutrient required every day to meet the nutrient needs of most (97% to 98%) healthy individuals.
- *Adequate intake (AI)*: In some cases, available evidence is inadequate to determine an RDA. In these instances, an AI is established at levels thought to allow for adequate nutrition.
- *Tolerable upper intake level (UL)*: Because many dietary supplements are not totally innocuous and may cause toxicity at some levels, ULs are often characterized to represent the maximum daily intake that is unlikely to lead to adverse impacts on health.

Nursing consideration: Good nutrition is a cornerstone to good health. Nurses should incorporate a discussion of nutritional needs into patient education. This conversation could begin with determining their patients' diets and an assessment to determine if they are obtaining the nutrients needed through their diet. Based on this evaluation, suggestions can be made for an appropriate regimen of dietary supplementation.

CATEGORIES OF DIETARY SUPPLEMENTS

A wide variety of dietary supplements is marketed for consumption to Americans, and they contain many ingredients intended to convey multiple benefits. For the purposes of this educational program, supplements covered are limited to those characterized by the National Institute of Health's Office of Dietary Health as those commonly encountered: vitamins, minerals, herbs/botanicals, amino acids, probiotics, and fish oil preparations. Because of the large number of products available, specific usage details are not included in this program. Instead, an overview of critical information that includes potential uses, supportive evidence, and safety issues is described. For details needed to guide the proper use of specific dietary supplements, practitioners are advised to consult a reputable reference source. A good overview of dietary supplements is provided by the NIH Office of Dietary Supplements and can be accessed at https://ods.od.nih.gov/

FDA publishes a dietary supplement ingredient advisory list designed to disclose to the public whenever FDA determines that certain ingredients used in dietary supplements do not appear to be lawfully used. Inclusion on this list is not necessarily an indication that FDA has definitively concluded that the ingredient is unsafe; rather, it means that FDA is working to further evaluate its safety. This list is kept current by FDA and can be accessed at https://www.fda.gov/food/dietary-supplement-products-ingredients/dietary-supplement-ingredient-advisory-list (FDA, 2019a).

Vitamins

Vitamins are a classification describing a category of organic substances that are available in very small amounts in the food that humans consume. Vitamins are critical to life; they help sustain normal metabolic processes. In cases where people do not ingest adequate amounts of vitamins, a variety of pathologies may result. All vitamins are organic compounds, meaning that they contain the element carbon. Further, the 13 vitamins classified as essential cannot be generated by the body and must be obtained either through foodstuffs or dietary supplementation (Brazier, 2017a).

The 13 essential vitamins fit into two distinct categories:

1. Fat-soluble vitamins are able to accumulate in fatty tissues throughout the body. The fat-soluble vitamins are vitamins A, D,

E, and K. In many cases, these vitamins can be absorbed more readily in the presence of dietary fats (MedlinePlus, 2020c).

2. The remaining nine essential vitamins are water soluble and cannot be stored by the body. As a result, these vitamins must be provided on an as-needed basis. Any surplus water-soluble vitamins are excreted. An exception is vitamin B12, which can remain in the liver for many years (MedlinePlus, 2020c).

Each essential vitamin plays an important and unique role in the body's proper function. In cases where a person does not receive an adequate amount of a specific vitamin, a vitamin deficiency may result. In some cases, deficiencies can lead to (sometimes serious) health problems (MedlinePlus, 2020c). The function of each of the 13 essential vitamins is briefly described below.

Fat-soluble vitamins

Vitamin A (retinol, retinoic acid) is an important nutrient critical to vision, cell division, reproduction, and immunity. In addition, vitamin A has antioxidant properties. Vitamin A naturally occurs in spinach, dairy products, and liver. When used as a dietary supplement, it may benefit those with pancreatic disease, eye disease, or measles (Mayo Clinic, 2017d).

Vitamin D sometimes colloquially referred to as the "sunshine vitamin," is not actually a vitamin, but a prohormone (hormone precursor) that can be made by the body if it is exposed to adequate levels of sunshine. In cases where not enough sunshine exposure is appreciated, vitamin D supplementation is needed because it is difficult to obtain adequate dietary vitamin D. Vitamin D facilitates calcium absorption and is thus useful in the promotion of healthy bones and teeth. Further, it supports immune, brain, and nervous system health while helping to regulate insulin levels (Ware, 2019b).

Evidence-based practice! Although vitamin D deficiency has been described in alarming terms, Cashman and colleagues (2016) recognized that available vitamin D levels in European people were of questionable quality. As such they set out to systematically evaluate the literature with an eye towards the NIH-led International Vitamin D Standardization program (VDSP). To estimate vitamin D levels across various age groups in Europe, they examined a total of 18 well-controlled studies (reanalysis of 15 studies as well as new analysis of samples from three studies using a validated assay), providing a total sample size of 55,844 participants. Using these datasets, investigators obtained estimates of the prevalence of vitamin D deficiency. When all of the data were pooled, irrespective of age or ethnicity, their data showed that 13% of the study participants were vitamin D deficient (< 30 nmol/L), on average, over the course of the year. Quite different results were obtained when evaluated by season: 18% were deficient in the winter; 8% were deficient in the summer. When participants were classified by skin pigmentation, analyses showed that dark-skinned ethnicities had higher (threefold to seventy-onefold) levels of vitamin D compared to fair-skinned participants. Investigators concluded that vitamin D deficiency is evident throughout Europe at concerning rates of prevalence requiring public health action.

Vitamin E functions as an antioxidant and occurs naturally in a variety of foods such as nuts, seeds, and leafy green vegetables. Vitamin E is critical for a variety of bodily functions, to include the creation of red blood cells and the proper facilitation of vitamin K (Drugs.com, 2019).

Vitamin K is involved in blood coagulation, bone metabolism, and the regulation of calcium levels in the body. A key role of vitamin K is to facilitate production of the blood clotting factor prothrombin. As a result of its potential to impact clotting, vitamin K, both through dietary and supplemental ingestion, must be carefully considered in patients using anticoagulants such as warfarin. It is critical to note that vitamin K deficiency in adults is rare (Ware, 2019a).

Water-soluble vitamins

Biotin is one of eight B vitamins, sometimes called *vitamin B7* or *vitamin H*, stemming from the German words haar and haut (hair and skin). Biotin is required by the body to facilitate the function of a number of enzymes called carboxylases. These enzymes are critical to a number of metabolic processes, to include the production of glucose and fatty acids. These reactions are useful for maintaining healthy nails and hair as well as supporting pregnancy and breastfeeding. Fortunately, because biotin exists in a wide variety of foods, deficiencies are rare, with the exception of some pregnant women and heavy drinkers (Palsdottir, 2020).

Niacin, also known as *vitamin B3*, is naturally present in many foods such as poultry, beef, fish, legumes, and grains. All the body's tissues are able to convert niacin into its active form, the coenzyme nicotinamide adenine dinucleotide (NAD). NAD is critical to life, with more than 400 enzymes needing it to function properly. In cases of severe niacin deficiency, the disease pellagra may occur, marked by a pigmented rash on skin exposed to sunlight, sometimes also manifesting with neurologic symptoms. Fortunately, pellagra is rare in the developed world, mostly limited to people living in poverty (NIH, 2020d).

Folic acid (sometimes referred to as *folate*) works in concert with vitamin B12 to assist in the formation of red blood cells. Further, folate is required in the production of DNA; it subsequently controls the growth of tissues and cell function. In pregnant women, low levels of folate are associated with birth defects such as spina bifida. As a result, a number of foods are fortified with folate to ensure adequate dietary folate (MedlinePlus, 2020c).

Nursing consideration: In addition to promoting good nutrition in all patients, it is critical that nurses caring for pregnant women stress the importance of folic acid. In addition to fortification in many foods, multivitamins that are designed for pregnant women typically contain additional folic acid.

Pantothenic acid, sometimes called *vitamin B5*, is found in a variety of foods, to include meat, vegetables, grains, and eggs. This vitamin is implicated in the proper metabolism of carbohydrates, proteins, and lipids. Further, it is sometimes associated with healthy skin. Typically, pantothenic acid is used in combination with other B vitamins. Although there is not solid, convincing evidence of its efficacy, it is commonly taken to prevent acne, allergies, baldness, asthma, and many other maladies (eMedicineHealth, 2019).

Riboflavin, sometimes called *vitamin B2*, works in concert with the other B vitamins. Specifically, riboflavin is associated with proper growth and the production of red blood cells (MedlinePlus, 2020c).

Thiamine (vitamin B1) helps the body to use carbohydrates for energy, also playing important roles in the function of nerves, the heart, and muscle. It is well established that thiamine requirements increase during pregnancy and lactation. Meat, fish, and grains all serve as good sources of thiamine. In some cases, white flour and breakfast cereals are enriched with thiamine. Because thiamine is not stored in the body, humans require a constant supply. Thiamine deficiency is associated with the disease beriberi, manifested by peripheral nerve problems and wasting (Brazier, 2017b).

Vitamin B6 (pyridoxine) participates in many bodily functions and is involved in more than 100 separate enzyme reactions, many critical to protein metabolism. Although present in many foods, the richest sources of vitamin B6 are fish, beef liver and other organ meats, potatoes, and fruit. It is critical to note that glycosylated forms exist in some fruits, vegetables, and grains, reducing its availability for absorption. Vitamin B6 deficiency is associated with microcytic anemia, weakened immunity, and a variety of other pathologies (NIH, 2020f).

Vitamin B12 (cyanocobalamin) is needed to maintain the proper function and development of the brain, nerves, blood cells (deficiencies may result in pernicious anemia), and a variety of other body systems. It is also useful in the treatment of cyanide poisoning and hyperhomocysteinemia. Vitamin B12 can be found in meat, fish, and dairy products. In some cases, vitamin B12 is synthesized in a laboratory (WebMD, n.d.d.). Deficiencies in vitamin B12 may lead to a variety of neuropsychiatric problems, including gait abnormalities and behavioral disturbances. Psychiatric manifestations of vitamin B12 deficiency may be related to abnormal neurotransmitter transmission, hyperhomocysteinemia, and increased levels of methylmalonic acid (Kerkar, 2018).

Case study 1

Advanced Practice Nurse (APN) Dan is caring for a 2-year-old patient, Will. Notable medical history showed that he suffers from granuloma annulare and nearly continuous constipation. In addition, as a newborn he was given a diagnosis of gastrointestinal reflux disease (GERD), which persisted until he was about 6 months old. He began walking at around 9 months of age but soon developed ataxia. A brain MRI at the time showed no obvious issues. About the time Will turned 1 year old, he began to experience behavioral problems, including irritability and an extremely harsh temper. He often woke in the night screaming, which worsened as he grew older. Will began self-harming at age 18 months and suffered from frequent violent outbursts. After his second birthday, the violence escalated, and he began biting and kicking anyone who came near him. A qualified behavioral therapist was astonished and unable to provide useful guidance. His previous pediatrician determined that Will was likely suffering bipolar disorder and oppositional defiant disorder (ODD).

Dan has a special interest in treating children with behavioral issues and was not certain that he agreed with the initial diagnoses. He began his assessment by collecting blood for a variety of tests to see if he could identify a biochemical rationale for Will's behavior. All of the test results came back within the reference range. Dan took interest in the serum B12 value, nonetheless, since it was near the lower limit. He was aware that this test's reference range is inaccurate in some cases, so he considers treatment with vitamin B12. In this case Dan administered a dose of vitamin B12. Within a week of daily injections, Will's demeanor had changed drastically. He had moved from a violent and depressed state to one of happiness and content. Will's parents were in shock by the seemingly impossible change to their previously distressed and crazy life.

Self-Assessment Quiz Question #1

In the case of Will, it appears most evident that the main consequence of vitamin B12 deficiency was manifested by behavioral issues. Nonetheless, this deficiency could also be associated with other problems. What are some examples of things that Dan should look into?

a. Blood cell development. If Dan did not obtain a complete blood count, he should.
b. Kidney dysfunction.
c. Visual field disturbances.
d. Adrenal function.

Self-Assessment Quiz Question #2

What can an astute nurse learn by observing Dan's care of Will?

a. Clinical laboratory levels are rarely useful as diagnostic tools.
b. Clinical laboratory reference ranges are based on a population of patients and may not represent normal for all individuals.
c. In many cases a second clinical opinion can provide value to making the correct diagnosis.
d. Both b and c.

Vitamin C (ascorbic acid) is acknowledged as an antioxidant that is useful in the promotion of healthy teeth and gums. Additional roles of vitamin C are to assist in the absorption of dietary iron, the maintenance of healthy tissue, and promotion of proper wound healing (MedlinePlus, 2020c). In the early 1970s, Linus Pauling, a winner of the Nobel Prize, proposed the theory that vitamin C administered as megadoses (up to 18,000 mg per day) is helpful in the prevention of colds. To confirm/refute this theory, many clinical studies were conducted examining supplementation with 200 mg or more vitamin C. Overall, these studies were unable to show reduced risk of catching a cold. Nonetheless, data do support that vitamin C supplementation can sometimes make a cold less severe and modestly shorten its duration. Some data suggest that 6 to 8 grams of vitamin C per day can shorten the duration of a cold in adults by about 18% (Gunnars, 2018).

A critical concept is the proper dose levels of essential vitamins, especially in cases of fat-soluble vitamins that can accumulate to potentially toxic levels in the body. In general, patients should follow vitamin RDA when considering proper dosages of dietary supplements containing vitamins. Naturally, clinicians may suggest different levels for some patients depending on their individual needs (MedlinePlus, 2020c). RDA may vary by age or sex; current RDA are described in a table provided by the Food and Nutrition Board of the Institute of Medicine, National Academies that can be found at https://www.nal.usda.gov/sites/default/files/fnic_uploads//RDA_AI_vitamins_elements.pdf

Nursing consideration: It is critical for nurses and nurse practitioners to distinguish between water- and fat-soluble vitamins relative to their ability to accumulate in the body. Unfortunately, the human mindset is often based on the premise that more is better. As such, massive doses of vitamins are not uncommon. In the case of water-soluble vitamins such as vitamin C, surplus vitamins are typically excreted in urine. Although this is economically wasteful, this is usually benign from a safety perspective. In contrast, elimination of fat-soluble vitamins is more difficult, meaning that excess vitamins can accumulate in the body. In extreme cases toxicities may result. This is important educational material that nurses should discuss with their patients.

Case study 2

Nurse Jeanine is a staff nurse at small college health center. Today she is meeting with a new student, Gerri, who has come to her for some advice on how to prevent and manage the cold and flu season. In addition to taking a full course load, Gerri works the predawn shift at a local bakery for extra spending money. She realizes that all of this work has created high levels of stress, and she is thus concerned for her health going into the fall cold and flu season. Her multiple commitments make it very important that she not lose time because of illness, further adding to her stress levels. Specifically, Gerri is interested in Jeanine's insights on a new supplement called MegaRed designed to prevent colds, flu, and a variety of other ailments. Although one of her friends highly recommended it, Gerri remains skeptical. Gerri learned through an Internet search that the supplement facts label showed that each MegaRed tablet contained (as a percentage of RDA) 33% for vitamin A; 700% for vitamin C; 200% for niacin; and 100% for vitamin B6. The label suggested that she take two to three tablets daily to maintain good health and another two to three tablets every 3 hours at the first sign of feeling unwell. To this point the product seemed to make sense to Gerri until she clicked on the "buy now" button and found that 100 tablets, described as a month's supply, cost $79.99. This seemed like a lot of money to Gerri, thus motivating her to get Jeanine's opinion. Jeanine, sharing Gerri's skepticism, decided to turn it into a teaching moment by asking Gerri a series of questions to see how well she understood vitamins and how to use them.

Self-Assessment Quiz Question #3

When MegaRed is used as directed, which of the vitamin ingredients will provide all that Gerri likely needs daily, based on the recommended dietary allowance?

a. Niacin.
b. Vitamin B6.
c. Vitamin C.
d. All of the above.

Self-Assessment Quiz Question #4

Although MegaRed appears to rely on relatively high doses of most vitamins, each tablet provides only 33% of the recommended dietary allowance for vitamin A. What would be a plausible reason for this difference?

a. Vitamin A has been proven to have little impact on colds.
b. The relatively high dose of vitamin C is compensatory.
c. Vitamin A is fat soluble allowing the possible accumulation of supertherapeutic doses.
d. Vitamin A is minimized because as an ingredient it is cost prohibitive.

Self-Assessment Quiz Question #5

It appears that the most prevalent (largest dose) ingredient in MegaRed is vitamin C. Why do you think that is?

a. Some data suggest that vitamin C can reduce the duration of a cold.
b. Other data show that vitamin C may decrease the severity of a cold
c. Both a and b.
d. Vitamin C is proven to prevent colds.

Self-Assessment Quiz Question #6

The cost of $79.99 for a one-month supply of MegaRed may be considered exorbitant to some individuals. Provide a plausible explanation for the relatively high cost.

a. The product is aggressively marketed, and the manufacturers suspect that the relatively high cost will suggest high quality.
b. The ingredients contained in MegaRed are uncommon and thus expensive.
c. The cost is required to recoup company research and development efforts.
d. The cost is largely driven by the relatively high dose of vitamin C.

Minerals

Dietary minerals work hand in hand with vitamins to provide complete nutrition. Minerals are needed for heart and brain function as well as the generation of certain hormones and enzymes. Dietary minerals can be broken into two main classifications based on how much the body requires: macroelements (large amounts required for proper nutrition: calcium, phosphorous, sodium, potassium, chloride, magnesium) and microelements (trace amounts needed: iron, nickel, zinc, fluoride, copper, chromium, manganese, selenium, iodine, molybdenum). Though an adequate quantity of minerals can usually be obtained with a healthy balanced diet, some populations may require supplementation. Candidates for mineral supplementation include pregnant women, nursing mothers, vegans, people who depend excessively on processed food, and older individuals (Kubala, 2020).

Key dietary minerals and their function are listed below.

Macrominerals

Calcium, the most common mineral in the body, is needed to form bones and teeth, for muscle function, nerve transmission, and hormonal secretion. Most (99%) of the body's calcium is stored in the bones and teeth. The body maintains the proper levels of calcium through constant resorption and deposition of calcium in the bones. In younger people, deposition generally exceeds resorption. The opposite is true in older people, especially postmenopausal women (NIH, 2020a).

Phosphorus is second only to calcium in terms of abundance in the body, with which it works closely to construct strong bones and teeth. Smaller amounts of phosphorus can be found in tissues throughout the body. This mineral also plays a key role in the storage and usage of energy, as well as the growth, maintenance, and repair of tissues and cells. Although most people will get plenty of phosphorus in their diet, some health disorders can lead to decreased levels in the body. Further, anorexia and the use of some antacids can also cause phosphorous levels to drop (WebMD, 2020b).

Sodium: The body requires some sodium to support the proper function of nerves and muscles and maintain a proper fluid balance, but most people receive too much sodium in their diets. Increased sodium levels can result in hypertension, which can lead to a variety of pathologies. Rather than supplementing sodium, most patients require assistance in limiting their intake of this mineral. This is especially important in people with high blood pressure, diabetes, and kidney problems; those who are African American; and people over age 50 (MedlinePlus, 2020b).

Potassium is an electrolyte, meaning that it can conduct electricity in the body. As such it is crucial to proper heart function and is required for skeletal and smooth muscle contraction. Potassium is found in a wide variety of foods, making supplementation unnecessary for most individuals. It is important to maintain proper potassium blood levels; both too much (hyperkalemia) or too little (hypokalemia) can be dangerous. A variety of pathologies can cause hypokalemia; hyperkalemia is more prevalent in older individuals. Lastly, a variety of medications can impact potassium levels in some patients (Weatherspoon, 2019).

Chloride can typically be found in the body in conjunction with sodium and water. It is useful to maintain the proper osmotic pressure of body fluids and is a critical partner to hydrogen in the formation of hydrochloric acid, a key digestive acid. Chloride is excreted or retained by the kidneys to maintain proper levels (Haas, n.d.).

Magnesium is required as a component for more than 300 biochemical reactions in the body. For example, it is important in the maintenance of nerve and muscle function, immune system, heart rhythm, and bones. Most people get enough magnesium in their diets and supplementation is not generally indicated. It is rare that a person is ever truly magnesium deficient (MedlinePlus, 2019).

Microminerals

Iron is needed by the body to make red blood cells. As a result, a lack of iron can lead to iron deficiency anemia. Though an adequate amount of iron can usually be obtained from the diet, some people may require supplementation. As an example, women who lose a large amount of blood during their menstrual cycle are at a higher risk of iron deficiency anemia and may be good candidates for supplementation. High doses of iron can be toxic, even fatal, especially in young children (National Health Service [NHS], 2020).

Nickel: Although nickel's exact mechanism of action is not well understood, it is useful in aiding the absorption of iron and treating osteoporosis. Although nickel deficiencies have not been reported in humans, low nickel levels have been observed in animals (WebMD, n.d.c.).

Zinc is extremely important to good health. It impacts the immune system, cell division, and DNA synthesis. Although zinc deficiencies have been observed in people with insufficient intake, poor absorption, alcoholism, those with certain gene mutations, and the elderly, in most cases it is easy for people to consume adequate zinc in their diet. Like many things, though, too much zinc can result in adverse events such as nausea and vomiting, headaches, and decreased HDL cholesterol (Kubala, 2018).

Fluoride aides in the development of strong bones and teeth. Fluoride is likely best known for its role in strengthening the enamel that protects teeth. It is critical to note that excess fluoride ingestion has been linked to a variety of health issues, such as dental fluorosis (tooth discoloration), skeletal fluorosis (decreased elasticity leading to pain and increased fracture risk), problems with the parathyroid, and some neurological issues (Brazier, 2018).

Copper is present in all body tissues and works in concert with iron to form red blood cells. In most cases dietary copper is adequate. In cases of low levels of copper, anemia or osteoporosis can result. In excess, copper can be toxic, leading to hepatitis and kidney and brain issues (MedlinePlus, 2020a).

Chromium has a variety of roles in the body, including the digestion of food. The presence of chromium may help slow the loss of calcium, to the benefit of people at risk of osteoporosis. It is critical to note that there is extensive commercial promotion of chromium as an aid in the building of muscle and burning fat. Nonetheless, there is inadequate available data to support these claims (WebMD, n.d.b.).

Manganese is present mainly in the bones, liver, kidneys, brain, and pancreas. Manganese is vital to a variety of functions, to include amino acid, cholesterol, and glucose metabolism. Further, it is involved in the formation of bone, the clotting of blood, and inflammation reduction. In addition to being found in many foods, manganese can sometimes be derived from drinking water. Deficiencies are rare, nonetheless, and are sometimes associated with reduced glucose tolerance, fertility problems, and other issues. It is important to note that it is much more likely that a person would suffer from overexposure to manganese than a deficiency (Fletcher, 2019).

Selenium, naturally available in a variety of foods, plays a critical role in thyroid hormone metabolism, reproduction, and DNA synthesis, as well as in providing protection from oxidative damage and infection. The major body storage site for selenium is in skeletal muscle, which accounts for 28% to 46% of the total body's pool. Although most people obtain adequate selenium in their diet, deficiencies can generate biochemical changes that may leave some people vulnerable to stresses that can predispose them to certain illnesses. Selenium is contained in most multivitamin supplements (NIH, 2020e).

Iodine is an essential part of the thyroid hormones thyroxine (T4) and triiodothyronine (T3). Thyroid hormones are involved in the regulation of several critical biochemical reactions in the body, including enzymatic activity, protein synthesis, and the regulation of metabolic activity. Further, thyroid hormones are needed to ensure the proper perinatal development of the skeletal and nervous systems (NIH, 2020c).

Molybdenum plays a role as a cofactor for at least four essential enzymes, including sulfite oxidase. Sulfite oxidase works to help degrade the sulfites that occur in a number of chemically preserved foods and specific proteins. Even though most of this mineral is absorbed and stored in organs, some is converted to molybdenum cofactor, and excess is excreted in the urine. As with many vitamins and minerals, true deficiencies are rare, although long-term molybdenum deficiencies have been linked to esophageal cancer (Rowles, 2017).

Just as with vitamins, it is critical that proper levels of essential minerals are maintained and supplemented only in cases where indicated by documented low-blood levels. This is especially important in situations where minerals can accumulate to potentially toxic levels in the body. In general, patients should follow vitamin RDA when considering proper dosages of dietary supplements containing minerals. Naturally, healthcare professionals may suggest different levels for some patients depending on their individual needs; RDA varies by age and sex. Current RDA are described in a table provided by the Food and Nutrition Board of the Institute of Medicine, National Academies that can be found at https://www.ncbi.nlm.nih.gov/books/NBK56068/table/summarytables.t3/?report=objectonly

Nursing consideration: For most patients, an adequate amount of all essential vitamins and minerals can be obtained with a daily multivitamin. As a result, an investment in multivitamins may be the most cost-effective health intervention for many patients. Nurses should consider sharing this insight as part of their approach to patient education.

Herbs/botanicals

Herbs and botanicals are plants or parts of plants that some patients use either as a treatment or preventive measure. Such products are formulated in teas, capsules, tablets, liquids, or powders. It is critical to note that, although these supplements are generally natural products, they are not always safer than prescription medications because they may be quite foreign to the human body. As a result, many of these products can be strongly impactful – sometimes causing serious adverse events. Some research has been conducted to characterize a few herbal/botanical products, but in most cases, a comprehensive understanding of the potential risks and benefits has not been achieved. Because these dietary supplements are classified by FDA as food, their safety and efficacy are not required to be proven. It is also important to know that some patient subpopulations can be at an increased risk of adverse events from herbal/botanical dietary supplements. Examples include those who are pregnant or breastfeeding or who have certain medical conditions. Some herbal products may cause problems with surgery, such as excessive bleeding. Further to that, some herbal products have the potential to impact the disposition of other medications. For instance, St. John's wort can affect the metabolism of a large number of medications, decreasing their concentrations and subsequent effects. It is always critical to discuss the usage of all supplements with appropriate healthcare professionals (Family Doctor, 2020).

Nursing consideration: Many patients do not consider dietary supplements when asked about their medications. Because of the potential pharmacologic properties of these products, especially herbal products, it is critical to specifically address supplements when obtaining medication histories.

Like all medications and dietary supplements, the FDA requires that herbal/botanical products are accurately and truthfully labeled. Labeling must include its name, manufacturer/distributor, a complete list of ingredients, and the quantity contained in the package. In addition, proper directions for safe usage should be included. Any products that do not have this information on the label should be avoided. If a dietary supplement is found to be unsafe or is mislabeled, FDA is empowered to remove it from the marketplace. Patients who decide to take these products should use the products as directed and in the recommended amounts (Family Doctor, 2020).

Although hundreds of different herbal/botanical dietary supplements are available, some of the more common herbal supplements include the following.

Cannabidiol (CBD), a component of marijuana, has been shown to have effects on the brain through unknown mechanisms. Apparently, it impacts pain, mood, and mental function. Preliminary research has shown that CBD may be effective for a variety of disorders, to include bipolar disorder, Crohn's disease, diabetes, dystonia, fragile-X syndrome, graft versus host disease, Huntington's disease, and insomnia. At this time, though, none of these indications has been proven out in properly powered, randomized, controlled clinical trials (WebMD, n.d.a.).

Nonetheless, specific CBD products have been shown to be safe and efficacious and thus approved as prescription drugs for the treatment of certain seizures (Epidiolex) and in combination with THC (Sativex) for the treatment of multiple sclerosis in 25 countries outside of the United States (WebMD, n.d.a.).

CBD has been shown to have the potential to interact with a large number of medications, both through modulation of at least two common metabolic enzymes and a key protein involved with the absorption and excretion of drugs (P-glycoprotein). As a result, the potential for CBD drug interactions with commonly used medications is great. Although a comprehensive list of all potential drugs is beyond the scope of this educational program, a list of medications with the potential to interact with CBD can be found in Brown and Winterstein's review article (2019): https://www.mdpi.com/2077-03/8/7/989

Spirulina is a variety of blue-green algae considered by some to be a superfood. Spirulina, high in protein and vitamins, is suitable for vegetarians. Some research has suggested that it has antioxidant properties and may be capable of regulating the immune system. People may take spirulina to aid in weight loss, improvement of gut health, managing the symptoms of diabetes, reduction of cholesterol, controlling blood pressure, prevention of heart disease, increasing basal metabolism, reduction of allergy symptoms, and supporting mental health (Burgess, 2018).

Although the literature contains a number of nonclinical and small human trials providing some evidence of effect, current knowledge can only suggest that spirulina is a safe food supplement without significant side effects. Its effectiveness is yet to be definitively established.

Nursing consideration: Many patients do not consider dietary supplements when asked about their medications. Because of the potential pharmacologic properties of these products, especially herbal products, it is critical to specifically address supplements when obtaining medication histories.

St. John's wort (Hypericum perforatum) is a European flowering shrub. The flowers and the leaves of this plant are known to contain a pharmacologically active chemical called hyperforin. Unlike many other herbal/botanical supplements, reasonable clinical evidence has been generated to demonstrate its potential efficacy in the treatment of mild to moderate cases of depression. In fact, some investigations suggest that it may incur efficacy on the magnitude of some prescription antidepressant medications. A potential pitfall to the use of St. John's wort is its drug interaction potential. St. John's wort reacts not only with antidepressants, but also with anticoagulants, birth control medications, HIV/AIDS medications, and many others. As a result, its use may be hazardous in patients using concomitant medications (Mayo Clinic, 2017c).

Turmeric is a spice that is commonly used to color curries, mustards, and other foods. Turmeric root is also widely used as an alternative medicine, possibly aiding in reduction of cholesterol, treatment of pain from osteoarthritis, and treatment of stomach ulcers, rheumatoid arthritis, tuberculosis, Alzheimer's disease, cancer, and inflammatory bowel disease (Multum, 2019). The literature contains a number of nonclinical and small human trials providing some evidence of effect, but current knowledge can only suggest that turmeric is a safe food supplement without significant side effects. Its effectiveness is yet to be definitively established.

Evidence-based practice! Apaydin and colleagues (2016) conducted a systematic review of the scientific literature to assess the safety and efficacy of St. John's wort (SJW) for the treatment of major depressive disorder (MDD) compared to both placebo and active control. They considered randomized controlled trials (RCT) employing at least a 4-week treatment period. A total of 35 published clinical trials enrolling a total of 6,993 patients met their criteria and were included in their analyses. Results showed a response rate for SJW-treated patients that was 53% higher than those who received placebo (16 RCT enrolling 2,888 patients). Reported adverse events were similar between SJW-treated and placebo-treated patients with the exception of those related to the eye, ear, nervous, hepatic, renal, and reproductive systems. Investigators noted that assessments of adverse events across studies were limited, lowering the quality of evidence. When SJW-treated patients experienced fewer adverse events, investigators concluded that SJW monotherapy is superior to placebo and not significantly different from antidepressant medications for the treatment of mild to moderate depression.

Case study 3

Mary M. is an 83-year-old woman with a history of hypertension and myocardial infarction. She is visiting with her APN, Jenny. Midway through their conversation, Jenny realizes that Mary seems a bit different than she remembers, somehow lacking the sparkle in her eye and the normal wit in her expression. After a bit of probing, Mary communicates that she has not felt normal lately. More specifically, she feels a bit down after the holidays. After she thought about it a bit, she admitted that this always happens in January. Jenny realized the importance of listening at this point, so she allowed Mary to continue. Eventually, Mary asked Jenny if she thought that she might be suffering from depression. She said that she had been discussing her feelings with a close friend, who said she often feels the same and feels better after taking St. John's wort. Now that Jenny was thinking about it, she realized that Mary could be suffering from a seasonal type of depression. Rather than going straight to a prescription antidepressant medication, Jenny wondered to herself if Mary might be a good candidate for a trial with St. John's Wort. Jenny had read publications that suggested that this herbal product can be as effective as conventional antidepressants and, because it is a natural product, perhaps it might be safer. She quickly reviewed a recent review article focused on the use of St. John's wort for mild to moderate depression and reviewed Mary's current medications. Mary was taking lisinopril 10 mg, hydrochlorothiazide 25 mg, and clopidogrel 75 mg.

Self-Assessment Quiz Question #7

Which of the following statements about St. John's wort is FALSE?

a. Although it is an herb, it has pharmacologically active properties.
b. According to some clinical studies, its efficacy against mild to moderate depression is similar to that afforded by prescription antidepressants.
c. No adverse events are associated with the use of St. John's wort.
d. St. John's wort has the potential to interact with other medications.

Self-Assessment Quiz Question #8

It has been established that St. John's wort should be treated like a prescription medication. Before prescribing it, drug interactions with existing medications must always considered. Which of Mary's concomitant medications has the greatest chance of interacting with St. John's wort?

a. Lisinopril.
b. Clopidogrel.
c. Hydrochlorothiazide.
d. None of the above.

Pomegranate juice and extract: Pomegranate (Punica granatum) is a tree bearing fruit native to Western and Central Asia with a long history of being grown in temperate climates worldwide. It can be consumed as a fruit, juice, or extract product. Pomegranates, enjoyed for millennia, were always thought of as having health benefits. Pomegranates are a good source of vitamin C, vitamin K, iron, calcium, potassium, and folate. Recent scientific research suggests that pomegranates also possess multiple key properties that may be beneficial to health. Many of these health claims are based on multiple polyphenolic compounds found in the pomegranate. These phytochemicals have been shown to act as antioxidants, impacting numerous body systems. Some examples of potential benefits include reduction of cholesterol and plaque buildup in artery walls and reduction of inflammatory cytokines, and decreasing the symptoms of osteoarthritis, rheumatoid arthritis, and other inflammatory diseases. Despite these potential benefits and a relatively benign adverse event profile, pomegranate has the potential to interact with multiple medications, to include warfarin, enalapril, and other ACE inhibitors (WebMD, 2020a).

Animal models have shown that some pomegranate components inhibit the metastasis of ovarian cancer by way of downregulating multiple matrix metalloproteinases. When pomegranate's effect on prostate cancer cells was evaluated, a similar effect on matrix metalloproteinases was observed, inducing apoptosis and impairing metastasis. Work with a pomegranate extract product suggested a prevention of breast cancer through multiple anti-inflammatory processes. Although these preclinical data are encouraging, more extensive clinical research is required for confirmation of effect (Memorial Sloan Kettering Cancer Center [MSKCC], 2019).

Evidence-based practice! Decreasing prostate specific antigen doubling time (PSADT) is generally associated with increased risk of prostate cancer recurrence. Paller and investigators (2013) conducted a double-blind, placebo-controlled trial in 104 recurrent prostate cancer patients with decreasing PSADT. Subjects were randomized to receive either 1 or 3 grams of pomegranate extract daily for up to 18 months. Data showed that PSADT was elongated from 12 to 19 and 12 to 18 months in the low- and high-dose groups, respectively ($p < 0.001$). There was no statistical difference between the two dose levels ($p = 0.554$). PSADT increases > 100% were observed in 43% of patients, and declining PSA levels were observed in 13% of patients. Although no significant adverse events were observed in either group, the incidence of diarrhea was higher in the high-dose group (14% vs. 2%). Investigators concluded that, although significant increases in PSADT were observed at both dose levels, these results need to be confirmed in a placebo-controlled trial.

Amino acids

The Internet is awash with opportunities to purchase a wide variety of amino acid-based dietary supplements designed to improve health. In one recent article describing the use of these products, amino acid supplements are purported to offer health benefits for people wanting to replenish their bodies after a workout or just remain healthy. The manufacturer's argument states that these supplements contain the essential amino acids – those that the body cannot make – needed to form necessary proteins. The idea is that there is a need to supplement the dietary input of amino acids. Thus, amino acid supplements serve as a sort of insurance policy to ensure that the body receives all of the amino acids needed. Further, it is theorized that the supplements are required at times of elevated protein demand, such as during illness or when recovering from an injury. Amino acid supplements are broken down into two distinct categories: branched-chain amino acids (BCA) (contain leucine, isoleucine and valine, potentially the most studied amino acids used for dietary supplementation), and those that are designed to be high in arginine and glutamine. Because 33% of skeletal muscle is composed of BCA, it follows that they may play a role in exercise recovery. The single amino acid supplements arginine and glutamine are described as offering specific health benefits. Arginine, an essential amino acid, can be converted to nitric oxide, which relaxes blood vessels and may be useful in the management of high blood pressure. Glutamine, which is not essential, is thought to assist in wound healing and reducing the rate of infection (Annigan, 2018).

Additional amino acid supplements intended to provide health benefits include L-tryptophan, aspartate, orthenine, lysine, tyrosine, and taurine (Annigan, 2018).

Unfortunately, the scientific literature does not contain a large body of research to solidly document the utility of these supplements (Annigan, 2018).

Evidence-based practice! Wolfe (2017) noted that a lucrative industry has formed based on the hypothesis that BCA, given alone, are able to drive an anabolic response in humans that stimulates the synthesis of muscle protein. His review of the literature revealed no studies in humans where the response of muscle protein synthesis was observed as a result of orally ingested BCA. Nonetheless, he identified two studies where BCA were administered via intravenous infusion. In these examinations, a decrease in muscle protein synthesis coupled to protein breakdown was correlated to BCA administration. These findings, then, suggest a decrease in the turnover of muscle protein. In other words, muscle protein catabolism exceeded the rate of new muscle synthesis during BCA infusion. He theorizes that muscle synthesis is rate limited by the lack of other essential amino acids. In summary, the author concluded that the claim of BCA, administered alone, stimulating muscle protein synthesis in humans is unwarranted.

The findings of Wolfe leave open the possibility that if BCA could be combined with other essential amino acids, a positive effect on muscle recovery could be realized. Unfortunately, such supplementation must be empirically based, as there are no reputable data available to support this hypothesis.

Nursing consideration: There is little evidence available to support the use of amino acid-based dietary supplements in most patients. Nurses may find that some of their patients are strong believers in the benefit of these products. In some cases, however, it may be useful to have a tactful, yet direct, conversation with their patients regarding the potential shortcomings of these products.

Probiotics

Probiotics are bacteria that are ingested in an effort to maintain a proper balance of intestinal microflora. The gastrointestinal (GI) tract typically hosts approximately 400 species of bacteria that act in concert to crowd out harmful bacteria. When functioning as intended, these organisms help maintain a healthy digestive tract. Assessment of the GI tract demonstrates that the most common probiotic bacteria are of the lactic acid variety. The most common species is *Lactobacillus acidophilus*, which is also found in live yogurt cultures. Other common organisms are classified within the yeast family. Many species are available as dietary supplements and are intended to treat a variety of gastrointestinal problems. Some people take probiotics in an effort to prevent the diarrhea, gas, and cramping that often accompany the use

of certain antibiotics. The theory behind this practice is that antibiotics often kill "good" bacteria, allowing opportunistic "bad" bacteria to flourish. This is thought to result in gastrointestinal distress, overgrowth of vaginal yeast, and urinary tract infections. The aim of probiotics is to replace the bacteria lost as collateral damage to antibiotic therapy (WebMD, 2020c).

It is critical to note that only certain species of yeast and *Lactobacillus* are beneficial. Further research is needed to clearly demonstrate which specific probiotic species are effective at treating disease. Further, many of the species with demonstrated efficacy are not widely available in practical supplement formulations. The majority of probiotics are composed of organisms native to the body and have been consumed for many years in the form of fermented foods and cultured milk products. As a result, these products do not raise significant safety concerns. Nonetheless, it is evident that additional research is needed to fully understand the safety of probiotics in immunocompromised young and older individuals (WebMD, 2020c).

Acidophilus *(Lactobacillus acidophilus)* is native to humans within the mouth, the GI tract, and the vagina. It is also a common dietary supplement ingredient. Acidophilus is found in a variety of dairy products, such as yogurt, and is generally formulated for use as a supplement in capsules, tablets, wafers, powders, and as vaginal suppositories. It is commonly used in an effort to prevent or treat bacterial vaginosis and various digestive issues, as well as to simply promote the growth of beneficial GI bacteria.

A large amount of clinical research has been conducted in an effort to promote the benefits of acidophilus. Efficacy has been demonstrated in the treatment of bacterial vaginosis. Data have also been generated supporting its use in the treatment of respiratory infections and some varieties of diarrhea, bloating, and cramps caused by antibiotic usage, to include the more serious *C. difficile*-induced diarrhea. Oral acidophilus may also be beneficial during pregnancy and breastfeeding to reduce the occurrence of atopic dermatitis in infants and young children who are breastfeeding. One issue with the use of acidophilus is a lack of standardization among available supplements, which complicates the proper dosing of this probiotic as a dietary supplement. Although additional research is required to provide the data needed to guide the proper use of acidophilus, available evidence suggests that there is little harm in using these products. Nevertheless, ingestion of a balanced diet that includes fermented foods may provide adequate levels of these useful bacteria (Mayo Clinic, 2017a.).

Fish oil

Fatty fish and some shellfish contain polyunsaturated fatty acids, collectively known as omega-3 fatty acids. Omega-3 fatty acids are critical to a variety of functions in the human body. The most abundant omega-3 fatty acids are alpha-linolenic acid (ALA), eicosapentaenoic acid (EPA), and docosahexaenoic acid (DHA). ALA is prevalent in vegetable oils, especially canola and soybean oils. Flaxseed oil is a good vegetarian source of ALA, but its use in the common American diet is limited. EPA and DHA can be generated in the body through ALA conversion, but this source too is limited. The best source of EPA and DHA is fatty fish such as salmon, trout, and tuna, as well as shellfish such as crab, oysters, and mussels. In addition to these sources, omega-3 fatty acids are widely available as dietary supplements. Although vegetarians may consider flaxseed and algae oils as supplemental sources of EPA and DHA, respectively, fish oil-based supplements are a common source of all three fatty acids (National Center for Complementary and Integrative Health [NCCIH], 2018).

It is well acknowledged that omega-3 fatty acids are critical to facilitate a variety of functions, including the activity of muscles, clotting of blood, cell division/growth, and fertility. More specifically, DHA is needed to support brain development and function. ALA is considered "essential," meaning that there is no way for the body to make it; it must be obtained from either food or dietary supplementation. Perhaps because of the many potential health benefits of omega-3 fatty acids, research has been conducted examining their role in a variety of pathologies. Examples evaluated include conditions affecting the circulatory system, brain, nervous system, mental health, the eye, rheumatoid arthritis, and infant development (NCCIH, 2018).

The 2012 National Health Interview survey showed that fish oil supplements are the most commonly used nonvitamin and nonmineral natural products consumed by American adults and children. This survey indicated that nearly 8% of adults had used a fish oil supplement in the previous 30 days (NCCIH, 2018).

Evidence-based practice! Calder (2015) acknowledged that inflammation contributes to the pathology of various disease states and that EPA and DHA, found in fish oil supplements, are able to partially blunt this condition through a number of distinct mechanisms. Further, he stated that both substances facilitate the generation of mediators that work to resolve inflammation through multiple linked biochemical mechanisms. Unfortunately, not all of these processes are fully understood. He goes on to note that animal research in models of rheumatoid arthritis (RA), inflammatory bowel disease (IBD), and asthma respond to treatment with omega-3 fatty acids. In humans, though benefit has been shown in the treatment of RA, clinical trials of fish oil in the treatment of IBD and asthma are inconsistent and unable to show any evidence of efficacy.

NCCIH's opinion aligns with Calder's findings and comments on other potential indications (NCCIH, 2018):

- Fish oil may be useful to relieve symptoms of rheumatoid arthritis.
- Omega-3 supplements have not been shown to reduce the risk of heart disease. People who consume seafood regularly are less likely to die of heart disease.
- High-dose omega-3 supplementation may reduce triglyceride levels (included as an indication for prescription-only fish oil products).
- Omega-3s have not been convincingly shown to be beneficial in the treatment of age-related macular degeneration and many other conditions (NCCIH, 2018).

When used as directed, fish oil supplements are typically considered to be safe and well tolerated. Nonetheless, belching, bad breath, heartburn, nausea, loose stools, rash, and nosebleeds have been associated with their use. Further, at high-dose levels, fish oil may increase the risk of bleeding and stroke. Lastly, it is unclear if people with allergies to fish or shellfish can safely use fish oil (Mayo Clinic, 2017b).

Nursing consideration: There appears to be reasonable evidence that eating seafood confers some health benefits. It is not clear, based on research conducted to date, that all of these same benefits can be obtained by consuming fish oil supplements. As a result, nurses should discuss these potential differences with their patients. In any case, all patients will benefit with a shift to more healthy eating habits.

Case study 4

In preparation for Steve's appointment with his APN, he is completing a medication history with Nurse Jill. In the past, he has been taking a prescription omega-3 ethyl ester supplement (Lovaza) to help reduce his chances of suffering heart disease. Unfortunately, as a result of the COVID-19 pandemic, Steve has lost his job and is unable to afford COBRA health insurance and its pharmaceutical benefit. He was happy with how Lovaza was working for him and asks Jill if she can suggest a less expensive alternative. His clinical laboratory results indicate a total cholesterol level of 220 mg/dL, LDL-cholesterol of 80 mg/dL, and a triglyceride level of 612 mg/dL. He is not taking any other medications other than a daily multivitamin and suffers no outward medical conditions.

Self-Assessment Quiz Question #9

Identify the parts of Jill's potential response to Steve that are factually correct based on currently accepted use guidelines for fish oil:

a. She recommends an over the counter (OTC) fish oil product with a high concentration of omega-3 that is verified by the United States Pharmacopeia (USP) to help prevent heart disease.
b. She reviews with Steve the approved indications for Lovaza, noting that it is not indicated for prevention of heart disease and that there is not sufficient data to support this use.
c. Jill notes that his triglyceride levels are greater than 500 mg/dL, indicating that fish oil may be appropriate to treat that abnormality.
d. Both b and c.

Self-Assessment Quiz Question #10

Steve appreciated Jill's sharing information on the proper use of fish oil and wanted to consider using an OTC fish oil product in an effort to bring down his triglycerides. This might be effective, and it might be less expensive than paying cash for a prescription product. Nonetheless, before taking this to his APN, he asks Jill what he might expect as far as side effects. He had experienced fatigue when taking Lovaza and wanted to know if he should expect this to continue. Which of the following adverse events is known to be associated with the use of fish oil supplements?

a. Nausea.
b. Heart palpitations.
c. Unexplained weight loss.
d. Alopecia.

Conclusion

The National Center for Complementary and Integrative Health has issued several themes that summarize the material presented in this educational program (NCCIH, 2019):

- Dietary supplements contain many ingredients. Although solid clinical research has confirmed the value of some, others remain unproven.
- The safe use of supplements requires that users carefully read the labels' directions. It is also important to recognize that claims of natural sources do not always translate to safety. This is especially true in the case of herbal/botanical products that may contain multiple ingredients – some unknown.
- Supplement-food and supplement-drug interactions are always a possibility; some interactions pose significant risks. Further, the majority of supplements have not been adequately evaluated for safety in children or women who are pregnant or breastfeeding.
- Although FDA does provide some oversight of dietary supplements, the regulations are generally less rigorous than those used for prescription or over-the-counter medications.

Nursing consideration: The combination of dietary supplements' sometimes unknown pharmacology and safety liabilities may complicate the provision of healthcare, especially in pharmacotherapy. As a result, it is critical that nurses work with the healthcare team to obtain comprehensive medication histories to include dietary supplements.

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AN OVERVIEW OF DIETARY SUPPLEMENTS FOR NURSES

Self-Assessment Answers and Rationales

1. The correct answer is A.
Rationale: Vitamin B12 deficiencies are sometimes associated with pernicious anemia. Many times, people with this condition are unable to properly form red blood cells, and those that they do make may not function properly.

2. The correct answer is D.
Rationale: It is important to know that diagnostic reference ranges are designed to represent normal for most people. As such, it is always possible that some individuals may not fall within those standards. Because of this, clinicians must always rely on their experience and discretion, even in cases where the diagnostic data do not exactly align with what is expected. Secondly, it is important to acknowledge the amount of subjectivity involved in patient care. As a result, it may make sense to get a second opinion, especially in cases where the consequences of a misdiagnosis are great.

3. The correct answer is D.
Rationale: MegaRed, when taken at a maintenance dose of two to three tablets per day, is formulated to provide more than is needed to meet the nutritional needs of 97% to 98% of healthy adults for niacin, vitamin B6, and vitamin C. If two tablets are taken, it would provide 66% of the daily suggested vitamin A intake; three tablets would give 99%.

4. The correct answer is C.
Rationale: Vitamin A is a fat-soluble vitamin. As a result, in cases where excess is ingested, it is typically stored in fat cells, allowing potentially dangerous accumulation.

5. The correct answer is C.
Rationale: There is no compelling data to suggest that taking large doses of vitamin C will prevent a person from catching a cold. Nonetheless, some studies have provided evidence that vitamin C may be able to reduce the duration and severity of a cold.

6. The correct answer is A.
Rationale: All of the vitamins used to make MegaRed are readily available at relatively low cost. The manufacturer of this product has developed a proprietary formulation with desirable, but questionable, utility. Although the product likely does not intrinsically command such a cost, it seems possible that the manufacturer is creating an illusion of value by demanding an exorbitant cost. Gerri, on a student budget, could likely procure similar amounts of each ingredient individually at a lower total cost.

7. The correct answer is C.
Rationale: St. John's wort contains drug-like, pharmacologically active substances. As such, it should be afforded the same consideration as prescription medications. Like most medications, the occurrence of adverse events has been associated with the use of St. John's wort.

8. The correct answer is B.
Rationale: St. John's wort is known to sometimes interact with anticoagulant medications such as clopidogrel.

9. The correct answer is D.
Rationale: Although fish oil has historically been used for the prevention of heart disease, this indication is not supported by current clinical guidelines and is not an approved use of prescription fish oil products. Nonetheless, fish oil has been shown effective in the treatment of triglyceridemia and is indicated as such in the package insert for Lovaza.

10. The correct answer is A.
Rationale: The most frequently reported adverse events associated with the use of fish oil are belching, bad breath, heartburn, nausea, loose stools, rash, and nosebleeds. At very high doses, fish oil can lead to bleeding or the occurrence of stroke.

An Overview of Geriatric Care

2 Contact Hours

Release Date: April 18, 2020

Expiration Date: April 18, 2023

Faculty

Author: Ruth G. McCaffrey, DNP, ARNP, FNP-BC, GNP-BC, FAANP, FAA, has been a geriatric nurse practitioner since 1996. She has worked in primary and geriatric practices since that time. Dr. McCaffrey is a professor emeritus at Florida Atlantic University in Boca Raton, Florida, and retired from Mercer University in Atlanta. She directed the Doctor of Nursing Practice program at each of these institutions. In the area of research, Dr. McCaffrey has been involved in geriatric research involving exercise and mental health.

Ruth G. McCaffrey has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Reviewer: Fayron Epps, PhD, RN, has been a registered nurse for 20 years and is currently serving as an assistant professor at Emory University, Nell Hodgson Woodruff School of Nursing. Dr. Epps is an active member of numerous professional organizations. She currently serves on the Board of Directors for Southern Gerontological Society, Alzheimer's Association Georgia Chapter, and Meals on Wheels Atlanta. Her career goal as a nurse scholar is to promote quality of life for families affected by dementia through research, education, and service. Her program of research involves evidence-based practices for promoting quality of life for African Americans with dementia and their family caregivers. Dr. Epps has presented her research at local, regional, and national conferences. In addition, she has published in the *Journal of Religion, Spirituality & Aging, Geriatric Nursing, Journal of Gerontological Nursing, Research in Gerontological Nursing,* and *Research in Nursing and Health*.

Fayron Epps has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Learning objectives

Upon completion of the course, the learner should be able to:

- Describe the categories and signs of elder abuse and appropriate nursing responses.
- Describe age-related memory changes.
- Identify common chronic health conditions associated with aging and effective ways to prevent or cope with age-related disease processes to promote independence and quality of life.
- Identify end-of-life issues and the role of palliative and hospice care.

How to receive credit

- Read the entire course online or in print which requires a 2-hour commitment of time.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- Provide required personal information and payment information.
- Complete the mandatory Self-Assessment and Course Evaluation
- Print your Certificate of Completion.

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Activity director

June D. Thompson, DrPH, MSN, RN, FAEN, Lead Nurse Planner

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Introduction

One in six Americans is over the age of 65, and it is estimated that by 2060, one in four Americans will be over 65 (U.S. Census Bureau, 2017). The old-old, or those over 85, are the fastest growing segment of the U.S. population and are projected to grow from 6.4 million in 2016 to 14.6 million (a 129% increase) by 2040 (Administration on Aging, 2018). Older adults are responsible for 50% of hospital days, 60% of primary care visits, 70% of home care visits, and comprise 85% of nursing home residents (Administration on Aging, 2018). Many nurses who care for older adults have not been educated in geriatrics or gerontology (Koroknay, 2015). Older adults face complex physical and mental health needs that require nursing care specialized for these areas of complexity. Complex issues in caring for older adults include understanding chronic disease, functional health, cognitive health in the aging brain, and end-of-life decision making.

This course is meant to give nurses additional knowledge related to caring and advocating for older adults. As America and the world ages, it will be necessary for nurses and other health care providers to be competent in the care of elders. Progressing through this course, the learner will become aware of important issues in the care of older adults.

GENERAL ISSUES IN CARING FOR OLDER ADULTS

Functional status assessment

Functional disability is common in older adults. It can be episodic or an indication of health decline (Lesende, 2019). Functional status is defined as the ability to function in everyday life. Older adults' functional status greatly affects their quality of life, goals, expectations, and concerns (Cabrita, 2017). Many older adults report that living at the maximum level of independence and functioning at the highest level of their ability is more important than long life. Functional status can be measured by using physical tests, such as ability to walk distances; ability to complete activities of daily living, such as dressing, eating, and bathing; and measuring executive function, such as check writing and shopping. Functional status predicts mortality, health care costs, and nursing home placement. The effects of aging, illness, and treatment options on quality of life are essential for health decision making in the older adult (Cabrita, 2017).

Nursing consideration: Older adults often feel neglected while receiving care when nurses do not speak directly to them when asking questions, but rather speak to family members or friends about them. When asking history questions or assessment questions, nurses should face the older adult and speak slowly and loudly enough for them to hear so that they are able to communicate.

Sleep and exercise in the older adult

Sleep is essential for quality of life in the older adult. Many studies have demonstrated an association between adequate sleep and quality of life in older adults. Physical activity has been shown to improve sleep for older adults (Gothe et al., 2019). Physical activity in general has been shown to increase quality of life and increase mental and physical health (Kell & Rula, 2019). Many types of physical activities are available for older adults almost everywhere, including Silver Sneakers, the cost of which is covered by Medicare (Kell & Rula, 2019). Nurses working with older adults should encourage exercise to the level of the older adult's ability. Exercises recommended should coincide with functional status of the older adult and could include seated or standing exercise.

Medication for the older adult

Medication can affect older adults differently than younger adults. This is because of several issues, including decreased absorption from the GI tract, decreased elimination through the kidney and liver, and a slower metabolism in general (Naganathan, 2018). Michael Beers, MD, created a list of medications in 1991 that could be dangerous when prescribed to older adults. This list is updated by the American Geriatrics Society each year and should be used to determine safe prescribing for older adults (DeRhodes, 2019).

Health care providers as well as patients and families should be aware of the Beers list in order to protect their health and the health of family members. There are three distinct categories within the Beers list: medications to avoid in all older adults, medications to avoid in older adults with certain medical conditions, and medications that should be used cautiously with any older adult.

For example, antihistamines should always be avoided in older adults, including Benadryl and diphenhydramine, because they may cause dizziness, confusion, falls, and even delusions. NSAIDS should be used with caution because they can cause GI, renal, and liver damage in older adults, as well as dizziness and increased risk for falls. Benzodiazepines, including diazepam, should be avoided in older adults because they are more sensitive to the effects of these drugs, which may increase the risk of cognitive impairment, falls, and weakness. Estrogen in older adults raises the risk for heart attacks, strokes, breast cancer, and endometrial cancer. A list of medications that appear on the Beers list may be found at: https://www.pharmacist.com/beers-revised-drugs-not-use-older-adults

Evidence-based practice: When reviewing the Beers criteria for the use of medications in the elderly, it is important to remember that these recommendations list potentially inappropriate, not definitely inappropriate, medications. Individual needs and health must be factored into the decision for prescribing. When inappropriate medications are being used, it is best to offer safer nonpharmacologic and pharmacologic therapies (American Geriatrics Society, 2019).

Opioid use among older adults

There is much concern in the United States related to opioid use overall. A large study completed in 2018 found that older adult opioid users were most often female aged 70 to 75, White, with high income. Most common medical issues requiring opioids included back pain, other musculoskeletal pain such as osteoporosis, and sleeplessness (Musich et al., 2019). Although pain is a real problem in the elderly, opioid medications can lead to dementia, increased risk for falls, and general weakness that decreases functional status. It is important for all health care providers to provide pain management that lessens the use of opioids if possible. Some of these strategies include physical therapy and other types of medications.

Being aware of medication use of all types and assisting older adults and their families with medication choices and administration are essential components of patient care. Nurses should be knowledgeable and provide guidance to their patients and families while meeting the health care needs of the older adult.

All self-assessment answers and rationales are at the end of the course.

Self-Assessment Quiz Question #1

Mary Thompson is a 74-year-old woman who is in good health and comes in for her yearly physical. The only complaint Mary has is that she has trouble sleeping and often needs a nap during the day to "catch up" on her sleep. Which of the following recommendations would be suitable for Mary?

a. A prescription for Ambien so that she can fall asleep better.
b. Give her a benzodiazepine to help her sleep.
c. Tell her to take a walk every day and not to nap because it can disrupt sleep.
d. Tell Mary that nothing can be done for older women who cannot sleep. It is simply common and untreatable.

ELDER ABUSE

Elder abuse is a crime affecting older adults that is often overlooked, undisclosed, or unrecognized by the victim as a crime. About 11% of older adults experience some form of abuse each year, and many experience multiple forms of abuse (Williams et al., 2017). Elder abuse is often the result of stress on family members attempting to provide support for older family members. It is believed that fewer than 1 in 14 cases are reported to a public agency (Roberto, 2016). Several interacting factors may contribute to an older adult's vulnerability to abuse: age, gender, race, ethnicity, living arrangements, cultural beliefs and values, physical and cognitive impairments, social isolation, and loneliness (Roberto, 2016).

Because nurses often provide care for older adults in hospital, nursing home, and home health settings, it is important to include the possibility of abuse in any assessment of older adults. If elder abuse is suspected, the nurse should interview the individual privately, and if abuse is still suspected, immediately report it through the proper channels. Sometimes the older adult may not provide accurate data about abuse because of the potential for retribution or loss of current care. For example, if a child that is caring for an older parent is abusive, the parent may not want to share what is happening because it could lead to the child no longer wanting to provide care.

Gerhart's story

Gerhart, an 82-year-old man, has had a stroke. He has been unable to care for himself because of left-sided weakness and has been unable to walk. Gerhart lived alone until his stoke. His wife died four years prior. He has one son, and that son and daughter-in-law invited him to move in with them so that he could receive care. Neither Gerhart nor his son had the financial means to hire extra help for Gerhart. Both the son and wife work during the day and have two teenage children who are involved in many activities after school and in the evenings. Gerhart has become very sad because he feels that he has become a burden to his son and family and tries as best he can to take care of himself.

Frank, a friend of Gerhart's, comes to visit several months after he moved in with his son. He was hoping to cheer Gerhart up and perhaps talk about the "good old days." He is surprised to see Gerhart alone in the house dressed in a dirty shirt and pants that smell of urine. Frank's old friend has lost quite a bit of weight and has some sores on his feet and shins. Frank feels that Gerhart is depressed and withdrawn. He does not want to talk much and keeps repeating that he does not want to be a burden on his family. Frank worries that Gerhart's family is neglecting him.

Self-Assessment Quiz Question #2

Does this example rise to the level of elder abuse?

a. Yes
b. No

Self-Assessment Quiz Question #3

Gerhart's friend calls the son and tells him that he is concerned about Gerhart. The friend has looked up several agencies that would be helpful to this family in caring for Gerhart, and he presents them to Gerhart's son. Which of the following responses would indicate that the family is NOT neglectful in a purposeful way?

c. We are doing the best we can for Dad. Dad is never satisfied with what we do for him. He is a very difficult man and has always been that way. He was not a great father, so we do what we can.
d. We realize that we need help. It is very hard to care for Dad properly with both of us working and with the children to care for. Thank you so much for looking into these areas of assistance, we will call them right away. We want Dad to get the best care we can provide.
e. Do these agencies cost money? We don't have much extra money, and Dad's coming to stay with us has really been hard. You know we have children to send to college, and Dad has lived a good life.
f. If only my mother had lived longer. She always took good care of Dad, and we did not have to worry about him. We can't afford a nursing home for him, and we are just too busy to find out what services are available to help Dad. He will have to put up with us as we are.

Categories of elder abuse

Abuse includes not only physical injury but also not properly caring for older adults. Following are types of abuse as defined by the National Institute on Aging (2017).

Physical abuse

Physical abuse is defined as the willful, nonaccidental use of force to inflict pain, injury, impairment, or unreasonable confinement on an individual. Physical abuse or mistreatment typically includes hitting, slapping, beating, pushing, punching, shoving, shaking, kicking, pinching, and burning.

Neglect

Neglectful actions can be intentional or unintentional and may include failure to provide adequate nutrition, personal care, medications, medical attention, or a safe and well-maintained home or place to live.

Emotional and psychological abuse

This type of abuse is the intentional infliction of emotional anguish by verbal or nonverbal behavior that is commonly difficult to detect unless witnessed. Examples of psychological abuse include name-calling, making unkind remarks within earshot, threatening, insulting, humiliating, ignoring, isolating, and excluding from day-to-day activities (Roberto, 2016).

Financial exploitation

Financial abuse occurs when someone forces an older adult to sell personal belongings or property; steals money, pension, or other checks; or withholds money that the older adult needs for daily expenses. Theft, fraud, forgery, extortion, and the wrongful use of a power of attorney are also forms of financial abuse (Roberto, 2016).

Sexual abuse
Sexual abuse is defined as nonconsensual sexual contact with an older adult. Sexual contact with any person incapable of giving consent is also considered sexual abuse. This type of abuse includes unwanted touching, rape, sodomy, coerced nudity, and sexually explicit photography.

Signs of elder abuse

Following are the most common signs of abuse or neglect (National Institute on Aging, 2017):

- Trouble sleeping.
- Frequent crying that is not caused by cognitive impairment.
- Depression or confusion, ceasing to enjoy or take part in formerly enjoyed activities.
- Unexplained weight loss.
- Signs of trauma like rocking back and forth or becoming withdrawn.
- Agitated or violent behavior.
- Messy appearance, unwashed hair, or dirty clothes.
- Bed sores.

The following are warning signs that may point to any type of elder abuse (California Advocates for Nursing Home Reform, 2017):

- Caregiver history of alcohol or drug abuse.
- Caregiver not allowing the older adults to speak for themselves or to speak without the presence of the caregiver.
- Obvious lack of assistance by the caregiver.
- Threats, harassment, or insults and other aggressive activities by the caregiver.
- Caregiver indifference to the older adult.
- Anger by the caregiver toward the older adult.
- Conflicting accounts of problems and accidents in the older adult.

Barriers to reporting elder abuse

A review of the literature has identified the following barriers to reporting elder abuse (Olomi et al., 2019). Nurses should review these common barriers and reflect on how to properly overcome them in order to report elder abuse.

- Lack of confidence in defining, identifying, and reporting abuse.
- Reluctance to report abuse unless there is certainty that abuse had occurred.
- Concern for the therapeutic relationship.
- Potential consequences for the victim.
- The risk of a long judicial process.
- Empathy with the abuser.
- A lack of screening procedures.
- Not having clear definitions of abuse.
- Shortages of available interventions for the abused and abusers.
- Perceptions regarding the intent of the perpetrator.
- A lack of training.
- A lack of time.
- The victim's health.
- Inability or unwillingness of victims to report their situation.
- Absence of clear legislation.
- Ignorance of laws concerning abuse.
- Not knowing where or how to report.
- A lack of protocols.
- Ethical dilemmas and paradoxes posed by reporting.
- The belief that abuse is a private family matter.
- Insecurity about whether the informant will be protected.

Strategies for managing elder abuse

Strategies for managing elder abuse and neglect must balance older adults' needs for safety against their need for autonomy and independent decision making. Teaching older adults what abuse is and that they do not need to tolerate it is the first step in stopping it. Health care professionals who work with older adults in all settings should be alert to signs and symptoms of elder abuse and know where to report and refer patients if elder abuse is suspected.

State legislation addresses specific elder abuse statutes for community and institutionalized older adults. Many policies and procedures exist to promote documenting, reporting, and treating elder mistreatment or abuse.

The following are ways for either the victim or the health care provider to report suspected abuse:

- Call the abuse hotline listed in the telephone directory.
- Notify the individual in the agency or facility, usually a social worker or administrator, who has been delegated the responsibility of handling abuse problems.
- If immediate danger is suspected, call 911.
- Contact a state agency such as adult protective services for assistance.

NORMAL AGING

The brain is made up of billions of cells called neurons that communicate with each other through small gaps called synapses. This communication is aided by chemical substances known as neurotransmitters. Memory depends on healthy neurons, but it is normal for neurons to die and decline in numbers during a natural life course. Memory peaks between ages 20 and 30, followed by a subtle decline until age 60, when memory difficulties become more pronounced simply because of aging. Although memory changes are associated with normal aging, the ability to learn new things does not decline. The health care professional should help older adults understand that simple memory loss is a normal aspect of aging and that they should not worry that they are experiencing cognitive decline.

All body systems become less efficient and slower with age, and so do thinking, problem- solving abilities, speed of learning, and recall. For most people, it is normal to require more time to learn new things, solve problems, make decisions, and retrieve information. Memory does not necessarily fade with age; it just takes longer for the neurons to communicate with one another. As a person ages, the ability to concentrate declines, distractions are more difficult to ignore, and interruptions may cause forgetfulness. Older adults also are slower to identify and comprehend incoming stimuli.

Memory cues and aids are often helpful when older adults attempt to retrieve information from memory. A cue can be a word, picture, smell, rhyme, or anything associated with information or events to be remembered. Encourage older adults to use memory cues such as lists, calendars, and electronic devices such as cell phones and computers.

Self-Assessment Quiz Question #4

Thomas Moore and his daughter meet with his nurse because they are concerned about Thomas's forgetfulness. He has lost his car keys in his house twice in the last two weeks; he put his hat in the refrigerator two days ago and could not find it. He is able to answer questions accurately and has had no problems with driving. What should the nurse tell Thomas and his daughter?

a. That he should receive neuropsychological testing for dementia.
b. That he might have delirium and should be checked for infections.
c. That he needs to be enrolled in a memory day care program for the elderly with dementia.
d. That his forgetfulness is most likely not dementia but normal changes that come with aging.

Current estimates suggest that more than 5.8 million Americans have some form of dementia, and that number could grow to 16 million for Alzheimer's disease alone by 2050 unless a cure is found (Alzheimer's Association, 2020). Nearly 50% of those older than age 85 have dementia (World Bank, 2017). More than 70% of people with dementia live at home (Alzheimer's Association, 2020). Alzheimer's can be a devastating diagnosis for older adults who fear loss of memory and cognitive deterioration. Many older adults worry that their forgetfulness is the first sign of dementia and assume that changes in memory mean that they have dementia. Because of the expense and time needed, many older adults who exhibit cognitive changes are not evaluated (United States Preventive Services Task Force [USPSTF], 2020). Families often simply feel that their loved one has dementia. Medicare allows for a yearly memory screening during the annual health visit; however, there is controversy about whether this minimal screening is appropriate or whether it unnecessarily increases concerns among older adults and their families (USPSTF, 2020) However, there are many reasons for memory changes besides dementia: some changes are normal, some indicate progressive diseases like Alzheimer's but others may be caused by a condition that can be treated and reversed.

The stages of Alzheimer's disease

Dementia typically progresses slowly in three general stages: mild (early stage), moderate (middle stage), and severe (late stage). Dementia affects people in different ways. Each person will experience symptoms and progress through dementia stages differently (Alzheimer's Association, 2020).

Warning signs of dementia

Warning signs of dementia differ from the typical signs of aging (Alzheimer's Association, 2020):

- Memory changes that disrupt daily life.
- Challenges in planning or solving problems.
- Difficulty completing familiar tasks at home, at work, or at leisure.
- Confusion over time or place.
- Trouble understanding visual images and spatial relationships.
- New problems with words in speaking or writing.
- Misplacing things and losing the ability to retrace steps.
- Decreased or poor judgment.
- Withdrawal from work or social activities.
- Changes in mood and personality.

Diagnosing dementia

A diagnosis of dementia is never made based on memory loss alone. Several memory screenings tools (Mini-Cog, Clock Drawing Test [CDT], and Mini-Mental State Examination [MMSE]) are available for the Medicare annual wellness visit. Additionally, the patient's primary care provider should conduct a complete physical workup. The examination performed should evaluate any physical, emotional, or psychosocial causes for the cognitive impairment, as well as to determine if dementia is present and, if so, what type of dementia is present. Because dementia can have many different causes—with many different types of treatment—an accurate diagnosis is essential. Labs such as vitamin B12 and folate tests are ordered to rule out pernicious anemia and folate deficiency. If either are suspected, human immunodeficiency virus testing, drug screening, and toxin screenings are then performed. Serological tests might be done for syphilis. Brain imaging techniques such as a computed tomography scan or magnetic resonance imaging may be ordered to rule out the presence of tumors, stroke, blood clots, or other factors. An electroencephalogram is performed if a seizure disorder is suspected. Often a more intensive diagnostic evaluation is needed with the help of a neurobiologist, a neurologist, a psychiatrist, and other specialists.

Prevention

The key to maintaining brain health is a healthy lifestyle (Alzheimer's Association, 2020). Older adults can be taught how to keep their brains healthy. Research on whether exercising the brain with puzzles, games, discussion groups, and writing keeps it healthy has yielded mixed results. It does appear, however, that although these types of brain exercises may not prevent dementia, such activities may delay the onset (Baretto et al., 2018).

Self-Assessment Quiz Question #5

Nancy Knowlton has received a diagnosis of early Alzheimer's dementia. She has moved in with her daughter and family. They are concerned because, since moving in with them, she has left the house without telling them and wandered until a neighbor was able to bring her home. She also left a pot on the stove after all the water boiled away, and the pot melted from intense heat. Nancy's daughter and her husband are concerned about leaving Nancy alone all day while they are at work. They do not want to put her in a nursing home because most of the time she is fine at home. What are some suggestions that could be provided to this family to keep Nancy safe and protect the quality of life for all three?

a. Put Nancy in a nursing home where she can be watched. Nancy will only get worse, and this is the inevitable ending for her, so doing it now might be easier on everyone.
b. Assist the family to find an adult day care center where Nancy can go during the day and be with others and participate in activities that might help her memory while keeping her safe.
c. Put up barriers so Nancy cannot get into the kitchen. Leave snacks and lunch in another room for her, and keep all doors locked.
d. Put cameras throughout the house so Nancy can be watched from where they work.

Differences between delirium and dementia

Delirium is usually caused by an acute illness or drug toxicity that causes a disturbance in cognition and consciousness level. Delirium usually develops suddenly and is often found in hospitalized patients who also have cognitive impairment (Merck Manual Professional Version, 2020). Although delirium can be life-threatening, it also can be completely reversed by treating the disease or reversing the drug toxicity. Major causes of delirium are infection, often urinary tract infection; dehydration; isolation; and anticholinergic, psychoactive, or opioid drugs. Delirium is characterized by difficulty focusing, maintaining or shifting attention, loss of consciousness, inappropriate behavior, paranoia, poor judgement, and hallucinations.

Dementia, on the hand, is typically caused by an anatomic change in the brain. It is characterized by a slower onset and deterioration of cognition over time and is not reversible. Most people think of Alzheimer's disease as the major cause of dementia. However, dementia can occur in patients with Parkinson's disease, Huntington's disease, and other disease as well as with brain tumors and traumatic brain injury. Dementia usually begins with mild cognitive impairment where cognitive functions are worse than age-matched healthy patients. Up to 50% of patients with mild cognitive impairment develop dementia within three years (Merck Manual Professional Version, 2020).

Factors that can cause problems for both delirium and dementia patients include visual defects not corrected with glasses, hearing deficits not corrected, inadequate sleep, pain, and underlying emotional problems such as depression (Wilson et al., 2018).

Medications that cause worsening delirium or dementia include anesthesia for surgery, anticholinergic drugs such as tiotropium (Spiriva), oxybutynin (Ditropan), flavoxate (Urispas), and diphenhydramine (Benadryl). Benzodiazepines also cause worsening dementia, especially longer active benzodiazepines such as Valium.

Self-Assessment Quiz Question #6

Norma Joseph brings her mother into the office because she could not recognize her daughter and her home yesterday. She was crying saying, "Where am I?" Until yesterday she seemed fine and was not having any mental issues. Her crying and confused behavior continues today and her daughter wonders if her mother has dementia or Alzheimer's disease. Norma's mother does not know where she lives or what day it is and is afraid of her daughter, who she says she has never seen before. The nurse knows the family well. What is her diagnosis?

a. Organic brain syndrome.
b. Delirium.
c. Dementia.
d. Schizophrenia.

DEPRESSION

Depression is one of the most common mental health problems among adults but is not a normal consequence of aging (Centers for Disease Control and Prevention [CDC], 2017a). Estimates of major depression in older adults living in the community range from less than 1% to about 5% but rise to 13.5% in those who require home health care, and to 11.5% in those hospitalized (CDC, 2017a). Depression often goes undiagnosed and therefore untreated or undertreated, especially in older adults (Mayo Clinic, 2016; Palinkas et al., 2019). Depression is often missed in older adults because they may exhibit nonspecific somatic complaints rather than the symptoms of depressed mood as classified by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). Nonspecific somatic complaints that actually might be depression include increased fatigue, heaviness, grumpiness, a churning feeling, difficulty digesting food, and even pain. There may be a change in appetite or sleeping patterns (National Institute of Mental Health [NIMH], 2016a, 2016b).

Depression may be associated with adverse effects of medications or even certain medical conditions. Depression may be caused by such psychological conditions as coping with chronic illness, pain, and even gloomy environments, as well as an assortment of losses, including losses of function, independence, social roles, friends and relatives, and past leisure activities (NIMH, 2016a, 2016b). Coping with chronic illness, disabilities, and losses often results in minor depression, which may in itself become chronic (NIMH, 2016a).

Some older adults with depression may appear to have dementia, showing signs of confusion, inattention, and memory difficulties. For some, there may be a family or past personal history of depression. Others may become depressed after losing a loved one, developing a serious illness, experiencing the serious illness of a loved one, or from the stress of being a caregiver. Some people become depressed for no clear reason.

Depression should be aggressively treated in older adults because untreated depression can lead to a decline in functional states and even death (Frost et al., 2019). Depression is associated with increased falls, increased fatigue, poor sleep, cognitive changes, cardiovascular disease, and increased pain (Magnuson, 2019). Often the first sign of depression is anhedonia, or the lack of ability to feel happy and joyous. One of the best questions to begin a dialogue about depression is, "In the last week, what made you happy?" (Domenech-Abella et al., 2017). Often family members will notice the change in their loved one before the elder does themselves. There are several scales that can measure depression in older adults, including the Geriatric Depression scale (Sheikh & Yesavage, 1986). This scale is short and has been validated with different groups of elders as identifying levels of depression.

Following are the most common signs of depression (NIMH, 2016b):

- Ongoing sadness, an empty feeling, or anxiety.
- Being tired, easily fatigued, exhausted, or lacking in energy.
- Loss of interest in everyday things.
- Difficulty sleeping or sleeping too much.
- Loss of appetite or overeating.
- Crying too often or for no reason.
- Aches and pains that do not respond to treatment.
- Difficulty focusing, paying attention, making choices, or remembering.
- Feeling helpless, hopeless, or suffering a loss of self-esteem.
- Grumpiness or irritability.
- Thoughts of death or suicide.

Treatment options include pharmacotherapy, support groups or counseling, increased opportunities for socialization, and—for more severe depression—electroconvulsive therapy. Family support, patience, and understanding are also critical.

Prevention

Although depression cannot always be prevented, older adults can take some approaches to lessen the risk (Krans, 2017):

- Plan ahead for known changes such as retirement or moving.
- Keep in touch with old friends and family members.
- Take time to develop hobbies.
- Let someone know if they are feeling sad, upset, or stressed.
- Exercise: choose an activity that they enjoy such as walking in the mall, gardening, dancing, or biking.
- Eat a balanced diet to optimize wellness.
- Maintain a healthy weight; being overweight causes fatigue and sluggishness.
- Manage their chronic conditions by following the advice of their health care professional.

Depression should not be dismissed as a natural consequence of the physical, cognitive, social, and economic problems of later life. The health care community can help older adults by preventing and treating depression so that older adults feel satisfied with their lives.

Self-Assessment Quiz Question #7

Bill Ashburn, an 80-year-old man, comes to discuss his fatigue and headaches. In the nurse's discussion with Bill, she discovers that he has just lost his best friend of many years. When the nurse asks him about what made him happy in the last month, he says that he never feels happy. He says that it is hard for him to get out of bed in the morning. What should the nurse do next?

a. The nurse diagnoses depression (situational) and tells Bill that this is a natural response to the death of his friend and other aspects in his life. The nurse tells him that an antidepressant may help both the fatigue and headaches. The nurse has him come back to the office two weeks after starting the antidepressant.
b. The nurse tells Bill that he may be having migraines and that she will prescribe a medication to stop the headaches, which may also help the fatigue.
c. The nurse sends Bill to see a psychiatrist for help with his symptoms.
d. The nurse gives Bill pain medication for his headaches and tells him to rest as much as he needs to.

Evidence-based practice: Research has uncovered encouraging evidence for the antidepressant effect of aerobic, resistance, or mind-body exercise as an effective treatment adjunct for older adults presenting with clinical depression. Health care providers should encourage older adults with depression to participate in exercise to the extent they are able in order to improve symptoms of depression (Miller et al., 2020).

MEDICAL CONDITIONS THAT IMPACT THE OLDER ADULT

Cancer

Cancer is more likely to occur in older adults than in younger persons. Although the chances of surviving cancer are improving, cancer is the second leading cause of death for older adults (Zaorsky et al., 2017). The key to surviving cancer is early detection and treatment. Older adults may reduce their risk for dying of cancer by living a healthy lifestyle, being aware of warning signs of cancer, and having regular medical checkups.

Following are common signs and symptoms of cancer (American Cancer Society [ACS], 2019):

- Changes in bladder or bowel habits, including frequency and consistency.
- A sore on the body that does not heal.
- Unusual bleeding or discharge from any part of the body.
- A lump or thickening in the breast or any other body part, including the mouth, testicle, or throat.
- Difficulty swallowing or persistent indigestion.
- An obvious change in a wart, mole, freckle, or other skin spot.
- Hoarseness or a nagging cough.
- Unexplained weight change.

Having one of these symptoms does not necessarily mean that the individual has cancer; however, it is important to consult a health care professional to determine the cause. Many older adults simply disregard these symptoms as normal aging changes. Fear and misinformation may also cause older adults not to seek medical attention. Most cancers do not cause symptoms in the early stages and routine screenings are the best method for detecting cancer before an older adult notices symptoms. Medicare now covers most of the screening tests for cancer.

Teaching older adults to watch for warning signs may help them detect possible cancers while they are still in early stages. Early detection often allows for more treatment options and better outcomes.

Hearing loss

Hearing loss is extremely common in the older population, especially among men. One-third of adults between the ages of 65 and 74, and one-half of those older than age 75 have hearing loss (National Institute on Deafness and Other Communication Disorders [NIDCD], 2017). Yet among adults age 70 and older who could benefit from hearing aids, only one-third have used them (NIDCD, 2016). Hearing loss impacts socialization and relationships. It can lead to the avoidance of social events and the appearance and feeling of being cognitively impaired. Some older adults are not aware of their impairment, and many are reluctant to report any problems or obtain treatment. Older adults with hearing loss may feel embarrassed, upset, and lonely. The hearing impairment causes frustration among everyone who comes into contact with the person—spouse, family members, and friends. Patients who acknowledge a hearing loss should be referred to an audiologist for complete assessment and determination as to whether a hearing aid could help. For patients who do not admit to a loss or who cannot get treatment, the health care professional needs to use good communication skills and ensure that the patient understands what is being said.

The following are common signs of untreated hearing loss (NIDCD, 2017; University of California San Francisco Medical Center, n.d.):

- Missing parts of conversations and continually asking people to repeat themselves.
- Experiencing loss of high and low tones, no longer able to hear birds singing.
- Turning the television, radio, or telephone volume up high.
- Being unable to distinguish speech from background noises and being unable to follow dinnertime conversation while others are talking or music is playing.
- Straining to read lips and facial expressions.
- Having difficulty hearing on the telephone.
- Having difficulty following a conversation when two or more people are speaking.
- Misunderstanding what people say.
- Accusing others of mumbling.
- Agreeing or nodding the head during conversations when the person is not sure what has been said.

Hypertension

High blood pressure, also called hypertension, is known as the "silent killer" because the symptoms cannot be felt or seen. Hypertension is a major health problem that, left untreated, leads to cardiovascular accidents, heart disease, eye problems, peripheral vascular disease, and kidney failure. Controlling blood pressure is extremely important to healthy aging.

To help the patient understand, prevent, and control high blood pressure, the health care professional needs to make the following points (Whelton, 2017):

- Be aware that even though high blood pressure may not make a person feel sick, it is serious.
- It is possible to lower blood pressure with lifestyle changes.
- If taking medications that have brought blood pressure under control and asked about high blood pressure, say, "Yes, I have hypertension, but it is under control."
- Maintain a healthy weight; being overweight is a significant risk factor in hypertension.
- Exercise daily, trying for at least 30 minutes per day, five days per week.
- Maintain a healthy diet that includes fruits, vegetables, and fiber, and limit fat intake.
- Cut back on salt and sodium intake.
- Avoid alcohol or limit alcohol intake to one drink per day.
- Follow the health care professional's recommendations for control of hypertension.
- Take hypertension medications exactly as prescribed, and do not stop taking them when feeling well. Take medications at the same time every day.
- Test blood pressure between office visits. Most pharmacies have free blood pressure machines, and home blood pressure devices are reasonably priced and easy to use. Keep a record of results to share with the physician. People older than age 60 should keep their blood pressure lower than 150/90. For patients with certain chronic health conditions or who have comorbidities such as diabetes and kidney disease, a blood pressure lower than 140/90 is ideal.

Exercise, diet, and medications should be employed aggressively to control and maintain hypertension in older adults. Effective management may prevent disability, cognitive decline, and mortality.

Osteoporosis

Osteoporosis is another of the "silent diseases" because bone loss occurs without symptoms. People may not know that they have osteoporosis until their bones become so weak that a sudden strain, bump, or fall causes a fracture, most commonly of the hip, backbone, or wrist. Osteoporosis has reached epidemic proportions in the United States. It is estimated that 54 million Americans have low bone mass, placing them at increased risk for osteoporosis (American Family Care, 2018). Approximately 80% of these people are women older than age 50. Although osteoporosis occurs primarily in women, men over 70 are also at high risk for osteoporosis.

The following are teaching points for keeping the bones healthy (National Institutes of Health, 2018):

- Do weight-bearing exercises at least five times per week.
- Get 1,200 mg of calcium every day. Foods high in calcium include low-fat dairy foods, leafy green vegetables, and fortified foods such as orange juice. Calcium supplements may also be required.
- Get the recommended daily doses of vitamin D from sun exposure or from eggs, fatty fish, and fortified milk. Vitamin D supplements may also be required.
- Avoid smoking and limit alcohol intake.
- Take any prescribed bone loss prevention medication exactly as directed.
- Practice safety measures in and around your home and community to prevent a fall.

Osteoporosis is preventable and a person is never too old to start preventive measures. The health care professional should encourage older adults to implement lifestyle habits that will strengthen their bones and help prevent fractures.

Evidence-based practice: Current osteoporosis medications reduce fractures significantly but have rare and serious adverse effects that may limit their safety for long-term use. New drugs using monoclonal antibodies and parathyroid hormone-related peptide analogs have had better results with fewer complications. On the horizon is the potential for cell-based therapies and drugs that target the elimination of senescent cells in the bone microenvironment (Cheng et al., 2020).

Osteoarthritis

Osteoarthritis is a noninflammatory, progressive, degenerative disorder of the movable weight-bearing joints. It is the most common rheumatological disorder and overall the most common disease in humans (Levenson, 2017). It is estimated that 27 million Americans are affected by osteoarthritis (Arthritis Foundation, n.d.). The prevalence among men and women is equal (Arthritis Foundation, n.d.). In addition to age, risk factors include joint injury, obesity, and mechanical stress.

The most common signs and symptoms are stiffness after a long period of immobility; morning stiffness; joint pain that occurs with activity; limitation of movement; crepitus; aching or nagging discomfort, usually experienced with motion, weight-bearing, or activity; and "flare-ups" of the disease that are associated with the use or abuse of the joint or trauma and are commonly relieved with rest.

The major goals of treatment are preservation of function, reduction of pain, and minimization of further damage to involved joints. Pain is generally treated with acetaminophen, nonsteroidal anti-inflammatory drugs, and sometimes opioids. Health care professionals need to work with patients on prevention and management by stressing the following (Arthritis Foundation, n.d.):

- Prevention of falls and injuries.
- Encouragement of low-intensity exercise.
- Encouragement of weight loss if the patient is over the ideal body weight
- Education concerning use of pain medications as prescribed.
- Encouragement of use of assistive devices such as canes or walkers, or gripping and grabbing tools.

Stroke

Cerebrovascular accidents are a leading cause of disability in the United States (CDC, 2017b) and the fourth leading cause of death (Heron, 2016). A transient ischemic attack (TIA) is sometimes called a little stroke, but it is actually a precursor to a cerebrovascular accident (CVA), also known as a stroke. A TIA may be recognized by focal neurological signs that occur suddenly, last a short time, and resolve completely within 24 hours. Most TIAs are caused by partial blockage of arteries in the neck. A small blood clot may lodge in a carotid artery and temporarily prevent blood flow to a part of the brain. As blood flow is restored, the symptoms disappear without permanent damage.

Symptoms of a TIA vary from person to person but generally include blurred vision or speech, flashes of light, migraine, vertigo, facial weakness, confusion, and ataxia. Patients experiencing a TIA should be evaluated in an emergency room so that a disabling stroke may be prevented by medications or a carotid endarterectomy.

A CVA is an emergency, and all older adults should be aware of the warning signs and know to call 911 right away. Increasing people's knowledge of the signs of stroke is one of the goals of the American Stroke Association. In conjunction with the American Heart Association, the American Stroke Association has launched a campaign that teaches people to use the word FAST as an acronym to identify signs of a stroke and seek emergency help (American Heart Association/ American Stroke Association, n.d.).

Face drooping.
Arm weakness.
Speech difficulty.
Time to call 911.

Here are additional warning signs (American Heart Association/ American Stroke Association, n.d.):

- Sudden numbness or weakness in the face, arm, or leg, especially if it is on one side of the body only.
- Sudden confusion, difficulty speaking or understanding, or slurred speech.
- Sudden problems with vision in one or both eyes.
- Sudden dizziness, loss of balance or coordination, or difficulty walking.
- Severe sudden headache with no known cause.
- Inability to smile fully.
- Inability to raise both arms equally.

Urinary incontinence

Although the occurrence of urinary incontinence increases with age, it is not a normal part of the aging process. Urinary incontinence is associated with skin irritation, urinary tract infections, and falls. It can lead to embarrassment, withdrawal from social life, depression, and loss of self-esteem. The person may restrict or avoid entirely activities outside the home, interaction with friends and family, and sexual activity. Urinary incontinence has significant physical, psychological, social, and economic consequences for older adults. Incontinence may occur for many reasons, some of which are temporary, as from a urinary tract or vaginal infection, constipation, certain medications, or an extended respiratory infection or cold with frequent coughing or sneezing. Some incidences of incontinence result from longer-lasting problems such as a weak bladder muscle, an overactive bladder, or nerve damage from diseases such as multiple sclerosis or mobility problems. Most incontinence can be treated and controlled, and sometimes cured. Older adults with urinary incontinence should seek the help of a primary care provider who may perform a number of tests, including urine and blood tests and bladder emptying tests. The health care professional may ask the patient to keep a daily diary of urination and leakage.

Health care professionals can recommend the following techniques to control incontinence (National Institute on Aging, 2019):

- Use habit training or timed voiding for urge incontinence. This is done by first keeping a diary of when the urge to void occurs. Making this determination can allow the bladder to be emptied before leakage takes place.
- People with cognitive deficits benefit from prompted voiding. Assist with toileting every two or three hours.
- Perform Kegel exercises for urge, stress, and mixed incontinence.
- Modify the environment for functional incontinence, including adequate lighting, altered clothing, or adaptive equipment.
- Provide a substitution such as a bedpan, bedside commode, or urinal for functional incontinence.
- When attending social events, be aware of the location of bathrooms and do not wait for intermissions to void because there may be long lines.
- Use absorbent undergarments, which are designed not to feel wet or bulky. There are many types, ranging from small stick-on pads to underwear replacements.

For older adults who do not respond to these interventions, surgery, biofeedback, medications, implants such as pessaries, and other devices may be appropriate.

Self-Assessment Quiz Question #8

Sally Gill is a 78-year-old woman who has urinary incontinence. She says that she no longer goes to the mall with her friends because she cannot be sure that she will not have an "accident." What can the nurse tell Sally to help with this problem?

a. She should just invite her friends to her house instead to avoid an accident.
b. She should just tell her friends about her situation and not worry about accidents. They will understand.
c. She should see a surgeon to see if there is a surgical fix for her incontinence.
d. She should go to the bathroom every hour whether she needs to or not—this includes while she is at the mall. That will reduce the accidents.

Palliative care

Palliative care aims to improve the lives of patients of all ages who are facing the challenges of life-threatening illnesses (World Health Organization [WHO], n.d.). Palliative care provides prevention and relief of suffering; early identification; holistic assessment and treatment of pain; and support for physical, psychosocial, spiritual, and bereavement issues (WHO, n.d.).

WHO highlights improvements palliative care can make to a patient's quality of life (WHO, n.d.):

- Provides relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten nor postpone death.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Offers a support system to help the family cope during the patient's illness and in their bereavement.
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated.
- Enhances quality of life and may also positively influence the course of illness.
- Is applicable early in the course of illness in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care can and should be initiated early in the trajectory of a life-threatening illness. Provided along a continuum that includes death, palliative care promotes and improves quality of life for those with a diagnosis of serious illness but who will fully recover, for those with advanced illness who may live long but will likely die from the disease, those who are very ill and will die shortly, and those who are dying (National Institute on Aging, 2017b). Care is comprehensive and holistic; centers on physical, psychosocial, and spiritual issues; and continues into the bereavement period. Palliative care helps patients and their family members handle the difficulties related to life-threatening illness. Consequently, the patient and the family comprise the unit of care.

Hospice care

The term "hospice" dates back to medieval times and refers to a place where travelers and people who were sick found a comforting setting for rest (American Cancer society, 2019). Hospice uses an interdisciplinary team of professionals to address the physical, spiritual, and psychosocial needs of dying persons and their families (Hospice Foundation of America, 2019). Hospice care is different from palliative care, as it begins with a referral from a health care provider who determines that a patient has six months or less to live, who is rapidly declining despite medical treatment, and is ready to live more comfortably and forego treatments aimed at prolonging life.

Hospice philosophy and central principles are as follows (American Cancer Society, 2019):

- Hospice is a philosophy focusing on end-of-life care; it is not a place.
- The philosophy of hospice affirms life instead of death.
- Hospice works to make quality of life as good as it can be.
- Hospice cares for the family as well as the patient.
- Hospice care is holistic.
- Hospice continues to support family members even after the death of their loved one.
- The hospice approach relies on interdisciplinary teamwork to provide both professional skills and a human presence.
- Hospice services are available around the clock, seven days a week.
- Hospice program participants support each other.
- The hospice philosophy is widely applied to various individuals and their family members who are coping with a life-threatening illness, dying, death, or the aftermath of the death of a loved one.

Self-Assessment Quiz Question #9

Frank Lehner has lung cancer. His health is declining rapidly, and his health care providers want to order hospice services. The family is skeptical because they believe they will not treat their dad and granddad and may even hasten his death. What would be the nurse's best response to their concerns?

a. Hospice affirms life instead of death. They will do whatever is necessary to keep Frank pain free, feeling positive, and able to communicate with family and friends. Although they will no longer attempt to combat the lung cancer, they will provide care for any other issues Frank has, such as fatigue, pain, or urine output.
b. Explain to the family that death is an inevitable part of life, and they will have to face it together. Hospice can help them face death and understand the medical issues that are facing Frank at this time.
c. Hospice will assist the family to make arrangements once Frank has passed, and this will be a comfort to them. It is best to have hospice once health care providers are unable to do more to cure Frank.
d. Maybe hospice can wait if you are not sure. It may hasten your father's death, and if that is not what you want, you have to make your choice.

Self-Assessment Quiz Question #10

Joe McCarthy has COPD. It has become very difficult for him to continue his activities of daily living with his shortness of breath. Joe is angry at himself for continuing to smoke after his health care provider encouraged him to stop. He is also having difficulties in his relationships with his children. His primary care office offers palliative care, and at his visit today his health care provider suggests that perhaps the palliative care team should be consulted. Joe asks if this means he is dying. Which is the best answer?

a. Joe is dying, and it is best to face that fact head-on rather than mislead the patient. The palliative care team will prepare him for his death.
b. Joe does not need palliative care because he has not been designated as within six months of death. He could live more years, so he is not really eligible for palliative care.
c. Palliative care coordinates an interdisciplinary team to assist Joe to meet all of his needs during this time. The team will most likely increase his quality of life and may prolong his life.
d. Joe could choose palliative care, but there is no proof that it is of any benefit.

Conclusion

This course has provided information about common health issues and concerns that older adults are likely to encounter. It is important for nurses to be aware of the factors that interfere with successful aging and the factors that encourage a healthy lifestyle. It is important for nurses to understand how elder abuse takes place, recognize its signs, and educate their patients on this subject. Screening for age-related memory changes and other chronic medical conditions is also important in promoting healthy aging and quality of life for older adults.

The goal of hospice and palliative care is to reduce patients' distressing symptoms (physical, emotional, and spiritual) and improve their quality of life. Making appropriate and timely referrals for hospice and palliative care is one way that nurses can prevent needless suffering for patients with life-threatening conditions and assist their patients in addressing end-of-life issues.

Nurses continue to play an ever-expanding role in educating older adults and their families on daily habits that contribute to healthy aging and encourage healthy behaviors, and in offering valuable information and suggestions to address issues related to end-of-life care..

Resources

- Alzheimer's Association: https://www.alz.org
- Alzheimer's Foundation of America: https://www.alzfdn.org
- American Academy of Hospice and Palliative Medicine: https://www.aahpm.org
- American Cancer Society: https://www.cancer.org
- American Society of Hypertension: https://www.ash-us.org
- American Stroke Association: https://www.strokeassociation.org
- Arthritis Foundation: https://www.arthritis.org
- CaringInfo (National Hospice and Palliative Care Organization): https://www.caringinfo.org/i4a/pages/index.cfm?pageid=1
- Center to Advance Palliative Care: https://www.capc.org
- Centers for Medicare and Medicaid Services: https://www.medicare.gov
- Elisabeth Kübler-Ross Foundation: https://www.ekrfoundation.org
- Growth House (educational materials and resources concerning end-of-life care): https://www.growthhouse.org
- Hospice and Palliative Credentialing Center: http://virtualex.nhpco.org/user/view.php?id=607
- Hospice and Palliative Nurses Association: https://advancingexpertcare.org
- Hospice Association of America: https://www.hospice.nahc.org
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AN OVERVIEW OF GERIATRIC CARE

Self-Assessment Answers and Rationales

1. The correct answer is C.
***Rationale**: Both Ambien and benzodiazepines are on the Beers list of drugs to avoid for older adults. These medications could put Mary at higher risk for falls and other complications. There are things that can help Mary sleep. Gentle exercise during the day and avoiding naps are both helpful for people who have difficulty sleeping.*

2. The correct answer is B.
***Rationale**: This is a tricky question. The family is doing the best they can; however, it is obvious Gerhart's needs are not all being met. CDC describes neglect as a form of elder abuse if it is a failure by a caregiver or other responsible person to protect an elder from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health and safety. It would be better to side with yes, especially because of the sores and weight loss as well as the depression.*

3. The correct answer is B.
***Rationale**: This answer demonstrates that the family is not mindfully neglecting their father but are simply overwhelmed with his care and unaware that there is help for them in this situation. The friend is also doing what is right by helping them find appropriate services for their dad rather than simply saying they are abusing him. Answer "a" would show that the family does not really care about their father and neglects him. This answer shows that they do not really understand the level of care needed by their father.*

4. The correct answer is D.
***Rationale**: Thomas is most likely experiencing the normal aging brain. Forgetfulness of simple things is common as we age. It is important to reassure both Thomas and his daughter about the common changes in the aging brain and the signs of more serious mental issues like dementia so that they are not overly concerned.*

5. The correct answer is B.
***Rationale**: It is not necessary to put Nancy in a nursing home now, even though that might be necessary down the road. Barriers can be overcome, and Nancy may find other ways to put herself and the house in danger. Cameras might not alert Nancy's daughter or husband in time for them to get home and get her back to safety. Adult day care centers would provide stimulation and like-minded people for Nancy to be with, as well as keep her and the house safe.*

6. The correct answer is C.
***Rationale**: Delirium is a sudden change in mental status. Mrs. Joseph's mother was fine one day and completely confused the next. Dementia comes on gradually. Organic brain syndrome is an older term for dementia so the same applies. Schizophrenia presents with different symptoms such as hallucinations and hearing voices.*

7. The correct answer is A.
***Rationale**: Bill is facing the situation of the death of his friend, realizing that he is getting older and that death will come at some point for him too. An antidepressant may help him put all of this into perspective and regain feelings of joy when appropriate. Migraines are very uncommon in the elderly. A psychiatrist is not required for situational depression. Pain medication may make things worse for Bill.*

8. The correct answer is D.
***Rationale**: She might become depressed if she is not able to go out with her friends. Having a urinary accident can be very embarrassing and difficult to hide. Few surgical "fixes" are effective. Making prompted voiding, going right before she leaves for the mall, and then while at the mall at least every hour for timed voiding will minimize the accidents.*

9. The correct answer is A.
***Rationale**: Affirming life is one of the principles of hospice. Hospice will allow Frank to feel comfortable enough to say his good-byes and be with the ones he loves in the time he has left. The family is aware of the medical issues Frank faces, and what they really need is the comforting care of hospice. Hospice does not make arrangements after the passing of a patient. Hospice should be consulted as early as possible to ensure Frank is comfortable. And hospice does not hasten death but preserves death with dignity.*

10. The correct answer is C.
***Rationale**: Palliative differs from hospice in that a person does not have to be diagnosed to be within six months of death, and a doctor does not have to order palliative care. Palliative care enhances quality of life through affirmations and the use of an interdisciplinary team to care for all of the needs of the patient and family. There are studies that demonstrate the value of palliative care and the improvement in quality of life for those who accept palliative care.*

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Assessing and Preventing Falls

2 Contact Hours

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Faculty

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Adrianne E. Avillion has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Peer Reviewer: Mary C. Ross, PhD, RN, is a nursing university faculty member teaching evidenced-based practice and research. She is a retired Air Force Colonel with clinical experience from multiple deployments, disaster response education, and care experiences from hurricanes and chemical disasters.

Mary C. Ross has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Learning objectives

After completing this course, the learner will be able to:

- Discuss the incidence and prevalence of falls.
- Describe the impact of falls in the healthcare setting.
- Identify fall risk factors.
- Discuss the development of a fall assessment process.
- Explain various fall prevention strategies.
- Discuss nursing interventions and intent to change practice.

How to receive credit

- Read the entire course online or in print which requires a 2-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

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Activity director

June D. Thompson, DrPH, MSN, RN, FAEN, Lead Nurse Planner

Disclosures

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INTRODUCTION

Falls are a major concern for all healthcare facilities. Falls can not only cause injury and mental anguish for patients, but can also be financially devastating to the organizations where falls occur. Falls not only affect patients, but can also affect visitors, volunteers, and employees. The ability to initiate a good fall assessment program and develop strategies for fall prevention requires an interdisciplinary approach and the commitment of everyone involved, including patients and families.

Case study 1

Sandy is an RN who has worked on the obstetrics unit of her hospital for 10 years. She loves her work and rejoices in helping families bond over the birth of a baby. She is also grateful that her unit has not had to deal with a patient fall for over two years. Sandy and her coworkers have, unfortunately, become rather complacent about fall prevention. They believe that "no one ever falls on our unit." Today, however, Sandy enters a patient's room in time to see her trip over a piece of furniture and strike her head on the edge of the nightstand before landing on the floor. The patient suffers a concussion and an extended length of hospital stay.

Self-Assessment Quiz Question #1

Which of the following statements best describes the impact of Sandy's actions as they pertain to fall prevention/assessment?

a. Sandy should move on to another specialty to help her get a fresh perspective on fall prevention.
b. Since there have been no falls for over two years, it is understandable that Sandy and her colleagues believe that falls do not occur on their unit.
c. Sandy knows that because the patient tripped over furniture and the fall was not due to her actions, there is no danger of a malpractice suit.
d. Sandy and her colleagues need to re-evaluate their unit's fall prevention program as well as their beliefs about falls on their units.

INCIDENCE AND PREVALENCE OF FALLS

It is important to understand the overall incidence and prevalence of fall occurrence, not just the type of falls that take place in healthcare settings. Identification of the reasons people fall in the home or other private settings helps to increase the body of knowledge concerning how and why people fall. It can also help to identify those at high risk for falls in healthcare settings and to develop effective fall prevention strategies.

Statistics pertaining to falls globally

Globally, falls are a significant public health concern. It is estimated that 646,000 persons globally die from falls every year. Eighty percent of these falls occur in low and middle-income countries. Regions of the Western Pacific and South East Asia account for 60% of fall-related deaths. Fatalities are highest among adults over the age of 60 years (World Health Organization [WHO], 2018).

Although not fatal, an estimated 37.3 million falls that are severe enough to require medical attention occur annually. The highest fall morbidity occurs in people aged 65 years or older, young adults aged 15-29 years, and children aged 15 years or younger (WHO, 2018).

Statistics pertaining to falls in the United States

Annually, millions of older adults (those who are 65 years old and older) fall in the United States (U.S.). Based on available data, it is estimated that more than one out of four older adults fall each year, but fewer than half tell their healthcare providers about falls. Falling even once doubles the chances of falling again (Centers for Disease Control and Prevention [CDC], 2017).

Falls are serious and costly. According to available data from the CDC (2017):

- One out of five falls causes serious injuries such as broken bones or head injuries.
- Three million older adults are treated in emergency departments for fall injuries annually.
- Over 800,000 patients are hospitalized each year because of a fall injury, most often because of a head injury or hip fracture.
- Each year at least 300,000 older adults are hospitalized for hip fractures.
- More than 95% of hip fractures are caused by falling.
- Falls are the most common cause of traumatic brain injuries (TBI).
- In 2015, the total medical costs for falls totaled more than $50 billion. Medicare and Medicaid were responsible for these costs in 75% of these cases.

Statistics pertaining to falls in hospitals in the United States

Every year, an estimated 700,000 to 1,000,000 people in the U.S. fall while hospitalized. A patient fall is defined as an "unplanned descent to the floor with or without injury to the patient (Agency for Healthcare Research and Quality [AHRQ], 2018).

Evidence-based practice! Research findings indicate that nearly one-third of falls can be prevented (AHRQ, 2018a). Healthcare facilities and their staff members must address the issue of falls and fall prevention on an ongoing basis.

Falls are consistently among the top 10 sentinel events reported to The Joint Commission. In 2018, the 10 most frequently reported sentinel events were:

1. Falls.
2. Unintended retention of foreign body.
3. Wrong-site surgery.
4. Unassigned.
5. Unanticipated events such as asphyxiation, burn, choking on food, drowning or being found unresponsive.
6. Suicide.
7. Delay in treatment.
8. Product or device event.
9. Criminal event.
10. Medication error.

(Bean, 2019)

Nursing consideration: Statistics pertaining to falls globally and within the U.S. are alarming. Education regarding fall prevention should include statistical information so that staff members can appreciate the scope of the problem. The cost of falls to the facility should also be shared with the staff, since this can easily translate into loss of funding for additional staff. However, many nurses "tune out" lengthy descriptions of statistical data. When incorporating this type of information in education programs, it will have more of an impact on staff members if data pertaining to falls in their own work settings is discussed. Some organizations are fearful that sharing such data will overwhelm employees, violate confidentiality, or make the organization "look bad." However, nurses and other healthcare professionals cannot correct a problem without knowing its extent. While maintaining patient confidentiality, educators must relay pertinent data. Nurses (and all adult learners) are more likely to learn and to put what they have learned into practice, if they know the extent of a problem and how their actions can make a difference (Avillion, 2015).

Nursing interventions and intent to change practice

Nurses should be aware of statistical data pertaining to falls. Such knowledge should be used to monitor their own organization's fall incidence as compared to international and national statistics. Nurses can then use this knowledge to monitor, review, and revise fall prevention efforts.

Case study 2

David is a rehabilitation nurse specializing in the care of stroke patients. He knows that his patients are at high risk for falls because of age and neurological compromise. He also knows that the incidence of falls on the unit has not decreased despite the best efforts of every RN. David is concerned that the nursing assistants on his unit have not been part of the development of the fall prevention program and do not have as much knowledge of fall prevention as he would like. He knows that every member of the team is essential to patient safety. David approaches his manager with a proposal to develop and implement a continuing education program designed for nursing assistants and their role in fall prevention. In the proposal he included national statistics, as well as statistics from his organization and his unit.

Self-Assessment Quiz Question #2

David works on a unit with a patient population that is at high risk for falls. He recognizes that everyone on the healthcare team plays a significant role in preventing falls and enhancing safety. Part of the research findings he presented to his manager were:

a. Globally, falls are as not as serious an issue as it is in the United States.
b. One out of 10 falls causes serious injuries.
c. Every year, about 700,000 to 1,000,000 people in the U. S. fall while hospitalized.
d. In 2018, falls were the third highest sentinel event reported to The Joint Commission.

IMPACT OF FALLS

Falls have considerable impact on the patients who fall, as well as on their loved ones, the healthcare professionals responsible for the patients' safety and well-being, and on the organization as a whole. As of 2008, the Centers for Medicare and Medicaid Services no longer reimburse for hospital-acquired conditions that increase the length of stay in hospitals. Thus, hospitals are now responsible for the additional medical costs of patient injuries that are the result of falls (Chu, 2017). A hip fracture or head injury may cost a hospital thousands of dollars and result in weeks of extended hospital days and possible rehabilitation costs.

According to the Centers for Disease Control and Prevention (2017), one out of five falls leads to serious injury. Adjusted for inflation, the direct medical costs for

fall injuries are $31 billion annually, with hospital costs accounting for 66% of the total cost.

Falls among adults age 65 and older are quite costly. Each year about $50 billion is spent on non-fatal fall injuries and $754 million is spent on fatal falls (CDC, 2019). For non-fatal falls:

- $29 billion is paid by Medicare.
- $12 billion is paid by private or out-of-pocket payers.
- $9 billion is paid by Medicaid.

(CDC, 2019)

In addition to monetary costs, another cost of falling is fear. Many people who fall, even if they are not injured, become afraid of falling. This fear may lead the person to reduce the extent of their everyday activities, including those activities that gave them pleasure and contributed to the quality of their interpersonal relationships. Individuals who have experienced a fall often become more sedentary. Lack of movement and exercise puts them at risk for additional health problems, such as heart disease. When someone is less active, he or she loses strength and becomes weaker, which increases the risk of falling (CDC, 2017).

Nursing consideration: In addition to patients' pain and suffering related to injury, increased length of stay, and healthcare costs, patient falls may lead to lawsuits that can result in settlements of millions of dollars (Chu, 2017). Nurses must be aware that there are legal ramifications of falls.

Case study 3

Sharon is an active 66-year-old. She enjoys an active social life and exercises regularly. One afternoon after returning from a brisk walk, she trips in her kitchen and falls abruptly to the floor. Although she is not hurt, the fall frightens Sharon. "What if I really hurt myself and no one is around to help me? I could lie here for hours and no one would know." As a result of this fear, Sharon begins to be refuse invitations to social activities and is even less active around the house. Sharon assumes that if she doesn't "move around" as much, she will be safer. In fact, Sharon's lack of exercise is putting her at risk for other health problems and additional falls.

Self-Assessment Quiz Question #3

Fear is one of the serious impacts of falls. This fear can lead to all of the following EXCEPT:

a. People who fall but are not injured seldom experience serious impact from the fall.
b. People who experience a fall often become more sedentary.
c. Reduction of physical activity after a fall can increase the risk of future falls.
d. Fear of falling can lead to reduced participation in pleasurable leisure activities.

Nursing interventions and intent to change practice

Nurses should work to incorporate data on the impact of falls into fall assessment and fall prevention programs. Understanding what can happen after a fall can help to improve assessment and prevention. Using such data can be used to change practice and reduce falls.

Monitoring trends in this data can also help to evaluate the outcomes of fall programs and reinforce the motivation of the staff in continued implementation of the initiatives.

FALL RISK

Angela is a professional development specialist who has just been assigned the task of developing a series of educational programs on fall prevention for her organization's nursing department. In addition to gathering relevant statistical data, Angela wants to highlight risk factors for falls. She also wants this information to draw attention to the problem, not just be information that nurses feel they already know. In order to do this, Angela works with the organization's Nursing Research Council to initiate research that identifies the risk factors present in patients who fell over the past 18 months. This way, Angela can make the information "real" and show the nurse-learners what factors contributed to falls within their place of employment.

Angela is correct in providing information that will have the most meaning to the nurses who will be attending her education programs. It is important to understand which patients are most vulnerable to falling and what puts them at higher risk of falling.

Although all people are at risk for falls, there are some factors that not only increase the risk of falling, but also affect the type and severity of injury that occurs after a fall. These risk factors include:

- **Age**: Age is considered to be one of the key risk factors for falls. Older adults have the highest risk of death or serious injury resulting from a fall. The risk increases with age. In the United States, 20% to 30% of older adults who fall sustain moderate to severe injuries, such as hip fractures and head injuries. Risk level for older adults may be due to physical, sensory, and cognitive changes associated with aging in conjunction with environments that make falling more likely (e.g. steps, clutter in the home, etc).
- **Gender**: Gender risk varies among countries. In some areas, males are more likely to die from falls than females, while females suffer more non-fatal falls. Research shows that older women and younger children are more prone to falls and increased severity of injury. Throughout the world, males consistently have higher death rates from falls. This may be due in part to higher levels of risk-taking behaviors and hazards associated with certain occupations, such as construction work.
- **Occupations**: The risk of falls increases with the hazards associated with certain jobs. For example, people who work at elevated heights are at higher risk for falls.

  Nursing consideration: When teaching patients and families about fall prevention, it would be wise to assess the risk associated with the types of jobs they have or leisure activities in which they participate. Patients and families would benefit from this type of risk analysis and from learning how to decrease risks associated with occupations or leisure activities.

- Socioeconomic factors: Various socioeconomic factors have been linked to falls. These include issues such as poverty, overcrowded housing, single parenthood, and young maternal age.
- Unsafe environments: Unsafe environments could mean various things to various people. For example, homes and work places that are cluttered, poorly lit, or unsanitary are associated with an increased risk for falls. Broken or uneven steps also pose a danger. This is especially true for people with poor balance, impaired mobility, or impaired vision.

(WHO, 2018)

Nursing consideration: Home assessment prior to discharge from an inpatient setting is important to facilitating safety. Such assessment could also be a recommendation made by healthcare providers in office and outpatient settings. Patients discharged on pain medication or mobility assistive devices, such as walkers, canes or crutches, should receive special instructions on fall prevention. Some elderly patients are reluctant to use walkers or canes for fear of the social stigma or appearing frail.

Specific health conditions have also been linked to an increase risk of falling. Such conditions include:

- Weakness of the lower extremities.
- Impaired mobility.
- Impaired balance.
- Vitamin D deficiency.
- Use of medications that affect judgment, balance, and/or cognition, such as tranquilizers, sedatives, antidepressants, and some analgesics.
- Impaired vision.
- Foot pain.
- Improper footwear related to disease, financial hardship, or lack of knowledge about fall prevention.
- Alcohol or substance use or abuse.
- Neurological or cardiac conditions.
- A combination of poor mobility, limited cognition, and poor vision, especially among people who live in long-term care or chronic care facilities.

(CDC, 2017; WHO, 2018)

Most falls are due to a combination of risk factors rather than a single item. The more risk factors a person has, the greater are the chances of falling (CDC, 2017).

Nursing consideration: There are identifiable risk factors for falls. However, nurses and other healthcare professionals should never become complacent about what type of patient does (and does not) fall. Any patient, regardless of age, diagnosis, or gender, may fall. That is why it is so important that the fall risk of all patients be assessed.

Nursing interventions and intent to change practice

Critical thinking question: How can nurses improve their assessment of a patient's fall risk factors? There is no simple answer to this complex question. In inpatient settings, risk is generally assessed in conjunction with the hospital environment and the patient's condition in the acute care setting. However, assessing risk factors confined to inpatient conditions is not enough. Since lengths of inpatient stay are getting shorter and shorter, nurses must begin discharge planning upon admission. What factors in the patient's home environment increase the risk of falls upon return home?

In order to change practice, nurses must know about the discharge environment's risk factors and take steps to help reduce or eliminate them. A home evaluation by members of the physical and/or occupational therapy departments may be warranted. Nurses and therapists will need to provide patients and families with education about safety at home as needed. In other words, the healthcare team's responsibility for safety initiatives is not confined to the inpatient setting. Discharge education can and must include teaching about ways to increase patient safety.

Self-Assessment Quiz Question #4

A nurse manager organizes a fall prevention task force. The manager stresses the importance of identifying persons who are at especially high risk for falls. For example, which of the following people would be at the highest risk for falling?

a. A 50-year-old male with a vitamin B12 deficiency.
b. A 30-year-old female who is taking a combination of antidepressants.
c. A 65-year-old female who exercises regularly.
d. A 40-year-old male who has residual weakness in his right hand following a car accident.

THE DEVELOPMENT OF A FALL ASSESSMENT PROCESS

Jane is the director of nursing for a 300-bed rural community hospital. She knows that falls have been increasing on the nursing units and her boss tells her to "fix" the problem. Jane wishes there were one simple way to implement a fall assessment process. That way, all patients could be assessed using the same tool and time would be saved. What Jane does not understand, however, is that assessment can vary depending on the patient population being assessed. Her nurse managers are working with her to develop a process that has a basic foundation and is adaptable for different patient populations. Such a process should take into consideration age, diagnosis, and risk factors. The nurse managers are having a hard time convincing Jane, who wants something developed "right away so that everyone can be doing the same thing."

A situation such as the one facing Jane and her managers is not uncommon. Jane is under pressure to find a "quick fix." The nurse managers want to develop a program that is grounded in evidence, so that patients can be properly assessed and resources will be used for programs that have been shown to be effective. Fall assessment, like any other assessment component, is a process that must be individualized to the patient.

Accrediting and quality improvement organizations fall prevention statements

The Center for Medicare and Medicaid Services (CMS) identified falls as a Hospital-Acquired Condition (HAC) in 2008. An HAC is defined as a complication or comorbidity or major complication or comorbidity that is the result of hospitalization. It is high volume and/or high cost, and is reasonably preventable using evidence-based guidelines. Thus, CMS will no longer cover the cost of care related to consequences of inpatient falls based on the presumption that falls are preventable (Fehlberg et al., 2017).

Falls with serious consequences are consistently among the top 10 events reported to The Joint Commission's Sentinel Event database. The Joint Commission requires hospitals that are accredited to conduct fall risk assessment in order to identify patients' risk for falls while hospitalized so that appropriate preventive measures can be taken (The Joint Commission, 2015). However, since such data is voluntarily reported, it is probable that the actual number of such events is much higher.

The Agency for Healthcare Research and Quality (AHRQ) serves as a resource for evidence-based practice. The AHRQ advocates a fall prevention approach that is consistent with a systems approach designed to improve safety and reliability of care. The agency believes that prevention strategies must address the multiple risk factors that exist and include multi-component interventions for fall prevention. In other words, no single action or strategy can prevent falls and/or enhance safety (AHRQ, 2019).

The National Database for Nursing Quality Indicators (NDNQI) is an external database to which many organizations report fall data as part of quality improvement initiatives. This provides organizations with the opportunity to perform an external benchmark comparison with similar types of nursing units/departments, assess their performance, and identify ways to improve safety (NDNQI, 2011).

Nursing consideration: There are many organizations that serve as repositories for fall data. Nurses should be aware of which ones their organization uses in order to make use of them as resources for evidence-based practice and quality improvement.

Suggestions for developing fall assessment programs

Jane is the director of nursing for a 300-bed rural community hospital. She knows that falls have been increasing on the nursing units and her boss tells her to "fix" the problem. Jane wishes there were one simple way to implement a fall assessment process. That way, all patients could be assessed using the same tool and time would be saved. What Jane does not understand, however, is that assessment can vary depending on the patient population. Her nurse managers are working with her to develop a process that has a basic foundation that is flexible enough to be adaptable for different patient populations. Such a process should take into consideration age, diagnosis, and risk factors. The nurse managers are having a hard time convincing Jane, who wants something developed "right away so that everyone can be doing the same thing."

A situation such as the one facing Jane and her managers is not uncommon. Jane is under pressure to find a "quick fix." The nurse managers want to develop a program that is grounded in evidence, so that patients can be properly assessed. Fall assessment, like any other assessment component, is a process that must be individualized to the patient.

Minnesota Falls Prevention

Falls are due to multiple factors and a holistic approach for their prevention is necessary (Minnesota Falls Prevention Initiative, n.d.). The Minnesota Falls Prevention program is an excellent resource for professionals. It offers information about screening, assessment, research done on fall assessment tools, and interventions by risk factor. The assessment tool or tools that work best for a specific unit or units should be used. An organization may want to adopt a fall assessment program that includes several tools, or a combination of tools, to capture necessary data based on individualized patient needs. The following information is a summary of the Minnesota Falls Prevention initiatives as well as information from other healthcare professional resources.

Gait and balance assessment
For patients with gait and balance issues, one or more of the following tools may be helpful:

- Timed Up and Go (TUG): This test is easily used in both inpatient and outpatient settings. It involves asking patients to perform various balance and gate-related tasks, such as rising from a chair without using their arms and walking and turning (Good Shepherd Rehabilitation, 2019; Minnesota Falls Prevention, n.d.).
- Berg Balance Scale (BBS): This tool is a 14-item scale used to measure adult's balance in a clinical setting. This tool is often used for people who have had strokes, spinal cord injuries, or traumatic brain injuries, or those with Parkinson's Disease, multiple sclerosis, or who are older adults with balance issues (Physical Therapy Haven, 2019a).
- Dynamic Gait Index: This eight-item test is used to rate the ability of a person to modify gait when responding to various task demands. It assesses dynamic balance and gait ability (Minnesota Fall Prevention, n.d.; Physical Therapy Haven, 2019b).
- Tinetti Performance Oriented Mobility Assessment (POMA): This is a task-oriented test that rates the ability of a person to maintain balance while performing activities of daily living tasks. It is used to assess gait and balance (Minnesota Fall Prevention, n.d.; Physical Therapy Haven, 2019c).

Fear of falling
As already noted, fear of falling can seriously inhibit a person's willingness to participate in usual activities. The following scales are used to assess fear of falling:

- Activities-Specific Balance Confidence (ABC) Scale: The ABC scale is a 16-item scale used to ask adults to rate their confidence that they will lose their balance or become unsteady during daily activities. This scale has the advantage of being able to be self-administered or administered by healthcare personnel via a personal or telephone interview (Minnesota Fall Prevention, n.d.; Shirley Ryan AbilityLab., 2019).
- Fall Efficacy Scale (FES): FES is a 16-item rating scale. It is used to assess the confidence of people in their ability to perform their daily activities without falling (Shirley Ryan Ability Lab, 2017).

Cognitive assessment
Cognition is closely linked to fall risk. The following tools are examples that may be used as part of a cognitive assessment.

- **Mini-Mental State Examination (MMSE)**: This is a widely used screening tool for cognitive impairment that has been well-validated. It is the most commonly used test for memory problems or other cognition issues. This test can also be used to help diagnose dementia and to help assess its progression and severity (Alzheimer's Society, 2019).
- Montreal Cognitive Assessment (MoCA): The MoCA is a 30-question test that takes about 10 to 12 minutes to complete. It is mostly used to assess people for dementia and evaluates orientation, short-term memory, and executive function/visuospatial ability (Rosenzweig, 2019).
- The Saint Louis University Mental Status (SLUMS): SLUMS is an 11-item questionnaire. Scores range from 0 to 30. It was developed to identify persons with mild or early dementia (scores 21-26) by measuring orientation, memory, attention, and executive functions (Tarig, Humosa, Chibnall, Perry, Morley, n.d.).

Depression assessment
There are a wide variety of tools available for the assessment of depression. Here are two examples of such tools:

- Geriatric Depression Scale (GDS-SF): This is a basic screening tool for use in older adults. The short form consists of 12 items used to identify depression in older adults. It takes about five to seven minutes to administer and has a yes/no answering format (Psychiatry & Behavioral Health Learning Network, 2019).
- Patient Health Questionnaire (PHQ-9): This is a self-administered screening and diagnostic tool for mental health disorders. This test objectifies the degree of depression severity (Infectious Diseases Education & Assessment, 2019).

Environmental asssessment checklists
It is imperative to thoroughly assess the patient's environment for safety. Here are some examples of assessment tools for that purpose:

- Morse Fall Scale (MFS): The MFS is widely used in acute care and long-term care inpatient settings. This tool requires assessment of fall risk upon admission, after a fall, with a change in status, and at discharge or transfer to a new setting. This assessment tool has been deemed both valid and reliable (Minnesota Fall Prevention, n.d.).
- Hendrich Fall Risk Assessment: This tool is used for inpatient assessment and in some long-term care settings. However, it has not been researched as extensively as the Morse Fall Risk Assessment (Minnesota Fall Prevention, n.d.).
- St. Thomas Risk Assessment Tool (STRATIFY): This tool is used to identify risk factors and to create a risk profile score (Minnesota Fall Prevention, n.d.).

Medication assessment
Patients' use of pain or psychotropic medications should also be evaluated.

Self-Assessment Quiz Question #5

Marjorie is a nurse practitioner performing a comprehensive fall assessment on a patient. She makes the PHQ-9 a priority. Marjorie has determined that her patient may be at significant risk for:

a. Mental health disorders.
b. Falling in a long-term care setting.
c. Cognitive impairment.
d. Gait abnormalities.

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (n.d.) has developed an algorithm for fall risk assessments and intervention, which can be found on their website at https://www.cdc.gov/steadi/pdf/steadi-algorithm-508.pdf. It is part of the Center's National Center for Injury Prevention and Control and part of the STEADI (Stopping Elderly Accidents, Deaths, & Injuries) initiative.

The Algorithm begins by having the patient answer key questions, such as:

- *"Have you fallen in the past year?"* If yes, *"How many times?"* "*Were you injured?"*
- *"Do you feel unsteady when standing or walking?"*
- *"Do you worry about falling?"*

If the answer is "no" to all of the preceding key questions, they are deemed to be at low risk for falling and individualized interventions are recommended.

If any of the questions were answered with a "yes," then further evaluation is performed, fall risk is determined, and interventions based on risk are performed.

Evidence-based practice! The Centers for Disease Control algorithm and tools described by the Minnesota Falls Prevention Initiative should be used not only for assessment and to determine interventions, but also to gather data for research purposes. As nurses assume more prominent roles in the research process, they should consider how to participate in research in order to add to the nursing body of knowledge and to provide evidence that can be used to improve patient care.

High Reliability Organizations

High Reliability Organizations (HROs) are those that have succeeded in avoiding catastrophes despite a high level of risk and complexity. Health care organizations have moved to incorporate the structure of HROs in working to enhance quality and safety (Jacobson, 2019).

In HROs every employee at every level of the organization is expected to think of ways their work processes might break down and how to prevent that breakdown (Jacobson, 2019).

Although it is not a falls assessment model, the HRO model can provide guidelines for developing any component of the safety process in healthcare organizations. The following is a summary of the five traits of HROs with some additional information applying to healthcare:

5. HROs are sensitive to operations. This means that both leaders and staff members must be constantly alert to how the organization's systems and processes affect the culture of safety and, indeed, of all operations. They should never assume anything or become complacent. They need to know what does and what does not work. Such constant evaluation means that systems and processes are constantly being reviewed and revised. Leaders of an organization must become more transparent. The more employees know, the more they will pay attention, and the more they will strive to improve the workplace. Executive level staff, as well as middle managers, should make organizational rounds on a regular basis and ask staff members, "What can we do to improve safety? Do you see anything that concerns you about patient care?"

Nursing consideration: It is not enough to ask employees questions. Leadership must act on the information they receive and let employees know how their input has improved patient care and safety.

2. HROs are reluctant to accept "simple" explanations for **problems.** Accepting the surface explanation may save time and encourage complacency. However, it is important to "dig" deeply into what actually causes problems. It is imperative that one person or a group of persons not be blamed for a particular problem. In all likelihood, errors and problems can be traced to faulty, inadequate, or outdated systems and processes. Healthcare leaders should regularly examine current research data for best practice evidence and determine how their own organizations function with this evidence in mind. Evidence should be used to evaluate organizational conduct such monitoring on an ongoing basis.
3. HROs are preoccupied with failure. At first glance, this sounds like a contradiction of priorities. However, if all employees (not just management) are encouraged to think of ways that current organization systems and processes might contribute to errors and safety violations, they will also think of ways to enhance the organization. Employees should also come forward with thoughts about systems and processes that work well. This type of shared vigilance must be constant. Concerns and successes should be shared with staff members. Hearing about what works in one department or on one nursing unit might trigger staff members to think about adapting known successes to their own practice setting.
4. HROs defer to expertise. In healthcare, organizations are sometimes reluctant to admit that another organization (or a competitor) has a better way of doing things than they do. Senior staff may also be reluctant to acknowledge that subordinates have identified problems or come up with solutions that are better than theirs. This is a serious mistake. HROs accept and value input from everyone. HRO managers encourage leaders to visit staff members at their workplaces to best encourage input, not in meetings, via email, or texting. Being in the actual work setting (e.g. nursing unit) increases effectiveness of communication. Employees should also be asked about experiences they have had in other organizations. This is especially true for newly-hired staff members. They come to the organization with "fresh" perspectives and are excellent resources. For example, a question that might be asked is, "Based on your prior work experiences, what are some ideas for improving processes and systems here?"

Nursing consideration: It is a good idea to ask employees for ideas about workplace improvement. However, they need to be assured that there will be no retaliation if they talk about things that "don't work." They also need to be acknowledged when their ideas contribute to and enhance safety and patients' well-being. Many safety initiatives also use data from patient interviews and surveys.

5. HROs are resilient. Leaders are able to respond quickly to errors and failures in systems and processes. The ability of these leaders to take steps to solve problems swiftly and make improvements readily is a necessary trait of all HRO leaders (and staff members). HROs are evidence-driven and know about the latest research and how findings affect the way they do business.

(Lippincott Solutions, 2017)

Nursing consideration: Healthcare leaders must be alert to an environment where employees are reluctant to question the wisdom of current systems and processes. Are they afraid of being labeled "trouble-makers?" Are they afraid of retaliation in the form of negative performance evaluations or unfair workloads? Do they believe that nothing will be done to address their concerns or ideas? A questioning attitude cannot exist if leaders implement overt (and covert) barriers to honest and open communication. Reward systems for improvements and successes should also be incorporated.

Four characteristics of HROs that reduce the number of adverse events include:

6. Prioritizing of safety, performance, and shared goals throughout the organization.
7. Implementing a culture of reliability in which authority figures include the input of employees at all levels of the organization.
8. Using a trial-and-error approach to improve safety following adverse events as well as near misses.
9. Strategizing the concept that one person steps up when a task needs completion. In other words, concerns, problems, and/or tasks are not "passed on" but each employee works to help resolve such issues.

(Lippincott Solutions, 2017)

Nursing interventions and intent to change practice

Nursing actions that support the development of HROs within health systems are crucial. Implementing the traits of such organizations should change practice for the better by increasing safety, despite the inherent risks associated with health care.

In summary, there are many factors that influence how a fall assessment program is developed. It is important that nurses gather information from multiple resources to establish an assessment process that ultimately decreases falls and enhances safety. The entire organization must be alert to factors that contribute to falls and how to reduce them.

Case study 4

Cheryl is a senior staff nurse working on a 40-bed adult oncology unit. She was a member of a task force that recently completed a revision to the organization's fall prevention program. Since the implementation of the new fall prevention program, the incidence of falls has decreased significantly. Cheryl is proud of the work that the task force has accomplished, and she feels that she has contributed to improving patient care, as well as to organizational effectiveness. One afternoon, Cheryl is preparing to educate a patient and his family about the medication regimen the patient will follow after discharge. As she walks toward the patient's room, she is startled to hear a scream and a loud "thud." She turns in the direction of the commotion and sees that a visitor has tripped and fallen to the floor, and that his cane is lying nearby. He is writhing in pain and, after diagnostic assessment, it is determined that he broke his left arm as a result of the fall. Cheryl is horrified and realizes that the fall prevention program did not address the issue of visitor or employee falls. She realizes that the safety of visitors, volunteers, and employees should be part of any safety initiative.

Self-Assessment Quiz Question #6

Cheryl has identified an important need for practice change. As she works to incorporate the issue of falls in non-patients, Cheryl recalls the characteristics of HROs that reduce the number of adverse events. She would include all of the following in her plans EXCEPT:

a. Prioritizing of safety, performance, and shared goals.
b. Using a trial-and-error approach to improve safety following adverse events and near misses.
c. Strategizing the concept that one person steps up when a task needs completion.
d. Implementing a culture of hierarchy in which authority figures make the majority of decisions.

STRATEGIES FOR FALL PREVENTION: EFFECTIVE IMPLEMENTATION

Lillian is a staff nurse who is the co-chair of the Nursing Practice Council. One of the Council's recent projects was to evaluate the occurrence of falls and the effectiveness of the organization's fall prevention program. The ways nurses and other staff members assess fall risk has been deemed to be effective. However, the actual implementation of the fall prevention program seems to have some inadequacies. Lillian and the other committee members have reviewed the organization's fall prevention program and (with input from members of the nursing department) revised it. Now they must determine the best way to educate staff members about the revised program and its implementation.

Lillian and her colleagues face a challenge that many nurses face. No matter how well written and evidence based a fall prevention program is, unless the strategies that it identifies are properly implemented, it will be no more than a document that has no impact on safety.

Self-Assessment Quiz Question #7

As Lillian thinks about the need for education, she should:

a. Plan to educate all direct patient care providers.
b. Provide education on the day shift.
c. Educate administrative staff regarding fall prevention.
d. Explain that nurse managers do not need to be educated since they seldom provide patient care.

Agency for Healthcare Research and Quality recommendations

As the Agency for Healthcare Research and Quality notes, (AHRQ, 2013; 2017) "No matter how good your fall prevention program is in concept, if it is not used by the staff, it will not be successful" (Agency for Healthcare Research and Quality [AHRQ] 2013; 2017).

There are multiple aspects of implementation of a fall prevention program. The AHRQ (2013; 2017) recommends asking and answering the following three questions:

What roles and responsibilities will staff have in preventing falls?
How is the organization going to assign roles and responsibilities? In order to make appropriate assignments, the organization must base assignments on evidence. Healthcare organizations vary in the way they staff departments and the ways that they do business. It is essential that not only staff nurses, but all members of the organization be involved in fall prevention. For example, a housekeeper should be able to recognize dangers such as a call bell that is located beyond a patient's reach or wet floors from spills, and take appropriate action. Although nurses bear a significant amount of the responsibility for fall prevention, they are not alone. Unless ALL employees take ownership for patient safety, it is doubtful that safety will be enhanced and a reduction in falls will occur.

What fall prevention practices go beyond the unit?
The focus of many fall prevention programs is the nursing unit. However, fall prevention programs should address fall prevention throughout the entire organization. Falls occur on nursing units, therapy departments, in hallways, and while patients are transported to and from tests and procedures.

All fall prevention strategies must be broad enough to involve all employees and all areas of the organization. Ways to manage this process include:

- Make sure that staff members are well trained in their roles and responsibilities pertaining to fall prevention.
- Ensure that staff members know the goals and objectives of fall prevention and the rationale behind any changes.
- Identify any barriers to implementation and reduce or eliminate them before the revised fall prevention program is put into place. Prior to implementation, the program should be piloted in specific areas to help identify problems (and correct them) before the program is implemented throughout the organization.

(AHRQ, 2013; 2017)

How do you put the new fall prevention program into action?
The AHRQ recommends that the following items are clearly determined:

- Identify a process for putting new practices into day-to-day operation.
- Determine a system for pilot testing the new program.
- Provide education and training for implementing the new program. Acknowledge the way input from staff members has contributed to the program. Acknowledge the way this new program is expected to enhance safety and improve patient care. And remember that ALL employees need education and training.

(AHRQ 2013; 2017)

Any fall prevention program must include a process for measuring fall rates and fall prevention practices. The AHRQ (2013; 2017) recommends that during the course of fall prevention efforts, ongoing monitoring must be implemented as part of the fall prevention process. The agency's recommendations for monitoring include the organization's regular monitoring of an outcome indicator, such as falls per 1,000 occupied bed days, assessment of fall risk factors, or actions taken to reduce fall risks. In order to help establish a monitoring system, the agency recommends that organizations answer the following questions when establishing a monitoring system:

- How are falls and fall-related injury rates measured? Falls are measured as falls per number of occupied bed days on a unit and/or an organization over a given period of days.
- How are fall prevention practices measured? Measuring falls is the overall indicator of how well a fall prevention program is working, it is imperative to assess the actual effectiveness of fall prevention practices. For example, an organization might monitor the performance of fall risk assessment within 24 hours of admission. Falls and risk assessment are two different factors that must be monitored in an ongoing manner.
- What should be done if data indicates that some fall prevention practices are not being implemented or are not effective? Review

and revision are key to addressing this question. Organizations are cautioned not to look for someone to blame, but to evaluate existing systems and processes for flaws and inadequacies as well as barriers to implementing fall prevention strategies. Revisions must then be made as appropriate.

(AHRQ, 2013; 2017)

Nursing consideration: All fall prevention programs must incorporate a process for managing patient falls. Who is responsible for immediate assessment? How can medical assistance be swiftly acquired? How will patients and families be told about the fall and how any resulting injuries are to be dealt with? Who will gather staff members involved in the fall for a debriefing? Debriefing is not to be used as a punishment or an accusation of wrong-doing. It is a tool to determine what happened, why it happened, and how its occurrence can be reduced in the future. Debriefing is also used to support staff members who are understandably distressed when a patient falls, especially if the patient is injured (AHRQ, 2013; 2017).

In summary, when determining how to develop, review, or revise a fall prevention program, the AHRQ (2013; 2017) recommends answering the following questions:

- What fall prevention practices should you use?
- Which universal fall precautions should be applied throughout the organization?
- How should a standardized assessment of fall risk factors be conducted?
- How should identified risk factors be used for fall prevention planning?
- How should patients be assessed and managed after a fall?
- How can the organization incorporate these practices into a fall prevention program?

General fall prevention strategies

There are a number of general fall prevention strategies that are components of most fall prevention programs. These may seem to be simple common sense, but failure to initiate these strategies can (and likely will) lead to serious falls.

Here are some basic strategies for fall prevention in the healthcare setting and at home:

- Encourage patients to undergo an assessment for fall risk factors. This should take place even if the patient has never fallen. Such an assessment can be done in the office practice setting, as well as the inpatient setting.
- Encourage patients to have appropriate preventive health examinations, such as vision evaluation and gait and balance evaluation.
- Teach patients about the side effects of any medications that can increase the likelihood of falls, such as sleeping aids and antidepressants. A large number of medications can cause sleepiness, dizziness, and impaired coordination, all of which can contribute to falls.
- Encourage patients to have their Vitamin D levels checked, since insufficient Vitamin D levels have been linked to falls.
- Unless medically contraindicated, teach patients exercises that can improve muscle strength and coordination.
- Teach patients to reduce environmental hazards, such as scatter rugs, clutter, slippery floors, and inadequate lighting. A home assessment may be of great value to patients as they work to avoid falling. Additional lighting, railings on both sides of stairs, and grab bars inside and outside tubs and showers and next to the toilet are all good ways to reduce fall risk.

(CDC, 2017; Chu, 2017)

In the inpatient setting, the following recommendations have been found to reduce fall risk:

- Hourly rounding has been found to be an effective deterrent to falls. Research shows that hourly rounding makes patients feel safer and less apprehensive and can reduce falls.
- Good communication among healthcare professionals and between healthcare professionals and patients and families has been linked to a reduction in falls and other safety hazards. Some organizations use color-coded wristbands to indicate fall risk.
- Medication review is essential to safety. Staff members, patients, and families must be aware of what medications have been prescribed and potential side effects of these medications. For example, even though nursing assistants are not responsible for medication administration and evaluation, they should know which of their patients are taking medications that increase the risk of falling.

(CDC, 2017; Chu, 2017)

Chu (2017) emphasizes the importance of education, not only for patients, but also for staff members. She has identified the following education initiatives that should be provided to reduce the risk of falls during hospital stays:

- Post a fall risk alert sign in proximity to the patient's bed and on the door as appropriate. Note that if the sign is on the door, the patient's name should NOT be included in order to meet confidentiality mandates.
- Use bed alarms. Be sure that alarm fatigue has been addressed when developing the fall prevention program.
- Use color-coded identification bracelets so that the patient's fall risk is clearly communicated to all employees.
- Perform hourly or more frequent rounds.
- Educate patients and families about the patient's risk for falling (including the risk at home). Teach patients and families how to make the home environment safer.
- Be sure that the call bell is within reach at all times and that patients know how to use it. Encourage patients to call for assistance when getting out of bed, especially at night or after taking pain medications.

Self-Assessment Quiz Question #8

When reviewing fall prevention strategies, it is important for the nurse to change practice, as needed, in order to ensure that fall prevention interventions are individualized for each patient. Interventions should include all of the following EXCEPT:

a. Perform rounds at least twice per shift.
b. Educate patients and families about how to make the home environment safer.
c. Place a fall risk alert sign in proximity to the patient's bed and door as appropriate.
d. Teach patients and families about the side effects of medication, including any increased risk for falls due to medication.

Nursing interventions and intent to change practice

Fall assessment must be conducted on every patient. Assessments may vary depending on the patient population. The fall assessment tools used by the organization must be appropriate for use in each setting. Fall prevention strategies are not a "one size fits all" proposition. Such strategies must be individualized to the patients. For example, it may be assumed that a strong, young, and generally healthy patient hospitalized for a bacterial infection is not in much danger of falling. Never assume. This patient needs to be assessed for fall risk and appropriate strategies need to be implemented accordingly. This patient may be taking medication that alters cognition and/or balance. Routine practice may need to be evaluated in terms of ensuring that all patients are assessed for falls.

Nurses play a major role in fall prevention. However, they do not act in isolation. All employees, regardless of profession or role, must receive appropriate education regarding fall prevention. A culture of safety is the responsibility of everyone who works within a given organization.

Self-Assessment Quiz Question #9

Intent to change practice should be characteristic of all healthcare professionals. Which of the following statements is accurate about nursing interventions and intent to change practice?

a. It is not necessary to have multiple ways of assessing patients for falls.
b. Fall assessment prevention plans should provide a mechanism to assess all patients for falls.
c. Placing a fall alert sign in proximity to the patient's bed violates HIPAA.
d. It is a waste of resources to educate non-patient care providers about fall interventions.

Case study 5

Nick works in the post-anesthesia care unit of a large outpatient surgery clinic. It is an especially busy day and the unit is short-staffed. One of his patients, Mrs. Mason, had a partial right mastectomy and is nearly ready for discharge. The charge nurse tells Nick, "Just give the patient her clothes. She's a nurse and won't need much help or teaching." When Nick gives Mrs. Mason her belongings, she appears dazed and does not respond when he tells her she can get dressed. In the midst of their hectic day, Nick and the charge nurse hear a moan and turn to see Mrs. Mason sitting on the floor. She is tearful and when they reach her, she says, "I can hardly move and no one even checked on me except to tell me to get dressed. I'm going to report all of you. This isn't the way to take care of patients."

Self-Assessment Quiz Question #10

Think about the assumptions that were made about Mrs. Mason. All of the following are true about taking care of this patient EXCEPT:

a. Nick failed to recognize that Mrs. Mason appeared dazed and uncomprehending.
b. Mrs. Mason is correct in pointing out that assessment of her status was inadequate.
c. As a nurse, it was OK for the post-anesthesia staff to assume Mrs. Mason would ask for help if she needed it.
d. Hectic days during periods of short staffing can contribute to unsafe conditions.

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ASSESSING AND PREVENTING FALLS

Self-Assessment Answers and Rationales

1. The correct answer is D.
Rationale: Sandy and her colleagues have become too complacent about falls. They need to look carefully at their unit's fall record, and the current falls assessment and prevention program, and revise as necessary. They also need to be sure that the entire staff receives education about fall prevention and assessment.

2. The correct answer is C.
Rationale: Every year approximately 700,000 to 1,000,000 people in the U.S. fall while hospitalized.

3. The correct answer is A.
Rationale: Even if people are not injured after a fall, they often become very fearful of falling again. This fear may lead to reduction in physical activity and participation in leisure activities.

4. The correct answer is B.
Rationale: The 30-year-old female is taking a combination of antidepressants, which can affect balance and cognition. Vitamin D is associated with increased risk for falls, not vitamin B12. Exercising regularly will decrease the risk of falling. Weakness in lower extremities increases the risk of falls, not necessarily weakness in an upper extremity.

5. The correct answer is A.
Rationale: The PHQ-9 is a self-administered screening and diagnostic tool for mental health disorders.

6. The correct answer is D.
Rationale: It is important to implement a culture of reliability in which authority figures include the input of employees at all levels of the organization.

7. The correct answer is C.
Rationale: All employees, including administrative staff and persons who do not provide direct patient care, should receive education regarding fall prevention and what to do if a fall occurs.

8. The correct answer is A.
Rationale: Hourly rounds should be performed. Hourly rounding has been found to be an effective deterrent to falls.

9. The correct answer is B.
Rationale: Fall assessment must be conducted on every patient. Assessments may vary depending on the patient population. The fall assessment tools used by the organization must be appropriate for use in each setting. Fall prevention strategies are not a "one size fits all" proposition. Such strategies must be individualized to the patients. As appropriate, a fall alert sign may be placed in close proximity to the patient's bed. All employees, regardless of whether or not they provide direct patient care, should be educated about fall prevention and intervention and their roles when a fall occurs.

10. The correct answer is C.
Rationale: Just because Mrs. Mason is a nurse is no reason not to assess her as any other patient should be assessed. Assessment was inadequate, and the fact that Mrs. Mason was dazed should have been a "red flag" that she was at risk for falling. Unsafe conditions such as short-staffing can contribute to unsafe conditions.

COVID-19 Loss, Grief, and Bereavement

2 Contact Hours

Release Date: October 20, 2020 **Expiration Date:** October 20, 2023

Faculty

Barbara Rubel, MA, BCETS, DAAE.TS, is a nationally recognized keynote speaker and trainer on compassion fatigue and vicarious trauma. Her programs motivate clinicians and healthcare providers to build personal resilience. She is the author of the book, But I didn't say goodbye: Helping families after a suicide (3ed) (2020), and the 30-hour continuing education course book for nurses, Loss, grief and bereavement: Helping individuals cope (4ed) (2019). She co-wrote the OVCTTAC training curriculum, Compassion Fatigue. Ms. Rubel received a Bachelor of Science degree in Psychology and a Master of Arts degree in Community Health, with a concentration in thanatology, from Brooklyn College. She is a board-certified expert in traumatic stress, and diplomate with the American Academy of Experts in Traumatic Stress. Her website is www.griefworkcenter.com

Barbara Rubel has disclosed that he has no significant financial or other conflicts of interest pertaining to this course.

Reviewer: Mary C. Ross, RN, MSN, PhD, is an experienced nursing educator with expertise in community health, disaster preparedness, and mental health. She has taught graduate nursing students and community leaders in a variety of areas including evidenced-based practice and research. Her doctorate is in nursing and encompassed specialty study in mental health.

Mary C. Ross has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

This course is for healthcare clinicians who want to identify ways to support grieving individuals because of the coronavirus disease (COVID-19). Characteristics that influence COVID-19 grief, bereavement, and mourning are identified. Policies such as social distancing may mitigate the impact of contracting the virus but increase risk factors for mental health issues and complicated grief (prolonged grief disorder). The course presents major theories and models of mourning as they relate to coping with COVID-19 ambiguous loss and disenfranchised grief.

Learning objectives

Upon completion of the course, the learner will be able to:

- Identify characteristics that influence COVID-19 grief, bereavement, and mourning.
- Give examples of mental health consequences and grief reactions related to COVID-19.
- Explain risk factors for complicated grief (prolonged grief disorder).
- Differentiate the major theories and models of mourning as they relate to coping with COVID-19 related grief.
- Review interventions for healthcare professionals to help bereaved families manage intense emotional pain.

How to receive credit

- Read the entire course online or in print which requires a 2-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

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Activity director

Michelle Doran, MS, RN, Lead Nurse Planner and Director of Nursing

Disclosures

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INTRODUCTION

The World Health Organization (WHO) has declared the coronavirus (COVID-19) outbreak a pandemic (WHO, 2020c). Generally, social distancing has lessened the chance of individuals contracting the virus and it has also safeguarded the health care system (Centers for Disease Control and Prevention [CDC], 2020). Social distancing and personal protective equipment have not prevented the tragic loss of life. In addition, physical distancing measures across the country have limited the ability of families to manage grief after a COVID-19 death (Denckla et al., n.d.). This course, intended for clinicians in the healthcare professions, is a useful guide in understanding COVID-19-related loss and bereavement. In addition, this course explores risk factors for complicated grief because of the pandemic.

CORONAVIRUS DISEASE 2019 (COVID-19)

This course begins with identifying the coronavirus disease, which has been confirmed in hundreds of thousands of people worldwide (Mehta et al., 2020). The Department of Health and Human Services (HHS) has announced that the pandemic, an infectious respiratory disease, is a national public health emergency (Lapointe, 2020). COVID-19 is a severe acute respiratory syndrome coronavirus two that was formally called SARS-CoV-2, and currently has no explicit therapeutic intervention or preventative vaccine (Pal et al., 2020). In the acronym "COVID", the 'CO' stands for 'corona,' 'VI' for 'virus,' and 'D' for disease (CDC, 2020). In December 2019, the virus first presented itself as severe pneumonia in patients in Wuhan, China, and later that month, China informed the Who that an outbreak had occurred (Singhal, 2020).

According to WHO, (2020b), an infected person spreads the virus through their saliva or nasal discharge when they cough or sneeze. It can also be contracted through yawning, singing, or speaking. Although many people are at risk for the virus, it can be considered a preventable death if certain precautions are put in place. Those at increased risk include people with conditions such as cancer, chronic kidney disease, COPD (chronic obstructive pulmonary disease), immunocompromised state (weakened immune system) from solid organ transplant, obesity, serious heart conditions, sickle cell disease, and Type 2 diabetes mellitus (CDC, 2020b).

According to the CDC (2020c), eight out of ten COVID-19-related deaths reported in the United States have been adults aged 65 years and older. However, there have been many advances in the field of medicine that have controlled diseases, prolonged life, and postponed death, especially for older patients (Río et al., 2020).

At the time of writing this course, there are a total of 7,583,200 cases in the United States and the total number of deaths because of the virus is 212,111 (CDC, 2020d). To cope with the coronavirus disease 2019 (COVID-19), clinicians need to be self-competent when working in situations involving death (Chi et. al., 2020). Although the goal is to achieve the highest quality of care and patient outcomes during a pandemic, this is not always the case when therapeutics and vaccines are still in the beginning stages. As clinicians obtain the knowledge and skills to treat patients during a pandemic, they need to recognize that their workplace might have a certain culture about death and negative attitudes about providing support to those who mourn. With overwhelming patient loads and families being supported virtually, clinicians are treating patients who are facing their own mortality, and family members facing grief, bereavement, and mourning in ways that they have never confronted before.

CHARACTERISTICS THAT INFLUENCE COVID-19 GRIEF, BEREAVEMENT, AND MOURNING

A pandemic in the American death system

Although COVID-19 is a global epidemic, Americans are experiencing loss within the American death system, a dynamic framework of societal networks related to individuals and death, which has five components: people, places, times, objects, and symbols (Kastenbaum, 2012). Nurses and other clinicians are "people" who work in the death system; "places" are the locations, such as ICUs (intensive care units) and long term care facilities; "times" are days when we honor the dead, as shown on daily news broadcasts; "objects", for example, are death certificates and caskets; "symbols" are represented though behaviors such as wearing a mask that covers both the nose and mouth when visiting a friend who is bereaved or socially isolating and not attending a funeral (Kastenbaum, 2012). Although the author and Professor Robert J. Kastenbaum died at home on hospice in 2013, his model sets the stage for coping with death for clinicians and the next of kin.

Next of kin are usually family members who were close to the patient and have become bereaved because of the patient's death. Close psychological proximity and dependency on the deceased can bring about distress and bereavement challenges (Smigelsky et al., 2020).

Although next of kin are the persons who are the proxy decision-makers for a patient, they are also the ones who may reach out to a clinician after a patient's death. Their reaching out for answers and/or support helps them come to terms with the reality that their loved one is dead, that a clinician was with them when they died, and that they did not suffer a painful death. Consequently, clinicians need to understand characteristics that will influence a person's grief process and be prepared to provide support immediately after a patient's death or, for that matter, months, if not years, later. Death related to a COVID diagnosis typically means that the families were not allowed to be with the isolated patient while they were dying. This compounds the grief experienced by the family.

As clinicians provide support during and after the COVID-19 pandemic, they need to recognize the functions of the American death system, which are to warn and predict a potentially life-threatening event such as a pandemic, prevent death during the pandemic, care for those who are infected and dying, dispose of the dead, achieve social consolidation after the death, and help family members make sense of the death (Kastenbaum, 2012).

Evidence-based practice! Findings from a study suggest that those who are traumatically bereaved because of a disaster can be affected by loss for several years after the event (Sveen et al., 2018). The pandemic is considered a disaster or mass trauma that is a major life stressor with long-term consequences. Although definitions of disaster differ, many definitions incorporate the central idea of situations that trigger large-scale disturbances that threaten many people (Masten et al., 2020). The pandemic is a disaster that has the same psychological impact as a mass trauma because of a hurricane, flood, wildfire, or terrorist attack.

Supporting COVID-19 loss, grief, and bereavement begins by recognizing that, although grief is a normal response to loss, the final separation that families experience goes beyond anything that they have ever gone through in their lifetime. Normal grief is experienced in a less intense way than complicated grief, otherwise known as prolonged grief disorder (PGD). Normal grief is as not persistent or debilitating as complicated grief. Although most people will experience normal grief after the pandemic, mourners are experiencing complications in their inability to receive the social support that they need. During the COVID precautions, mourners can't express physical comfort by offering hugs, touching the casket, or sitting near one another to socialize to say their farewells (Burrell et al., 2020). Therefore, this lack of ritualization and memorialization may complicate the grief process of some individuals.

According to Mason et al. (2020), a risk factor for complicated grief is a low perception of social support. The disruption in the way people live as they are forced to socially distance themselves from one another can bring about loss of freedom and relationships (Nair et al., 2020). According to Bartel (2020), there has been a shift in focus through the years from an individual grieving process to an interpersonal one that focuses on cross-culture, society, and families who grieve, whether alone or together. Although social support is needed in the time of COVID-19, social distancing and visitor restrictions in healthcare settings have negatively impacted the grief process. All things considered, two characteristics that influence COVID-19 grief, bereavement, and mourning are ambiguous loss and disenfranchised grief.

COVID-19 is an ambiguous loss

Generally, ambiguous loss is an unclear type of loss that leads to a complicated type of grief (Boss, 2016). Although most people will not experience psychopathology, an individual who experiences an ambiguous loss during the pandemic will find difficulty bringing their mourning to a satisfactory close (Suzuki, 2020). According to Boss (2016), there are two types of ambiguous loss with both types related to a stressor situation. The first type of ambiguous loss is a physical ambiguous loss when circumstances are unresolved because of physical absence and psychological presence. Examples are a missing body and not being sure if the person is dead or alive, military deployment, women who are victims of sex trafficking, incarceration, divorce, kidnapping, miscarriage, and infant death. Comparatively, Covid-19 is an ambiguous loss for those who are separated from the patient, whether they are in their home, care home, or hospital. In addition, people who are separated from their coworkers in the workplace because of work relocation can also become an ambiguous loss. Further, Covid-19 is an ambiguous loss for patients, as they are left to hope that loved ones will return to their bedside.

Children can experience a sense of abandonment when cared for in isolation. Even teens and young adults may have their sense of belonging traumatized because of the loss of contact with family and friends.

Physical Absence and Psychological Presence

Lenferink et al. (2018) studied patterns of functioning over time of nonclinical relatives of long-term missing persons. The study contributed to understanding ways individuals cope with ambiguous loss. Participants reported that as time passed, they accepted that they had no control over their loved one being missing, speaking with others gave them the social support they needed, going back to work or exercising helped them to disengage from the experience, and that they felt better after venting their feelings of sadness and anger. The findings underscore ways that the bereaved who experience physical absence and psychological presence can cope with ambiguous loss through active coping (practical or legal issues), instrumental social support (psychological support or justice system), planning (take action by searching), and positive reinterpretation (find meaning) (Lenferink et al., 2018).

Psychological Absence and Physical Presence

Boss (2016) conceptualized the second type of ambiguous loss as psychological ambiguous loss, where there is "psychological absence" and "physical presence". Examples of psychological absence with physical presence are dementia, chronic mental illness, traumatic brain injury, or addiction. Comparatively, COVID-19 examples include a patient who is not allowed visitors, a patient's cognitive impairment, a patient on a ventilator, or when a family member experiences complicated grief.

Nursing consideration: To alleviate the stress related to ambiguous loss, clinicians can help families stay safe yet connected through family conferencing, written information, resources, and the use of technology to assure the family that the patient is comfortable and not abandoned (Johns et al., 2020).

Case study 1

Debbie, who is an RN, usually works in surgical services, which is closed during COVID. She is now caring for dying patients. Debbie is preparing to perform an exam on Jane, a 75-year-old woman who has COVID-19. The patient's condition is worsening. Over the course of two days, Jane's daughter has left Debbie several messages asking about Jane's condition. The last text was, "Is my mom still breathing? I don't know if she is dead or alive." Although Debbie is overwhelmed with the number of patients in her care, Debbie realizes the need to make a compassionate call to the patient's daughter to discuss Jane's deteriorating condition.

Self-Assessment Quiz Question #1

Since the daughter is uncertain whether her mother is dead or alive, she is experiencing:

a. Disenfranchised grief.
b. Complicated grief.
c. Ambiguous loss.
d. Psychological absence.

Recognizing disenfranchised grief amid COVID-19

According to Verdery et al. (2020), although it is estimated that, on average, every COVID-19 related death will leave approximately nine closely bereaved family members, that estimate would be higher for broader kin ties such as in-laws, aunts, and uncles. When supporting the bereaved, a clinician needs to assess for psychological proximity, which focuses on the quality and closeness of a relationship, attachment, shared experiences, and how dependent the individuals were on each other. To put it differently, the decedent could have had special close relationships with a friend, a co-worker, or neighbor, who may be devastated by the loss. Consequently, the pandemic may exacerbate their reactions to loss and disenfranchise their grief.

Disenfranchised grief is a loss experience that is not or cannot be openly acknowledged, publicly mourned, is unrecognized, or socially supported by society (Doka, 2017). Examples of disenfranchised grief that are not related to a pandemic include infertility or pregnancy loss (Garrod et al., 2019). Also, when a home care worker's patient dies, they lose a connection with that person, as well as losing their employment, which also disenfranchises their grief. Moreover, animal companion loss and divorce are painful losses that are often not recognized. Likewise, foster parents experience disenfranchised grief when a child is returned home or adopted by another person (Lynes et al., 2019). These examples can teach clinicians that a bereaved individual may believe that they do not have the right to grieve a particular loss. Therefore, they remain silent and grieve alone.

The bereaved need to feel supported, especially if they may feel like they had infected the patient with the virus. We, as a society, are living in unprecedented times. To reduce the spread of the virus, hospital regulations ensure flexible patient scheduling, keeping patients distant while in the waiting area, limiting companions, and ensuring that they wear a cloth face covering (American Medical Association, 2020). These regulations are critical to keeping people safe.

Likewise, hospitals and other health organizations are seeing high incidents of the virus in those who do not wear a face covering. If a person who refuses to follow the mandated rules of wearing a mask becomes infected or spreads the COVID-19 illness, they can experience disenfranchised grief because of feelings of blame or guilt. For instance, if they infect their sibling, who then dies, they will find it difficult to openly acknowledge what happened. Hence, they won't feel socially supported because of the role they played in spreading the virus to someone they cared about, and they may experience guilt as well. Ordinarily, guilt is a risk factor for PGD if a person infects a loved one with the virus (Johns et al., 2020). What this can teach clinicians is that disenfranchised grief is a risk factor for negative bereavement outcomes.

In any case, grief can become complicated when a family member dies of a cause other than the virus during the pandemic (Boelen et al., 2020). In the United States, heart disease and cancer are leading causes of death (Murphy et al., 2018). If the bereaved feel as though they are not being supported because the death was not because of COVID-19, this can also disenfranchise their grief. According to Doka (2019), grief can become disenfranchised when a bereaved individual experiences changes in their identity after their loved one's death because of new upsetting information (e.g., spouse had an affair) that invalidates their conception of the deceased and the relationship they shared. They may feel shame and not want others to learn about the news. They may also not want to speak badly about the deceased, so they do not share the new damaging information they learned, nor seek support for dread that the secret may come out. Changes in their identity complicate their grief, undermine the view they had of the deceased, and disenfranchise their grief.

In summary, once a clinician understands characteristics that influence pandemic grief, bereavement, and mourning, they can recognize ambiguous loss and disenfranchised grief. Because these two factors can weigh heavily on a bereaved individual, clinicians can focus on the mental health consequences and grief reactions related to a person's loss experience.

Case study 2

Michael is a 67-year-old male with a medical history significant for obesity and Type 2 diabetes mellitus. The patient initially presented to the emergency room at the local community hospital for a high fever. Once the attending physician diagnosed COVID-19, Michael was sent immediately to the COVID-19 Floor. After spending two weeks in the hospital, Michael died. Before Michael's death, his wife, Ida, would come to the hospital daily, hoping to visit him. She felt fortunate that on several occasion she was able to speak to the hospital social worker about not being able to visit Michael. Ida also complained to a friend her need to be by Michael's side. Ida's friend responded, "Well, at least Michael is still alive, and you do get to speak to Michael's nurse and the hospital social worker on the phone." Later that evening, Ida received a call that their niece had died in a car crash. When Ida called the same friend to share the news of their niece's death, the friend asked if it was because of COVID. When told that it was not, the friend said, "Well, that's a relief. At least it wasn't COVID. That's a terrible death."

Self-Assessment Quiz Question #2

Which of the following bereavement risk factors impacted Ida's bereavement?

a. Disenfranchised presence.
b. Psychological proximity.
c. Psychological absence with physical presence.
d. Disenfranchised grief.

Mental health consequences

While a public health approach must strategically plan for disease prevention and intervention, it must also include approaches for mental health consequences. According to the HHS (2020), there are common reactions to a pandemic (see Box 1). The most significant and shared emotion during the pandemic is fear which, when felt maladaptively, can bring about anxiety and worry (Ahmadi et al., 2020). Namely, fear is a fundamental adaptive defense mechanism to survive a possibly threatening situation, such as COVID-19 (Ornell et al., 2020). Patients infected with the virus are fearful that they may die. According to the CDC (2020e), when an infected patient can return to society, they may feel stress, relief, worry about their loved one's health or about getting reinfected, frustrated with those who dread getting the disease from them, and guilt about not being able to work while sick.

Evidence-based practice! A study focused on the challenges palliative care clinicians face when supporting a patient who is experiencing emotional suffering (Rattner, 2020). Clinicians reported that patients can experience nonphysical suffering as they face emotional challenges, such as death anxiety. The patient attempts to accept that they are dying, worries about those they leave behind, and how difficult it becomes when a relationship has been strained (Rattner, 2020).

Clinicians who have not worked in palliative care need to be trained in advance care planning, theoretical models that focus on coping with dying, and ethical issues related to end-of life care after a mass trauma (Rubel, 2019). The pandemic has brought nurses and other clinicians into the daily stress of end-of-life care and palliative care, and many are not prepared for the patient's dying experience or the aftermath. The WHO's (n.d.) definition of palliative care underscores the necessity for a support system for patients and their families during the pandemic. Palliative care improves the quality of life of both patients with a life-threatening illness and their families through early identification and treatment of pain and other problems, as well as psychosocial and spiritual support, and if warranted, bereavement counseling. Perhaps we are all now recognizing the importance of getting our end-of-life wishes in order.

Nursing consideration: Clinicians who have limited training in palliative care may be sufficiently prepared to offer emotional and spiritual support to terminally ill patients or their family member at end of life (Galbadage, Peterson, Wang, Wang, & Gunasekera, 2020). Those clinicians who do not customarily work in palliative care must participate in training so they are prepared for the next pandemic. Since palliative care clinicians are present at end of life and implementing these interventions, they need to be on committees that develops and approves the evidence-based protocols.

It is especially important to have advance care planning if one is infected with the virus. Individuals need to make their preferences known in advance in case they are not able to make decisions for themselves regarding life-sustaining medical treatment preferences. Specifically, individuals need to complete written documents, such as advance directives (e.g., Durable Power of Attorney for Health Care, Living Will, Combined directives, Physician Orders for Life-Sustaining Treatment) that communicate their values and beliefs concerning their health care if they should become incapacitated because of being infected with COVID-19 immediately upon being admitted to a hospital, or even better, before they even get infected. Since approaching a patient with the need for these documents on admission may intensify their fear, primary care providers need to encourage patients to complete these while they are healthy.

Box 1: Stress Takes Many Forms

To build your personal resilience, be aware of common reactions to traumatic events now and as the COVID-19 pandemic evolves.

- Mood swings and intense feelings, including fear and worry about your own health and the health of your loved ones, sadness, anger, guilt, and disorientation.
- Denial, detachment or avoidance.
- Difficulty concentrating or making decisions.
- Irritability, strained relationships and conflicts with family, friends and co-workers.
- Changes in your normal sleep or eating patterns.
- Soreness, nausea, head or stomach aches.
- Elevated breathing, heartrate, and blood pressure.
- Sensitivity to unusual sounds, smells, and changes in your environment.
- A worsening of preexisting chronic or mental health conditions.
- Increased use of alcohol, tobacco, or other drugs.

Wisconsin Department of Health Services (2020). COVID-19. Resilient Wisconsin. https://www.dhs.wisconsin.gov/covid-19/resilient.htm

Patients and those who are quarantined may experience guilt, fear, shame, stigma, psychological distress, distrust, helplessness, and anxiety (Ho et al., 2020). Even for those who have had the virus, they may be facing loss of employment, financial concerns, a lack of social support, the need to isolate from others, and the need to homeschool their children, and many are managing preexisting disorders (Plakun, 2020). According to Plakun, once the coronavirus is over, those uninfected may experience survivor guilt, as they feel relief that they and their loved ones got through the pandemic without contracting the virus, and that they remained employed. Patients and family members are facing an uncertain threat which brings about distress caused by the unknown.

Nursing consideration: Chew et al. (2020) studied 20 years of the literature on coping strategies during an infectious disease outbreak. The study found that common coping strategies individuals use to manage anxiety, fear, guilt, and stigmatization include problem solving, social support, and positive appraisal.

Those who live with a chronic disease are more susceptible to being infected. This can increase their stress levels. Also, those with prior psychiatric issues can find it difficult dealing with the added stress. Likewise, age, gender, and occupational risk factors can also increase the risk of anxiety and fear. As years pass, research studies will explore mental health issues in more detail. For now, we are living through unchartered waters and must rely on a handful of studies. For instance, one study suggests that women, those with prior psychiatric issues, those who live in urban neighborhoods, and those who also have a chronic disease, are most psychologically affected by the pandemic (Özdin et al., 2020).

Evidence-based practice! A recent study assessed the relationship between perceived anxiety and fear related to COVID-19 infection in relation to age, sex, and occupational risk (Andrade et al., 2020). Women reported higher anxiety levels, and women and younger individuals showed higher fear of infection. Older participants reported lower levels of fear of infection. Males with occupational risk of contamination reported higher levels of fear, and those who suspected the possibility of testing positive had higher fear of infection.

Others who may experience anxiety and fear are those who work with people. According to the WHO (2020a), those with high risk occupations include home care workers, personal service providers, pharmacy front-line workers, those who transport people who have the virus in enclosed vehicles, and those who have contact with the bodies of those who died because of COVID-19.

By and large, there is a great deal of anxiety felt by patients with COVID-19 and their family members. However, clinicians who have

never treated those who were dying or supported a bereaved person may also experience anxiety and fear. Some clinicians, such as those who work in an emergency department or ICU, face death almost daily. For instance, an intensive care nurse may treat an anxious patient with a terminal illness and support a highly anxious family member, while experiencing their own personal anxiety if they are not able to offer adequate patient care (Ceyhan et al., 2018). Although these ICU nurses frequently encounter death, they still experience some level of anxiety.

Uncertainty distress

Although the mental health consequence of the pandemic includes stress, anxiety, and depressive symptoms, it also involves uncertainty distress (Bertuccio et al., 2020). Patients and family members are uncertain when the pandemic will end, and that uncertainty is stressful. According to Freeston et al. (2020), uncertainty distress is a unique response that can occur alongside emotions of sadness and guilt during abnormal circumstances. Uncertainty fuels feelings of alarm, which result in behaviors that try to reduce fear in situations that are out of one's control (Usher et al., 2020). As an example, media have shown people clearing supermarket shelves of food and toilet paper because of the threat of the virus and to regain a sense of control (El-Terk, 2020). The pandemic is causing Americans to participate in panic and irrational behaviors because of the perceived threat of the virus.

Helping patients and family cope

In the absence of COVID-19-related research literature and available data, we need to be creative as we explore ways to keep families connected to their loved ones. For example, clinicians can help patients and families stay connected through family conferencing, written information, and resources (Johns et al., 2020). Other ways to remain connected are through photos, music, audio recordings, posters, and phone calls. Since this health emergency is keeping families apart and social support at a minimum, uncertainty distress must be addressed.

Uncertainty distress can also occur in those who are experiencing anticipatory grief. Maryland et al. (2020) found a common theme of uncertainty that influences bereavement, such as uncertainty around the prognosis of not knowing if they need to prepare for their loved one's death, and uncertainty regarding the information about coronavirus that they are being given by the authorities. Generally, most people are resilient and are able to cope with their non-death and death related losses. However, a proactive mental health response is needed to manage the emotional strain of uncertainty distress and anticipatory grief. Bereaved individuals can also develop a better tolerance for uncertainty distress through cognitive behavioral therapy (CBT) models and treatment approaches (Freeston et al., 2020). Although outside the scope of this course, other techniques to support those who are traumatized from their experience include sensorimotor psychotherapy, EFT-taping, somatic experiencing, hypnosis, Polyvagel-informed practices, EMDR, movement-based practices, contemplative practices, and yoga. Although many researchers have examined distress after a traumatic event, it is still unclear how these findings generalize to studies comprised only of those who are bereaved (Lenferink et al., 2020). Clearly, more research is needed to focus on the bereaved during a pandemic. Particular care needs to be provided for children, adolescents, and those who have experienced previous trauma, since this puts them at increased risk of long-term consequences.

Evidence-based practice! A recent study using the Coronavirus Anxiety Scale (CAS) has shown that dysfunctional anxiety is associated with the pandemic. Participants either reported significant anxiety symptoms in the beginning stages of the pandemic or were infected with the virus. Elevated CAS scores were associated with a COVID-19 diagnosis, being impaired by the virus, using alcohol and/or drugs to cope, negative religious coping, extreme hopelessness, suicidal ideation, and attitudes toward the President and products made in China (Lee, 2020).

Case study 3

A son receives a call from a friend who is a physical therapist in the skilled nursing care facility where his parents reside. The friend shares that they are waking up in the middle of the night imagining that they have the symptoms of COVID- 19. During the call, the friend reports their not being able to catch their breath, pain upon inspiration, and dry cough. The friend mentions that the speech therapist at the facility had been experiencing tremendous stress because of contracting COVID-19 and decided to stay in a hotel away from their family, so their spouse and children would be safe. Now recovered, the speech therapist has returned to work and is avoided by some staff members for fear that they were possibly still contagious. Lori, age 84, and Marty, age 85, have been married for 40 years and reside in the skilled nursing care facility where both therapists work. Although Lori does not have COVID-19, Marty does, and was taken to a local hospital. After a week, Marty is being sent back to the long-term care facility. Their son is concerned about bringing Marty back to live with Lori. Lori speaks with their son on the phone and shares feelings of anxiety, fear, and worry, and is uncertain about the virus. Their son is concerned that the experience is too much for her to deal with. Marty mentions feeling guilty about not being able to keep Marty from Lori and feels out of control. After the call, the son spent the morning clearing his supermarket shelves of food and toilet paper.

Self-Assessment Quiz Question #3

Which of the following is the son experiencing?

a. Complicated grief.
b. Uncertainty distress.
c. Anticipatory grief.
d. Disenfranchised grief.

Pre-loss adjustment

Patients who experience anticipatory grief or pre-loss adjustment can have psychological problems, such as loneliness, despair, and anxiety (Li et al., 2020), so staying connected to family is important. Family members can also experience anticipatory grief before their loved one dies. Although adverse grief reactions can occur, people can cope and grow in that time of anticipatory grief. Rogalla (2020) recommends that clinicians assess protective factors, such as a person's outlook on social support and how they pursue getting support. Of 120 adults who were experiencing anticipatory grief, most participants (82.5%) reported that conversations with family and friends were the social support used (Rogalla, 2020). The results of this study highlight that growth can not only be a result of hearing bad news, but that growth is a continuing process that starts before a loved one's death.

Nursing consideration: Focus on the family member's need to know that, at the end of their loved one's life, they did not suffer because holistic and compassionate palliative care was provided (Ting et al., 2020).

To alleviate some of the distress of anticipatory grief in both patients and families, the focus should be on pre-loss adjustment. When a person has grief symptomatology before a death occurs, anticipatory grief can occur (Patinadan et al., 2020). According to Singer (2020), lack of preparation, lack of communication, and misinformation can bring about adverse effects during pre-loss grief, such as confusion, emotional distress, and feeling dazed. Generally, a factor that increases the risk of complicated grief is not being prepared for a loved one's death (Robert et al., 2020). Furthermore, for family members who seek out bereavement support, they must be reassured that the patient was comfortable and not abandoned at the end of their life (Johns, et al., 2020).

According to Selman et al. (2020), bereavement risk factors before a death include the family member's focus on the patient's breathing difficulty, having restricted access to their loved one, being in an ICU, and lack of social support. Various modern approaches can help patients and family members communicate effectively by providing patients with a cellphone and electronic tablet and encouraging them to record and share their messages with family members who are not allowed to visit (Ingravallo, 2020). According to Morris et al. (2020), clinicians can converse with the family about the patient's occupation and hobbies, ask to see a photo of the patient before their contracting the virus, and play their favorite music in their room. To manage the stressful experience of being separated from a loved one infected with the virus, clinicians can promote mental wellness though virtual platforms. To reduce the psychological impact of the virus, these can include online psychotherapy, video conferencing (e.g. Zoom), smart phone-based psychoeducation, Cognitive Behavioral therapy (CBT), mindfulness-based cognitive therapy (MBCT), and peer support (Ho, Chee, & Ho, 2020). Occupational or physical therapy staff may be requested to help patients with these connections. Even hearing the voices of family members can help sedated patients and family members to endure the separation with less stress. Hospital ministers have also been a resource for busy nursing staff in ICUs to help patients communicate with loved ones.

Nursing consideration: The psychological impact of a COVID-19-related death is reduced when bereaved ICU patients stay connected to their family, when clinicians communicate with the relatives and allow them into the ICU, and when family members are involved in end-of-life decisions (Gesi et al., 2020).

Palette of Grief® reactions

In addition to psychological (e.g., emotional, spiritual) and physiological effects, grief has also been associated with alterations in thought processes and behaviors. By definition, Palette of Grief® is a metaphor that captures the blending of physical (e.g., lost energy, exhausted, heartburn, insomnia, lightheaded, feeling rundown), emotional (e.g., fear, guilt, distressed, lonely, lost, helpless), cognitive (e.g., confused, trouble making decisions, feel lost, forgetful), behavioral (e.g., pace, procrastinate, create an altar, treasuring certain items), and spiritual reactions (e.g., struggle with beliefs, feel forsaken, feel judged, difficulty finding meaning) after a final separation (Rubel, 2019). When a patient dies, bereaved family members need support, not only to manage their grief, but also to manage concurrent stressors. These stressors are changes and difficulties that occur because of a death and can include economic issues or changes in old routines. Social services, ministers, and discharge planners may assist families in handling these stressors.

Grief patterns

Clinicians need to be aware of grief patterns when supporting the bereaved. Doka and Martin (2010) offer three patterns of grief expression: intuitive, instrumental, and dissonant. Although people can have either an intuitive or instrumental style, many have a blended grieving style. The intuitive pattern of grief expression occurs when feelings are intensely experienced. The bereaved are comforted by openly sharing their deeply felt emotions and venting to others. These individuals benefit from support groups where they can openly share their loss narrative. In contrast, the instrumental pattern of grief expression occurs when thinking is predominant over feelings (Doka et al., 2010). Although these individuals feel the pain of loss, they have a general reluctance to talk about their feelings, need to control themself, and try to problem solve. This strategy enables mastery of feelings and helps them to control their environment as they express their emotions in private. Although instrumental grievers are less likely to seek out bereavement support, especially talking about their grief, when they chose to get help, their focus is usually on getting information, finding ways to cope, and practical suggestions that focus on problem solving (Gamino et al., 2020).

In any event, instrumental grievers, whether male or female, do not express their emotions overtly and are, therefore, less supported by those around them. Still, those with a dissonant pattern seem to be fighting within themselves on how best to handle their grief, so they may self-medicate with drugs and alcohol (Doka and Martin, 2010). For example, intuitive grievers may quash their emotions around others and be concerned about how others see them as being out of control. On the other hand, instrumental grievers may feel guilty about not expressing their grief emotionally in front of others and question the way they grieve. As clinicians work with a bereaved individual, they need to recognize grief styles as internal concepts that can be utilized to identify automatic ways to respond to loss (Gamino et al., 2020)

Case study 4

Chris is a 28-year-old occupational therapist in a skilled nursing facility. Chris works with both short-term and long-term residents. Chris helps the short-term residents regain the skills they need to return home. In the past few days, six of these residents died by COVID-19. Beforethe pandemic, Chris spoke with several family members of the short-term residents to address activities of daily living and home safety. These residents were expected to go home, so their deaths were shocking to both Chris and the family members. Yesterday, Chris got on a Zoom call with a patient's daughter, who told Chris that she doesn't think she is grieving. Overall, the daughter is reluctant to talk about her feelings and feels the need to remain in control around other family members, who are openly expressing their grief. Chris attempts to problem solve by discussing the different ways people grieve.

Self-Assessment Quiz Question #4

How would the daughter's pattern of grief be classified?

a. Instrumental style.
b. Intuitive style.
c. Ambiguous style.
d. Disenfranchised grief.

RISK FACTORS FOR COMPLICATED GRIEF (PROLONGED GRIEF DISORDER) IN A PANDEMIC

What is prolonged grief disorder?

According to the American Psychiatric Association (n.d.), a new formal diagnosis, prolonged grief disorder, is being proposed. Although grief has existed for centuries, the way we assess bereavement is shifting and newly defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) (Bandini, 2015). Although a mental health professional is responsible to assess complicated grief, they may not be familiar with the disorders in both the DSM-5 and International Classification of Disease, 11th Revision (ICD-11; Wada et al., 2020).

The formal diagnosis will be a revised category in Section 2 in the Depressive Disorders chapter, and the criteria will modify Persistent Complex Bereavement Disorder. The proposed diagnostic criteria for prolonged grief disorder include the experience occurring more than a year after a death. Feelings include intense yearning and being preoccupied with intrusive thoughts about the deceased. A minimum of three symptoms are felt clinically nearly every day for the last month. Symptoms include a disruption in identity, disbelief, avoidance, intense emotional pain, not being able to move on, numbness, finding no meaning in life, and feeling alone. Significant distress is experienced to a clinical degree. They also experience impaired functioning. The duration of the reaction goes beyond the bereaved person's cultural norms and is not due to another mental illness (American Psychiatric Association [n.d.]).

Assessing bereavement and prolonged grief disorder symptoms

Bereaved families are facing the primary loss of their loved one, secondary losses, and stigmatized losses, as well as multiple losses (Zhai et al., 2020). Multiple deaths can occur when the bereaved experience the deaths of two or more family members and/or close friends in a relatively short period of time.

Evidence-based practice! A study found that, although the incubation period for the novel coronavirus disease was estimated to be 5.1 days, 97.5% of participants developed symptoms within 12 days, and 101 out of every 10,000 cases developed symptoms after 14 days of infection (Lauer, 2020). For the most part, COVID-19-related deaths are sudden and do not occur over a gradual period of time. Since death is unexpected, it will influence negative bereavement outcomes, such as not being able to cope or having a problem adjusting to loss (Pattison, 2020).

Findings of a recent study illuminate that those bereaved by a sudden death realize that death, as a part of life, leaves them with unanswered questions as they navigate their abruptly altered ordinary way of life (Carlsson et al., 2020). These individuals may reach out to clinicians who need to be aware of complicated grief disorder. Accordingly, they will know when to refer individuals to a mental health professional. Since complicated grief will probably increase during and after the pandemic because of the circumstances of death, evidence-based grief interventions need to be available (Eisma et al., 2020). Much of the current empirical literature has focused on identifying bereavement risk factors for conditions other than a global pandemic. Although studies have shown an increase in mental health consequences after disasters and viral outbreaks, there is limited research on complicated grief, otherwise termed prolonged grief disorder (PGD; Eisma et al., 2019). Nevertheless, we need to be ready for the complications that may arise. From a public health standpoint, there is a need to increase bereavement outreach to lessen the chance of PGD, as well as other mental disorders (Morris et al., 2020). These complications can include social isolation, diminished sense of self, inability to move on, and sleep-related difficulties. These complications may have dire consequences in terms of family relationships, work performance, and risk of substance abuse.

PGD, PTSD, and depression

Evidence-based practice! A study by Djelantik et al. (2020) investigated the relationship between symptoms of prolonged grief disorder (PGD), posttraumatic stress disorder (PTSD), and major depressive disorder symptoms in trauma-exposed bereaved adults. In total, 458 participants were referred to a psychotrauma clinic and sought treatment because of psychological trauma. Participants were identified by sharing the same profile of PGD, PTSD, and depression. Most participants (65%) had PGD symptoms. The study found that PGD, PTSD, and depression symptoms highly overlapped, but were distinct symptoms. Social isolation and diminished sense of self were symptoms reported. Those who had a close relative die had the most issues with moving on. These findings demonstrate the importance of assessing bereavement and PGD symptoms in those who are traumatized and seeking clinical support.

Further, although not much is known about sleep related difficulties in complicated grief, sleep disturbances are associated with depression and PTSD. A recent study focuses on the impact of sleep on complicated grief severity. The study found that greater CG severity is related to sleep impairment beyond PTSD and depression (Szuhany et al., 2020).

Evidence-based practice! Complicated Grief Therapy (CGT), is the most extensively tested method offered to support those with complicated grief. Overall, 641 participants were in CGT treatment research studies. Findings of the studies show that 70% of those who received CGT were much improved (The Center for Complicated Grief, n.d.).

Bereavement support

Maass et al. (2020) note that most bereaved individuals who have PGD do not pursue or receive suitable bereavement support. Those who do pursue complicated bereavement support have several options, such as grief counseling, psychotherapy, or a professionally run bereavement support group. A group that may provide effective COVID-19 grief support is a restorative retelling group, which is designed as a 10-week therapy closed groupdesigned to teach those violently bereaved stress management skills, to share stories to reconnect with positive memories, and to retell the story of their loved one's dying (Williams et al., 2018). As an evidence-based technique, the sessions help to facilitate a person's adapting to their loss (Smigelsky et al., 2018).

This is accomplished through exercises, which are completed consecutively to build resilience and help them explore their loss (Blakley et al., 2018). According to Rynearson (2018), these exercises are in the form of writing, drawing, and role playing. Although designed for those violently bereaved, those with complicated grief because of the virus can perhaps benefit from restorative retelling to build resilience and focus on their loved one's dying experience. This might be especially helpful for those who were not able to be at their loved one's side at the end of their life.

Evidence-based practice! According to Ogińska-Bulik et al. (2019), clinicians can encourage those who have experienced a loss to pursue social support. Participants in their study reported that they appreciated life and that the intensity of their pain was lessened through social support, and that related to others influenced their PTG.

Complicated grief therapy

Research demonstrates that grief-related pathology does exist in the general population. Studies have shown that ten percent or one in ten adults will develop PGD (Lundorff et al., 2017). However, until more research is done, we will not know how a COVID-19-related death will complicate grief. Accordingly, complicated grief (PGD) is a syndrome that will most likely elevate in bereaved family members because of the pandemic. When a bereaved family member requests additional assistance to manage their painful sudden loss, a health professional can recommend a specific type of psychotherapy called complicated grief therapy (CGT). In therapy, the bereaved may be able to:

- Learn about complicated grief and how it's treated.
- Explore such topics as grief reactions, complicated grief symptoms, adjusting to loss, and redefining life goals.
- Hold imagined conversations with the deceased and retell the circumstances of the death to help become less distressed by images and thoughts of the deceased.
- Explore and process thoughts and emotions.
- Improve coping skills.
- Reduce feelings of blame and guilt.

(Mayo Clinic, para. 6, n.d.)

According to Iglewica et al. (2020), an evidence-based protocol, complicated grief therapy (CGT), is available for mental health practice. In CGT, the mental health professional provides a safe place for the bereaved to talk about what they valued about the relationship and any problems they had, to share their story, what life is like without the deceased, grief symptoms, and efficacy of their current support system (e.g., friends, family, religious community). CGT helps the bereaved accept the death and adapt through seven core themes:

1. Understanding and accepting grief.
2. Managing painful emotions.
3. Planning for a meaningful future.
4. Strengthening ongoing relationships.
5. Telling the story of the death.
6. Learning to live with reminders.
7. Establishing an enduring connection with memories of the person who died.

(Iglewica et al., Table 3, pg. 94, 2019)

Case study 5

Matthew is a nurse who worked in an outpatient center that is closed during COVID. He is currently caring for a variety of COVID-19 patients. Michael attended 'just in time' training class and then partnered with nurses who regularly care for critical and dying people. Also, Matthew is especially interested in risk factors for complicated grief (PGD) and watched a webinar to learn more about current evidence and practice related to COVID-19 bereavement outcomes. Matthew discussed the webinar with the pastoral care staff, social worker, and the respiratory therapist. At least three symptoms have to be experienced to a clinically significant degree, nearly every day, for at least the last month for a PGD diagnosis, and a year must pass to assess for PGD. Matthew tells the ICU team that some family members of patients who died from COVID-19 may experience PGD.

Self-Assessment Quiz Question #5

Which one of the following did Matthew learn during the webinar?

a. Risk factors for PGD include identity disruption, marked sense of belief about the death, and avoidance of reminders that the person is dead.
b. Risk factors for PGD include intense emotional pain related to the death, identity disorder, and emotional numbness.
c. Risk factors for PGD include identity disruption, feeling that life is meaningless, and intense loneliness.
d. Risk factors for PGD include no difficulty moving on with life, embracing reminders that the person is dead, identity disorder.

EVIDENCE-BASED CONTEMPORARY MODELS OF GRIEF AS THEY RELATE TO COPING WITH COVID-19-RELATED LOSS

Coping with uncomplicated mourning

It is important to understand how most people cope with mourning. Although mourning is a normal process, what the world is currently going through is far from normal. The pandemic is a public health emergency like no other in our lifetime. As in any public health emergency, clinicians need to be aware of strategies to provide grief support. Mourning is the explicit expression of grief and the customary response to bereavement. Customs of mourning vary depending upon culture, which is a shared set of beliefs, values, and practices that structure behaviors and the way people act. Restrictions caused by social distancing have limited the ability of people to share their traditions. Accordingly, practices related to mourning customs have been disrupted during the unprecedented pandemic outbreak (Moore et al., 2020).

A clinician who helps an individual with uncomplicated grief may direct their attention to how the individual is coping with the death, using contemporary mourning theories as a guide to provide the best care. Coping can be positive and helpful or unhelpful. For example, those with a positive coping style can reframe their problems, maintain a positive attitude, focus on their faith, use humor, be optimistic, vent emotions, and accept social support. Unhelpful coping strategies in the adaptation to a COVID-19-related death includes avoidance coping. The bereaved may blame others, deny the death occurred, or self-medicate. Coping style can depend on an individual's attitudes toward death. Death attitudes (e.g., fear of death, avoid death, death can end pain) can focus on one's self or others.

Nursing consideration: Attitudes toward death and the place of death can be affected by a person's age, culture, and what they have learned about death through their personal experiences (Portorani et al., 2020).

Clinicians need to be mindful not to misguide patients' families through the five stages of grief. Kübler-Ross's Five Stages Model (2014) for dying individuals helped us to understand the grief process. However, the stage-based model has never been empirically reviewed, and it does not identify those at risk for complicated grief. People do not have to go through stages of grief for a positive bereavement outcome, and clinicians can, instead, focus on contemporary models of grief (Stroebe et al., 2017). Clinicians are a part of communities that need to develop their ability to provide helpful and appropriate bereavement support by being aware of current grief theories (Logan et al., 2018). Over the past 20 years, researchers and grief experts have developed theories of mourning such as Tasks of Mourning (Worden, 2018), The Dual Process Model (Stroebe & Schut, 2016), and Continuing Bonds Theory (Klass, Silverman, & Nickman, 1996). Brief descriptions of each of these models follow. Contemporary grief theorists have noted that essential needs of bereaved individuals are to recognize goal-oriented tasks, that an oscillation occurs between coping with the stressor of loss and coping with the stressor of restorations, that bonds with the deceased can be continued, that growth can result from a death, and that meaning can be found after a loss.

Four tasks of mourning

Healthcare clinicians can identify the task or tasks of mourning that are not completed and help the bereaved to resolve each task. William Worden suggests that individuals accomplish tasks in mourning through a cognitive behavioral approach. According to Worden (2018), abnormal grief reactions occur when people are unable to complete the four tasks of mourning. These tasks are goal oriented and are helpful to people who desire structure or steps to guide them through their grief.

First, grieving persons must "accept the reality of the loss". They understand that their loved one is not returning. The pandemic has brought about many unexpected deaths. The bereaved may be in denial and find it difficult to accept that the person is dead, especially if they were isolated from the person as they were dying, which is common in COVID cases. Worden's (2018) second task of mourning is "to process the pain of grief". The bereaved experience physical and emotional pain and may attempt to numb their pain with illegal drugs or alcohol. Others may work long hours to avoid the deep pain or not visit places their loved one may have been.

The third task of mourning is "to adjust to a world without the deceased" (Worden, 2018). If the individual does not adjust, they may withdraw from life. Bereaved individuals have new responsibilities and must take on roles previously performed by their loved ones. The fourth and final task of mourning is "to find a way to remember the deceased while embarking on the rest of one's journey through life" (Worden, 2018). As a bereaved individual develops healthy new relationships with others, they may feel disloyal to their deceased loved one. Their task is to create new relationships, while not forgetting their loved one, and move on as part of the grieving process. Being that spiritual adjustment is linked to making sense of a death, a failure in this

final spiritual task may bring about doubt toward the world and their belief system (Kaul, 2020).

Case study 6

Alicia is assigned to work with Judy, a 32-year-old, mother of two children, age two and five. Judy was employed as a chef in a restaurant and was recently admitted to the hospital infected with the coronavirus. Judy's condition deteriorated quickly and she did not survive. A month after Judy's death, Alan, the patient's husband, calls to speak to Alicia. Alan mentions taking on Judy's love of cooking for their daughter, something Alan had never done before Judy's death. Alan enjoys cooking as it offers special time with their children. Alicia listens closely and realizes that Alan is completing one of the goal-oriented tasks that is helpful to people who desire steps to guide them through their grief.

Self-Assessment Quiz Question #6

The clinician has identified which task of mourning that is completed and does not need to be resolved?

a. To accept the reality of the loss.
b. To process the pain of grief.
c. To adjust to a world without the deceased.
d. To find an enduring connection with the deceased in the midst of embarking on a new life.

Dual process model of coping with bereavement

Stroebe et al. (1999, 2001) proposed the Dual Process Model (DPM) as a model of coping with mourning that focuses on oscillation. To manage daily stressors, the bereaved oscillate between two coping strategies, loss-oriented (LO) and restoration-oriented (RO; Fiore, 2019). If one type of coping is used disproportionately from the other, mourners are likely to experience higher levels of distress. DPM involves a biopsychosocial outlook that focuses on different grief styles, the various ways people cope with loss, and how they take the time to rest from grief (Cantwell-Bartl, 2018).

The LO coping includes the loss experience, confronting the intrusion of grief, accepting the loss, reminiscing, or visiting the cemetery (Stroebe et al., 2016). The bereaved may confront the LO stressors, such as breaking the physical bonds with the deceased and deny or avoid restoration changes (Chen et al., 2019). Although in the time period following a death the bereaved use more LO coping (e.g., thinking about the deceased and the events connected to the death), as time goes on, they use more RO coping to manage secondary sources of stress (e.g., new tasks and new roles; Fiore, 2019).

The RO strategies refer to the processes used to face the practical stressors secondary to the loss, such as new roles or challenges with their new status as a bereaved person (Fasse et al., 2016). Secondary losses can include a decline in finances, parenting without a partner, family chores, tasks of daily living, and loss of a close confidant (Li et al., 2016). On an individual level, RO processes refer to secondary stressors that result from the death. These stressors can include doing things that the deceased used to do, learning to live without the decedent, earning a living, needing assistance with childcare, or relocating to a less expensive home (Stroebe & Schut, 2016). During the pandemic, individuals can attempt to finding distractions from their grief as they address their sources of stress.

Comparatively, the RO approach can be seen on a large scale during a pandemic when communities come together to build their resilience. A collective RO approach can occur during a disaster, when livelihoods are destroyed because of unemployment and there is a demand to rebuild communities (McManus et al., 2018). By alternating between LO and RO, individuals and communities either confront their grief or avoid it as they take a respite from dealing with LO or RO as part of their adaptive coping with death.

Evidence-based practice! Harrop et al. (2020) found that bereavement support during and beyond the COVID-19 pandemic needs to include structured psychoeducation to enable loss and restoration-focused coping.

Case study 7

Brian is a 62-year-old male whose wife recently died by COVID-19. Brian had called Jillian, his wife, Mindy's ICU nurse every day to find out Mindy's condition. A month after Mindy's death, Brian texted Jillian, "I'm drowning in my grief. I am not able to work. I don't pick up the phone when my friends call me. I think constantly of my wife. I can't watch tv or read. I'm lost." Jillian discusses Brian's distress with the patient care technician and case manager. They agree to request that the social worker reach out to Brian.

Self-Assessment Quiz Question #7

Brian is experiencing high levels of distress because of not oscillating from the:

a. Loss-oriented approach to the dual-oriented approach.
b. Loss-oriented approach to the mourning-oriented approach.
c. Restoration-oriented approach to the loss-oriented approach.
d. Loss-oriented approach to the restoration-oriented approach.

Continuing bonds model

Although in the beginning of the 20th century, the research recommended helping bereaved persons relinquish the emotional bond with the deceased, in the 1990s, researchers contended that continuing the relationship with the decedent is a normal and common part of grief (Klass et al., 2018). Over two decades ago, Klass et al. (1996) studied how bereaved individuals did not have to sever the bonds with their loved ones. Rather, they could maintain inner representations of them, keep them in their memories, and be comforted by continuing the spiritual connection. For example, this connection can be felt by talking about special places they visited together or actually going to those places. Although their loved one has died, they remain behind and are alive to share their stories (Mahlke, 2020). According to Jonsson and Walter (2017), continuing bonds can be rooted in a specific location where the mourner and deceased visited together (e.g., ancestral place, a home). Whether sharing stories, visiting places, recalling memories, or feeling their loved one's presence, continuing bonds can be a healing experience.

The continuing bond model argues that continuing bonds can be an internalized or externalized experience. According to Black et al. (2020), internalized continuing bonds are deliberate where the bereaved reminisce or recall memories of their loved one, and externalized continuing bonds are usually spontaneous and intrusive where the bereaved have visions of the deceased. For example, internalized continuing bond occurs when the bereaved look at photographs of the deceased. This helps them to recognize how the deceased was a positive influence or role model, how they can participate in activities that honor them, continue their legacy, and find comfort by engaging with them to manage a personal issue (Currier et al., 2015).

An example of an externalized continuing bond is when the bereaved person occasionally feels the presence of the deceased. Klass et al. (1996) conceptualized that, rather than detachment, the internal ties remain and mourning becomes a time of transformation. Thus, clinicians can help the bereaved understand that they have a choice in maintaining a post death relationship. For relationships that were abusive, violent, or neglectful, the mourner may not want to continue

the bond. They may be uncomfortable or ambivalent regarding continuing the bond, find no personal meaning in their loss, or cherish the relationship they shared (Jonsson et al., 2017). Accordingly, they may feel that it is necessary to loosen the maintained bond with the deceased. However, if a bereaved individual has the need to enhance their connection, as it would aid them in relocating the deceased, they have that option (Levi-Belz, 2017). Family Bereaved individuals have a choice to maintain the connection if the relationship was a positive one or release the bond if the relationship was not a healthy one. For those who chose to continue the bond, Park (2020) found that being connected with the dead can be a significant part of one's life, both mentally and socially, and the relationship that continues after the death can be symbolized through customs and traditions, religious practices, and memorialization.

Case study 8

Jillian, an ICU nurse, is on the phone with Brian, whose wife, Mindy, died by COVID-19. Jillian was Brian's wife's nurse and called him daily with information about Mindy. Brian mentions that Mindy's sister calls Brian daily to talk about Mindy. The sister spiritually talks to Mindy throughout the day, visits the cemetery twice a week, and created an alter with photos and mementos of Mindy. Brian's sister-in-law told him that last night Mindy's presence was felt at bedtime. Brian is uncomfortable with the intensity of this spiritual connection the sister-in-law is discussing on the phone.

Self-Assessment Quiz Question #8

Brian's sister-in-law is experiencing:
a. A dual process.
b. Continuing bonds.
c. Identity disruption.
d. A stage of grief.

INTERVENTIONS TO HELP BEREAVED FAMILIES

Posttraumatic growth

Undoubtedly, clinicians will need to recognize ways to help bereaved individuals manage their distress with the understanding that most people are resilient and experience posttraumatic growth. Most people challenged by the pandemic will grow from the experience. According to SAMHSA (2020), resilience in disaster recovery is ordinary and people often recover, especially those who use helpful resources to address stress and other hardships, which is a critical component of resilience. They will accept the loss, adaptively cope, build their resilience, and experience posttraumatic growth (Verma et al., 2020). The posttraumatic growth model is defined by Tedeschi et al. (2008) as "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (p. 1). The positive change can comprise appreciation for life, compassion for other people, and thoughts that focus on new possibilities (McClatchey, 2020). All of which can come about when certain actions are taken (see Box 2).

Box 2: If You Have Lost a Loved One During the COVID-19 Pandemic

For those grieving the death of a loved one in the COVID-19 pandemic, some actions you can take to help you cope with feelings of grief after the loss of a loved include:

- Connecting with other people:
  - Invite people to call you or host conference calls with family members and friends to stay connected.
  - Ask family and friends to share stories and pictures with you via mailed letters, email, phone, or video chat or via apps or social media that allow groups to share with each other (e.g., group chat, group messaging, Facebook).
  - Coordinate a date and time for family and friends to honor your loved one by reciting a selected poem, spiritual reading, or prayer within their own households.
- Creating memories or rituals.
  - Develop a virtual memory book, blog, or webpage to remember your loved one and ask family and friends to contribute their memories and stories.
  - Take part in an activity, such as planting a tree or preparing a favorite meal, that has significance to you and the loved one who died.
- Asking for help from others
  - Seek out grief counseling or mental health services, support groups, or hotlines, especially those that can be offered over the phone or online.
  - Seek spiritual support from faith-based organizations, including your religious leaders and congregations, if applicable.
  - Seek support from other trusted community leaders and friends.

Note: From CDC (2020). Grief and Loss. https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/stress-coping/grief-loss.html

Case study 9

Jillian is an ICU nurse who is called by a bereaved sister, a Christian, age 22, whose 27-year-old brother died by COVID-19. Recently, Jillian took a webinar on evidence-based practice and bereavement outcomes. Although she had years of clinical experience, the skills-building session helped Jillian to feel confident in providing the patient's sibling with support. Jillian asks about any particular foods that were shared with the patient. The sister discussed memories of Sunday meals they both shared with others in their faith community. Recognizing that the sister needs additional support, Jillian makes a recommendation to continue reaching out to friends and clergy.

Self-Assessment Quiz Question #9

Jillian recognizes the issue of interest and makes which of the following suggestions based on the advice of the CDC?
a. Ask family members to not share stories as they are too painful to hear, develop a virtual memory book, seek out grief counseling.
b. Invite people to call to stay connected, seek spiritual support from faith-based organizations, and refrain from attending a support group.
c. Coordinate a date with family to honor the deceased by reciting a certain poem or spiritual reading, plant a tree, and refrain from creating a webpage about the deceased.
d. Prepare a favorite meal that has significance to the bereaved and the deceased and seek support from other trusted community leaders and friends.

Coping with bereavement

If a bereaved individual is having a difficult time adjusting, a clinician can refer to a mental health professional who specializes in grief counseling or grief therapy. These clinicians provide psychotherapy, such as complicated grief treatment, may prescribe antidepressants (e.g., citalopram), offer bereavement follow-up visits, and cognitive restructuring of grief (Sun et al., 2020). Although most people do not experience complicated grief, bereavement does pose a risk for substance abuse, major depressive disorder, and PTSD (Lichtenthal et al., 2020). The bereaved can benefit from intervention if their grief becomes complicated.

A study by Cooper and associates (2020), focused on individuals whose loved ones died in an emergency department and were contacted one year after the death to identify their bereavement needs. Participants reported needing clarification regarding the circumstances of death, autopsy reports, and recommendations for local bereavement resources (Cooper et al., 2020). The findings indicate the importance of having immediate practice guidelines in place. According to Chamberlain et al. (2020), practice guidelines can include an involved physician calling a family member postmortem, bereavement leaflets on local support services and online bereavement support and sending a personalized condolence letter. Furthermore, individuals will benefit from psychoeducation that focuses on grief reactions, managing a traumatic death, prolonged grief disorder, and resource in the community, all of which normalize their symptoms of grief (Williams et al., 2018a).

The problem of bereavement and its likely mental health outcomes must be considered when discussing the infectious virus public health challenge (Verdery et al., 2020). Clinicians can provide support through psychoeducation, sharing empirically-informed strategies for reducing stress, such as watching the news in moderation, eating regularly, getting enough sleep, finding ways to be socially connected, and exercising (Marques et al., 2020). Recognizing that many people are experiencing anxiety and fear during the pandemic, clinicians can also point out the importance of exercise during this difficult time. A study of 937 individuals, mostly women and young adults, evaluated the association between self-reported moderate to vigorous physical activity and sedentary behavior with anxiety symptoms during the pandemic (Schuch et al., 2020). The study suggests that over 30 minutes of daily moderate to vigorous physical activity or over 15 minutes of vigorous physical activity a day is associated with reduced anxiety symptoms (Schuch et al., 2020).

Clinicians need to mitigate the indirect effects of COVID-19 by increasing the family member's understanding of emotional grief reactions, especially any guilt feelings, and how they can change from moderate to extreme intensities. As time move on, the intensity will lessen. If the family member infected their loved one with the virus, explore various methods to ease issues related to their guilt feelings. It is not uncommon to hear "If only I had worn a mask" or "If only I had stayed away from her when I started feeling sick." Encourage the bereaved to test their reality based on the evidence. Furthermore, help them identify how they were able to stay connected with the patient through family conferencing, written information, and other technologies to reassure them that they did not abandon their loved one at the end of their life.

Case study 10

Jillian has been a nurse for 30 years. Fourteen of those years have been spent in the ICU. Jillian is very familiar with palliative care and helping families who are experiencing anticipatory grief. Brian, the patient's husband, called daily to inquire about his wife's condition. Six weeks have passed since the patient's death. Brian calls Jillian and mentions that his wife's doctor called him immediately after the death and explained what was done to try to save his wife's life. The doctor offered his condolences and was compassionate. Brian also told Jillian that he was comforted from the bereavement material that the hospital sent to him, and that he called a few numbers listed that offer online and phone support. Although having a hard time coping, what was done in the immediate aftermath of the death and the support given was much appreciated.

Self-Assessment Quiz Question #10

The hospital ensured that the husband:

a. Got a call from an involved physician postmortem and received bereavement leaflets that include local support services.
b. Received information on online bereavement support options, a personalized condolence letter, and a bereavement gift basket.
c. Received a condolence letter and psychoeducation after his wife's death that focused on managing anticipatory grief.
d. Received information on how to access a telemedicine visit for access to specialists in grief and bereavement who are directly available in person.

Meaning reconstruction

Neimeyer (2019) maintained that death frequently disrupts a person's life story in a profound way, initiating a painful search for meaning in the death where no answers are found. According to Neimeyer's constructivist grief theory, meaning reconstruction is the central process in grieving (Verman et al., 2020). Neimeyer (2000) maintains that one aspect of meaning reconstruction is accomplished through life narratives—stories that are significantly marked by experiences of loss of relationships, people, and culture. Clinicians listen to the story of loss as they support an individual with uncomplicated mourning. This narration helps the bereaved individual to think, feel, and act in a certain way through their account of what happened, weaving it into an overall story of their lives.

Nursing consideration: Although sleep disturbance is common when grieving, clinicians can recommend healthy sleep practices and avoid sedative-hypnotic medications or carefully use them for a short period of time (Goveas & Shear, 2020).

Spirituality, rituals, and social support

A protective factor against complicated grief is high spiritualty before the loss (Mason et al., 2020). Spiritual intervention can focus on a person's core beliefs about faith, the afterlife, heaven, bereavement rituals, and the meaning of suffering. According to Milman et al. (2020), if a bereaved individual is struggling with the loss of their core beliefs (e.g., fair and controllable world, predictability of the future, finding meaning, spiritual and religious beliefs), clinicians can ask:

- "What did you once believe about life that you no longer are sure of?"
- "How has this pandemic challenged or changed the way you view your life, the world, or your future?"
- "What have you lost?"

Stressors in their ambiguous loss can involve a lack of clear death rituals and social difficulty in participating in mourning rituals (Mahat-Shamir, 2020). The pandemic has disrupted normal death rituals, such as funerals and wakes, where the bereaved can feel supported and comforted (Carr, 2020). A bereaved person's different grief style, and how they find meaning through their rituals and remembrances will impact their interpersonal relationships (Bartel, 2020). Perhaps after the pandemic has resolved, health care systems can create a memorial for bereaved family members for all patients who have died because pf COVID-19 (Wang, Teo, Yee, & Chai, 2020).

Pandemic funeral regulations have demanded minimal ritualization and limits on the number of mourners (Maddrell, 2020). Aoun et al. (2019) studied the experience of the bereaved with their funeral service provider. Participants reported that after the funeral, funeral directors should consider offering them bereavement information about ongoing community support (e.g. grief counselors, bereavement brochures,

support groups), as well as offering follow-up support (e.g., phone call, a card on anniversary of the death) to continue the relationship with the funeral director. The results of the study suggest that the bereaved need instrumental and informational support before the funeral, but also emotional support after the funeral. Grief and coping are highly individual and may require extended support over time.

Telehealth and online support

An advantage of attending a community bereavement support group is that they provide group members with role models, in person, who have experienced similar losses and have learned ways to manage their grief, and they provide a place to share common experiences with those in their community (Maass et al., 2020). However, until the pandemic is over, those who are bereaved will need to seek out online groups. Unützer et al. (2020) note that 90% of mental health hospital outpatient visits have now been moved to telehealth care. A telehealth visit can offer the bereaved access to specialists in grief and bereavement who are not directly available in person (Hollander et al., 2020). Moreover, Moyer et al. (2020) found that bereaved individuals post public messages on Facebook, Twitter, or Instagram to share their loss, to honor the deceased person, to feel connected with others, and to recollect special times. Mourners may benefit from a referral to Internet-based support (e.g., virtual grief counseling or an online bereavement group). A study surveyed bereaved individuals who got support through online bereavement support group on sites similar to Facebook (Baglione et al., 2017). Participants reported appreciating the 24/7 availability, feeling connected with others, and that they could be anonymous with no pressure to share. However, 15% found the online groups to be depressing because of the many posts from others who were bereaved.

Conclusion

To ensure that bereaved individuals have access to support, recommended action can be taken on three important fronts: 1. building capacity of clinicians to understand ambiguous loss and disenfranchised grief during a pandemic; 2. increasing availability of behavioral and mental health services to support bereaved individuals suffering from anxiety, fear, and uncertainty distress; and 3. increasing availability of community-based behavioral health services that focus on anticipatory grief, uncomplicated grief, and prolonged grief disorder. In the time of writing this course, the world is facing a pandemic where many thousands are dying, and even more are grieving. Pandemic grief can become complicated as it shares some of the characteristics of disaster or mass trauma related deaths. This course highlights several factors that can influence the grief process. There are recommended guides available for facilities to use to update practices or put new policies and procedures in place to achieve optimal patient outcomes. An interdisciplinary approach with support from leadership is necessary to operationalize and maintain these practices. According to Wilson et al. (2018), providing evidence-based bereavement support and developing bereavement policies are necessary to provide assistance to the bereaved. After appropriate policies and procedures have been put into practice, nurses and the healthcare team should be alert for new evidence-based practice recommendations and update their practices accordingly.

Resources

Aging with Dignity is a nationally-acclaimed non-profit that has touched the lives of tens of millions of Americans, has influenced public policy, and its Five Wishes publication is America's most popular advance care planning tool that has helped countless families get the kind of end-of-life care they desire. https://agingwithdignity.org

American Academy of Bereavement is a professional organization that takes the responsibility for the promotion of standards of excellence in bereavement care. http://www.thebereavementacademy.com

American Academy of Hospice and Palliative Medicine is a professional organization for physicians specializing in hospice and palliative medicine, and nurses and other healthcare providers who are dedicated to advancing hospice and palliative medicine and improving the care of patients with serious illness through education and training, resources, networking, and advocacy. http://www.aahpm.org

Association for Death Education and Counseling is a Thanatology Association® and is one of the oldest interdisciplinary organizations in the field of dying, death, and bereavement. Its nearly 2,000 members include a wide array of psychologists, counselors, social workers, educators, researchers, hospice personnel, clergy, and volunteers. http://www.adec.org

A Program of National Grief Support Services has partnered with caregiving professionals to help those who grieve understand and cope with loss. http://www.griefsupportservices.org

Center to Advance Palliative Care provides essential tools, training, technical assistance, and connection for all clinicians caring for people with a serious illness. http://www.capc.org

Centers for Disease Control and Prevention (CDC) is a major health protection agency within the Department of Health and Human Services that increases the health security of our nation, fights diseases and provides health information. https://www.cdc.gov

Compassionate Friends is an organization for those who experienced the death of a child (at any age, from any cause). http://www.compassionatefriends.org

Dignity in Care provides practice ideas and tools to support a culture of compassion and respect throughout the health care system. https://www.dignityincare.ca/en/

GriefNet is an Internet community of persons dealing with grief, death, trauma, and major loss with over 50 email grief support groups and two websites. https://griefnet.org/

Mental Health America is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all. http://www.nmha.org

Posttraumatic Growth Research Group, through the University of NC, Department of Psychological Science, the web site devoted to research and theory on the processes underlying posttraumatic growth. https://ptgi.uncc.edu/

Vermont Ethics Network is an organization whose aim is to advance healthcare ethics and to offer COVID-19 Ethics considerations and resources. https://vtethicsnetwork.org/medical-ethics/covid-19-resources

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COVID-19 LOSS, GRIEF, AND BEREAVEMENT

Self-Assessment Answers and Rationales

1. The correct answer is C.
Rationale: The type of ambiguous loss Jane's daughter is experiencing is a physical ambiguous loss where circumstances are unresolved because of physical absence and psychological presence.

2. The correct answer is D.
Rationale: Ida is experiencing disenfranchised grief because her friend is not socially supporting her. For example, the friend does not recognize the loss of Michel in the hospital, as well as the niece's death because it is unrelated to COVID-19 (Doka, 2017).

3. The correct answer is B.
Rationale: Lori and Marty's son is distressed over the uncertainty of his mother contracting the virus and Lori becoming emotional over the experience.

4. The correct answer is A.
Rationale: The Daughter is an instrumental griever who is reluctant to talk about feelings and remains in control around others.

5. The correct answer is C.
Rationale: Although Matthew is an ICU nurse and not a mental health provider, he understands risk factors for complicated grief (PGD) and its symptoms and will refer a bereaved family member accordingly.

6. The correct answer is C.
Rationale: Alan is experiencing the third task of mourning, which is to adjust to a world without the deceased. The nurse recognizes that if Alan does not adjust, he may withdraw from life.

7. The correct answer is D.
Rationale: Although Brian is confronting the intrusion of grief, accepting the loss, reminiscing, and breaking the physical bonds with the deceased, he is avoiding restoration changes, which can complicate his grief.

8. The correct answer is B.
Rationale: Brian's sister-in-law chooses not to sever the bond with the deceased and is continuing the relationship with the decedent, maintaining an inner representation of them, keeping them in her memories, and feeling comforted by maintaining the spiritual connection.

9. The correct answer is D.
Rationale: According to the CDC, those bereaved after COVID-19 can take actions to cope with their grief, such as connecting with other people, creating memories or rituals, and asking for help from others

10. The correct answer is A.
Rationale: A study found that practice guidelines in a hospital setting can include the patient's physician calling a family member after the patient's death, sending bereavement literature and online bereavement support information, and sending a condolence letter.

Course Code: ANCCWV02CV

Hospice and Palliative Care for Healthcare Professionals

5 Contact Hours

Release Date: September 17, 2021 **Expiration Date:** September 17, 2024

Faculty

Jennifer Shepherd, DNP, MHA, RN, NEA-BC, NPD-BC, CHPN, CCRN-K, is a Registered Nurse leader with substantial experience across diverse healthcare settings. She has served as a member of clinical leadership for various provider facilities in roles dedicated to professional development and analytics. She previously served as Director of Clinical Education for Capital Caring Health, one of the nation's oldest hospice and palliative care organizations. She is adjunct faculty for George Mason University in the Department of Nursing and currently serves as Director, Nurse Content Development and Continuing Education, for the American Nurses Association.
She is certified by the American Nurses Credentialing Center (ANCC) in nursing professional development; as a nurse executive, advanced, in hospice and palliative care by the Hospice and Palliative Nurses Association (HPNA); and in pediatric critical care by the American Association of Critical Care Nursing (AACN). Her DNP capstone work, *COVID-19 and Hospice Care: Self Care and the Effect on Compassion Fatigue and Patient Outcomes*, focused on the link and challenges between compassion fatigue, self-care, and quality outcomes among hospice clinicians during the COVID- 19 pandemic.

Jennifer Shepherd has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Reviewer:
Amisha Parekh de Campos, PhD, MPH, RN, CHPN, is an Assistant Professor at the University of Connecticut School of Nursing and serves on the Leadership Team at Middlesex Health Hospice Program in Connecticut. Dr. Parekh de Campos has worked in hospice and palliative care in various roles including patient care, advocacy, legislation, and academics. Currently, she manages research, quality, and education for the hospice program, which serves approximately 150,000 people in Connecticut. In addition, Dr. Parekh de Campos is working on research and palliative care curriculum development at the University of Connecticut for undergraduate students. She is a Robert Wood Johnson, Future of Nursing Scholar (2017-2020) and Jonas Scholar for Chronic Health (2017-2020). Dr. Parekh de Campos has presented at numerous national conferences and published on palliative care, COVID-19, and advance care planning. Dr. Parekh de Campos is also the recipient of the 2021 Hospice and Palliative Credentialling Center Certified Hospice and Palliative Nurse of the Year, the 2021 Young Investigator Award from the Connecticut Coalition to Improve End-of- Life Care, and the 2019 Hospice and Palliative Nurses Foundation Scholarship.

Amisha Parekh de Campos has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

This course provides an overview of hospice and palliative care and describes care that meets the physical, psychological, social, and spiritual needs of suffering of patients and families. The goal of this course is to provide nurses and other clinicians information on how to care for their dying patients. The course will review theoretical models of the dying process, the psychological and physical symptoms as death approaches, and postmortem care. Lastly, misconceptions and barriers to providing end-of-life care are reviewed.

Learning objectives

After completing this course, the learner will be able to do the following:

- Describe the purpose of both hospice and palliative care and how they address life-limiting illness for the patient and family.
- Define and explain the relationship between hospice and palliative care and how they contribute to the improvement of quality of life of patients with life-limiting illness.
- Describe the settings, patient population, and incidence of hospice care delivery in the United States.
- Identify the different levels of hospice care, services provided, and Medicare (CMS) eligibility requirements.
- Discuss the Medicare Hospice Benefit and performance measures required for hospice programs.
- Discuss different types of population-based palliative care.
- Explain the delivery of hospice and palliative care including the support required for patients and families with life-limiting illness.
- Explain post-mortem care and strategies for healthcare teams following the death of a patient.
- Identify misconceptions and barriers to providing hospice and palliative care.
- Discuss professional and educational resources clinicians can provide to support patients and families coping with life-limiting illness as well as healthcare professionals caring for them.

How to receive credit

- Read the entire course online or in print which requires a 5-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

CE Broker reporting

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Activity director

Lisa Simani, MS, APRN, ACNP

Disclosures

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Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

INTRODUCTION

When a patient has a life limiting illness, it affects not only the patient, but the entire family. Palliative care likely originated in Roman times, as members of the community wore a protective cloak named "pallium". Today, palliative care is defined as the protection of and prevention of suffering "through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual" (World Health Organization [WHO], 2020).

Palliative care is the overarching, supportive approach that helps seriously ill patients and families address problems and improve their quality of life (Mayo Foundation for Medical Education and Research [MFMER], 2021). Hospice is a type of palliative care, specifically for those that have a terminal disease and life-limiting prognosis. Hospice and palliative care can improve a patient's quality of life by:

- Providing relief from pain and other distressing symptoms such as nausea and fatigue.
- Integrating emotional, psychological, and spiritual aspects of patient care.
- Offering a support system to enhance quality of life as much as possible.
- Offering bereavement and grief counseling to help the family cope during the patient's illness and after death (Livestrong, 2020).

HOSPICE CARE

What is hospice care?

The term hospice dates to medieval times and refers to a place where travelers, some who were sick, found a comfortable place to rest. The first modern hospice was founded by Dame Cicely Saunders in 1967 in England (St. Christopher's, 2021). In 1974, Hospice, Inc., the first hospice in the United States, opened its doors; it was later renamed Connecticut Hospice. Today, according to the National Hospice and Palliative Care Organization (NHPCO), 4,639 hospice agencies operate in the United States (2020). A subset of palliative care, hospice care is for individuals who are facing a serious or life-limiting illness of six (6) months or less and is provided by an interdisciplinary team (IDT) of clinicians. This team provides pain management and emotional and spiritual support that is expressly tailored to the patient's needs and wishes at the end of life (EOL). Hospice care does not end with the patient's death; bereavement and grief support continue for the family for up to 13 months (NHPCO, 2020).

Incidence and distribution of hospice service

To be eligible for hospice, two physicians (including the medical director of the hospice agency) must agree on a patient's terminal diagnosis (NHPCO, 2020). Cancer remains the most common hospice primary diagnosis, while the most common noncancer primary diagnoses are heart and circulatory disorders, followed by dementia. The number and frequency of hospice services in the US have increased during the past decade. The latest statistics show consistent growth of hospice providers in both urban (81%) and rural (19%) areas (Medicare Payment Advisory Commission [MedPAC], 2020). For-profit hospice providers continue to make up the majority of hospice organizations at 70 percent and also represent the majority of growth; 27% are not-for profit and 3% are government owned (NHPCO, 2020). In 2020, it was reported that hospices in the US admitted a total 1.48 million Medicare hospice patients, which represent a 23.9% increase since 2014 (NHPCO, 2020). Of those patients, approximately half identified as female, and the majority (61.4%) of hospice-enrolled patients were 75 years of age or older (NPHCO, 2020).

In hospice and palliative care, 82% of patients were White, followed by African American/ Black (8.2%), Hispanic (6.7%), and Asian/ Pacific Islander (1.8%). Since 2000, hospice services have grown across all racial and ethnic groups, but especially among minority older adults (CAPC, 2021). Despite this growth, disparities still exist because of "cultural or religious beliefs, preferences for end-of-life care, socioeconomic factors, disparities in access to care or information about hospice, and mistrust of the medical system" (MedPAC, 2020, p 335). Because of poor access to disease prevention and detection, along with lower quality curative care, patients from racial and ethnic minorities are often diagnosed with late-stage illness and have worse outcomes (CAPC, 2021). This issue is quite complex, as experts have found that those suffering from advanced illness are also limited by social inequities, "such as paying for expensive medications, reduced access to nutritious foods, transportation, translation services, and safe housing" (CAPC, 2021, p.1). For Black, Hispanic, Latino, American Indian/ Alaska Native (AI/AN) and other persons of color, these barriers are much more common because of "generations of systemic racism; and, as a result, these populations experience significantly worse health outcomes than white Americans" (CAPC, 2021, p.1). Hospice and palliative care organizations and healthcare professionals can help ensure access and awareness to high quality care by providing educational programs, outreach, and by meeting the cultural and language needs of various minority groups within their community.

Social workers are healthcare providers who are the most prepared to advocate for these vulnerable populations and help other healthcare providers ensure equity and access. Social justice, dignity, integrity, and competence are a few of the core values that social workers work towards in their practice with patient and families (CAPC, 2021). The National Association of Social Work's (NASW, 2021) Code of Ethics states that a social worker has the "ethical duty and responsibility to guide practice with clients of various cultures and be able to demonstrate skills in the provision of culturally informed services that empower marginalized individuals and groups" (NASW, 2021). This statement, with regard to social determinants of health (SDOH), equity, and access, means that social workers help to address the "barriers to equitable care for the most vulnerable persons in need of care for a serious illness" (CAPC, 2021).

In addition to, and regarding the SDOH, social workers apply their knowledge of the person-in-environment framework, which is a holistic framework dedicated to providing care to the patient at several levels (CAPC, 2021). First, the micro-level, or family system, followed by the mezzo-level, which includes the local environment and relationships, and finally the macro-level, defined as systemic factors, all of which factor in to SDOH (CAPC, 2021). This comprehensive understanding about these levels and the SDOH within their practice highlight even more that the practice of social work is very closely linked to health and vulnerable populations (CAPC, 2021). Hospice and palliative care providers, therefore, can work to help support greater health equity and access. The Center to Advance Palliative Care provides action items to support this effort. These include:

- "[Asking] the social worker on your team about the greatest burdens and unmet needs in the population you serve.
- [Leading] with purpose and [developing] a vision and mission encompassing reducing health inequity. This requires development of and adherence to an equity strategic plan.
- [Listening] to patients and families about what matters most to them, and about their greatest worries". (CAPC, 2021, p.1).

Length of stay

The median length of stay (LOS) for Medicare patients receiving hospice care was 18 days, and more than 25% of decedents enrolled in hospice during the last week of life (MedPAC, 2020; NHPCO, 2020). Despite having 6 months eligibility on the Medicare Hospice Benefit, most patients receive care for a few days to a few weeks. Research has shown that a longer LOS has an increased benefit on patient care, therefore these short LOS deprive patients and families support and education needed at the end of life (EOL; MedPAC, 2020). Research indicates there are multiple factors most likely contributing to these short stays; these factors include, but are not limited to:

- Physician/provider reluctancy or discomfort with EOL conversations until death is imminent.
- Patients' or families' lack of acceptance of a terminal prognosis.
- Continuation of aggressive clinical interventions because of financial incentives in the fee for service (FFS) plans (MedPAC, 2020).

Physician/ provider reluctancy

Barriers affecting timely referrals to hospice care by physicians or other providers include uncertainty of prognosis, education regarding the criteria for admission to hospice services, and discomfort in discussing the prognosis with the patient and family (Tran, 2020). More specifically, these practitioners have difficulty in decision making when the patient has met the terminal or 6 months or less measurement criteria (Tran, 2020). In addition, many healthcare providers have difficulty speaking about EOL. According to Cicolello & Anandarajah (2019), there is an aspect of avoidance and emotional stress among physicians. "One physician stated, 'Sometimes I can get very close to people, and I don't want to do it too, so sometimes it's my own personal barrier'" (Cicolello & Anandarajah, 2019, p.873). Because of this delay, oftentimes the patient is imminently or actively dying when the decision is made to approach the family.

Patients' or families' lack of acceptance

Many hospice clinical teams point out that families are misinformed about what hospice care is and that it makes them feel as if they are giving up on their loved one (Cicolello & Anandarajah, 2019). The most common misconception was that one can only go to hospice when they are imminently dying (Cicolello & Anandarajah, 2019). In one study that looked at barriers to hospice care, participants commented on both the beneficial and potentially detrimental beliefs, including how families can find comfort at EOL; however sometimes the hope of a miracle "could lead to prolonged suffering because of nonmedically indicated life-sustaining measures" (Cicolello & Anandarajah, 2019, p. 875).

Continuation of aggressive clinical interventions because of financial incentives

The FFS payment system has historically paid for and provided financial incentives towards specific tasks, procedures, or services which aim the focus more towards volume than the quality of care and has been more focused on the acute care and institutional care, rather than community-based care (C-TAC, 2019). Unfortunately, this type of payment structure and emphasis has caused practitioners to delay advanced care planning, palliative care, and hospice referrals by continuing unnecessary and arguably futile clinical interventions for financial gain (MedPAC, 2020). This practice has resulted in an underutilization of hospice services as indicated by the percentage of

palliative care deaths and discharges that were higher in larger hospitals (C-TAC, 2019).

All these barriers further emphasize the need for clinicians to educate themselves on the benefits of early palliative care and hospice referrals, as these services have been proven to improve quality of life, patient outcomes and goals, and reduce costs (C-TAC, 2019). As the population ages, life expectancy increases, and the prevalence of advanced illness rises, clinicians must be ready to introduce hospice and palliative care services early in a patient's serious illness trajectory and not in the last days of a patient's life.

Levels of hospice care and services

There are four levels of hospice care, defined by Medicare, which correspond to both acuity level and payment structure: routine home care, continuous (aka crisis) home care, respite care, and general inpatient care (Centers for Medicare and Medicaid Services [CMS], 2020).

1. Routine home care: the level of care that most patients receive at home. This consists of interdisciplinary care delivered on an intermittent basis at the patient's home. This includes skilled nursing facilities (SNFS), group homes, and assisted living facilities (ALF; CMS, 2021).
2. Continuous home care: used when patients have symptom management needs that require temporary 24-hour support (CMS, 2021). This level of care, also known as crisis care, assists patients who may require a higher level of nursing care but desire to stay at home (CMS, 2021).
3. Respite care: caregivers are allowed a period of rest while patients are cared for by an IDT in a facility. In respite care, patients are allowed 5 days of care while on hospice services. Respites are pre-planned stays in facilities (e.g., inpatient units or SNFS) which can occur under the following circumstances:
   - Caregivers who may be suffering from physical or emotional exhaustion from taking care of a patient around the clock.
   - Caregivers who would like to attend a family event such as a graduation, wedding, funeral, etc.
   - Caregivers who become ill and cannot take care of the patient (NHPCO, 2019b).
4. General inpatient care: When the patient develops uncontrolled acute symptoms or a medical issue which cannot be resolved in the home or with continuous care, general inpatient care must be provided by the hospice. This includes issues such as:
   - Uncontrolled pain and/or agitation.
   - Uncontrolled seizures.
   - Uncontrolled nausea and vomiting.
   - Unmanageable dyspnea.
   - Complex wound care.
   - Minor comfort care procedures (e.g., paracentesis; NHPCO, 2019a).

Volunteer services

Hospice volunteers are used in day-to-day administrative and/or direct patient care roles. More specifically, volunteers must provide this type of support "in an amount that, at a minimum, equals 5% of the total patient care hours of all paid hospice employees and contract staff" (CMS, 2020, p. 102). Volunteers are an essential part of the IDT and endure rigorous training to participate in hospice programs. Their role in the IDT is to assist in various tasks including caregiver support, patient companionship, legacy writing, and administrative duties.

Bereavement services

As indicated previously, both hospice and palliative care programs offer support to bereaved family members as they anticipate the patient's death. However, hospice programs that are Medicare certified are required to also offer bereavement care to the family for 13 months after the death. These bereavement services may include monthly phone calls to the family members, acknowledgements of anniversaries, receptions honoring those on hospice services, and resources for support groups (CMS, 2021).

Hospice Medicare benefit

Sources of payment for hospice care include private health insurance, veteran's benefits, the patient's own income or family support, charitable donations, Medicaid, or Medicare (American Hospice Foundation, n.d. -b). Medicare patients have a specific Hospice Medicare Benefit (HMB) that reimburses the hospice on a per diem basis. The hospice provides clinical support from the IDT, as well as durable medical equipment and coverage of medications associated with the terminal illness. Approximately 85 percent of hospice reimbursement/payment comes from the HMB (CMS, 2021a).

The HMB does not cover curative treatments or medications, care from specialists not approved by the hospice provider, room and board for hospice care provided in a patient's home or another facility, such as a nursing home (CMS, 2021a). In addition, hospice items and services under the HMB require that items and services be provided by Medicare-approved hospice programs that include physician and nursing services, physical and occupational therapy, speech-language pathology, medical social services, home health aides, counseling (including dietary counseling), medical supplies and medical appliances, and short-term inpatient care (including both respite care and procedures necessary for symptom management; CMS, 2021a).

The HMB consists of two 90-day benefit periods and unlimited 60-day benefit periods (American Academy of Professional Coders [AAPC], 2018). At the end of each benefit period, the provider must document changes in the patient's status and eligibility to stay on hospice care. According to CMS (2021), hospice care is continuous from one benefit period (90-90-60) to another unless the patient revokes the hospice benefit or the physician discharges or does not re-certify the patient. If this occurs, the remaining days in the benefit period cannot be used (CMS, 2021a). The patient can be readmitted to hospice if they elect coverage again and if they meet the hospice coverage requirements (AAPC, 2018). The HMB also stipulates that the IDT includes members of specific disciplines. These disciplines are (CMS, 2021a):

- The medical director, who oversees all patients' medical care and assists the team in creating patients' plan of care. The medical directors can but are not required to be the attending physicians for hospice patients. They work with the IDT to provide suggestions and collaborate with the patient, family, attending physician, and hospice team.
- Nurses coordinate patients' care and assess and manage symptoms. They provide patient and family education, collaborate with the physician and other team members, initiate, and administer treatments, provide physical care, and offer emotional support.
- Home health aides are certified Nurses Assistants who provide personal care, support, and light housekeeping for the patient and family.
- Social workers evaluate and support caregiving resources, seek out community resources, assist patients and families with any legal or insurance concerns, and offer supportive counseling.
- Chaplains or pastoral counselors offer spiritual support to patients and family members directed by the patient and family members' needs, values, and beliefs.
- Bereavement counselors facilitate support groups, train bereavement volunteers, and design and distribute bereavement material to families. Following the patient's death, bereavement support is made available to caregivers, families, and friends for 13 months.
- Volunteer coordinators administer and develop the volunteer programs for each hospice. The coordinators recruit, train, and assign volunteers to hospice patients.
- Other members of the hospice team can include counselors, physical and occupational therapists, speech-language pathologists, homemakers, and volunteers.

Initiation of hospice care

Anyone can inquire about hospice services for a patient; however, initiation of hospice care requires a physician's referral and certification (NHPCO, 2021). Once this occurs, a nurse will conduct an initial assessment within 24 hours, beginning with the presenting problem and moving through the individual's history to ensure the patient meets hospice requirements. The comprehensive assessment, different than the initial assessment, must be completed within 5 days of the election of hospice care. This assessment is required to be submitted to CMS as part of an assessment of quality measures. If hospices do not provide this information in a timely manner, CMS penalizes hospices by withholding reimbursement payment. The nurse then provides information about hospice philosophy, along with identifying specific patient needs. The most prevalent issues facing the patient and family members are identified, which directs the development of an initial individualized written plan of care (POC; NHPCO, 2021). Oftentimes, other members of the IDT, such as a social worker or chaplain, will be involved with the initial assessment and add to the POC. If the patient is alert and oriented, they make the decision to receive hospice care and determine the family members' level of involvement. If the patient does not have decision-making capacity, the designated, documented Power of Attorney (POA) makes the decision for the patient. A comprehensive assessment needs to be completed within 5 calendar days after the election of hospice (NHPCO, 2021).

After the comprehensive assessment is completed, the hospice team creates an interdisciplinary plan of care. The plan of care identifies the patient- and family- specific needs and related goals. This initial plan of care is developed to guide the care provided during the first days of hospice care. This plan can be updated as frequently as required by patient needs but regulations require that the plan be updated every 15 days based on the ongoing assessments of the full IDT (CMS, 2021a).

Hospice performance measures

Under the Tax Equity and Fiscal Responsibility Act of 1982, CMS established the Conditions of Participation (CoPs), requiring hospices to comply with specific components of patient care and processes (MedPAC, 2020). Hospices must undergo an initial certification and subsequent audits to ensure regulatory requirements are met. In 2010, as part of the Patient Protection and Affordable Care Act (ACA), CMS established a quality reporting program for hospices, requiring all Medicare-certified hospices to report quality measures (CMS, 2021b). The performance of these seven measures, called the Hospice Item Set (HIS), is then evaluated and benchmarked against other hospice programs and determines financial impact (payment) to the hospice (CMS, 2021b). Finally, in 2015, CMS implemented the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), developed by the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality [A], 2019). This survey, similar to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for hospitals, "assesses the experiences of patients who died while receiving hospice care and their primary informal caregivers (CMS, 2021b). The survey treats the patient and caregiver as a single unit of care. Its purpose is to :

- Provide a source of information on patient/caregiver experiences that can be publicly reported to beneficiaries and their family members to help them select a hospice program.
- Support hospices with their internal quality improvement efforts and external benchmarking with other facilities.
- Provide the Centers for Medicare & Medicaid Services (CMS) with information for monitoring the care provided by hospices"(ARHQ, 2019, p.1).

Because grief can be felt intensely immediately after the death, the survey is sent out 3 months after the patient's death to the primary caregiver of the decedent. The CAHPS® survey can be administered via telephone, mail, or mixed mode, and includes the following measures of patient experience:

- Hospice team communication.
- Getting timely care.
- Treating family member with respect.
- Providing emotional support.
- Providing support for religious and spiritual beliefs.
- Getting help for symptoms.
- Information continuity.
- Understanding the side effects of pain medication.
- Getting hospice care training.
- Overall rating of hospice care.
- Willingness to recommend the hospice (CMS, 2021b).

Self-Assessment Quiz Question #1

You are talking to your clinical colleagues about end-of-life care for a patient. Someone states that hospice is the same as palliative care and that only private insurance pays for hospice care. You know this isn't accurate and clarify to your colleagues that:

a. Hospice is a subset of palliative care.
b. Hospice is a subset of palliative care and can be paid for by private health insurance, veteran's benefits, the patient's own income or family support, charitable donations, Medicaid, or from the Medicare hospice benefit.
c. Hospice can only be paid for by private health insurance.
d. Palliative care is the same hospice care but for those in a hospital setting.

Self-Assessment Quiz Question #2

The four levels of hospice care are:

a. Routine, continuous, general inpatient, and respite.
b. Routine, conventional, acute, and respite.
c. Home care, palliative, general inpatient, and routine.
d. Crisis care, routine, and respite.

Self-Assessment Quiz Question #3

Any patient can qualify for hospice care as long as they have all of the following EXCEPT:

a. An advanced illness.
b. Certification of terminal illness by a physician.
c. A family to care for them.
d. 6 months or less to live.

PALLIATIVE CARE

What is palliative care?

Palliative care is the treatment of the discomfort, symptoms, and stress associated with advanced or life-limiting illness (National Institutes of Health, National Institute of Nursing Research, 2021). The emphasis of palliative care, which occurs across the patient's illness trajectory, is on (1) encouraging conversations about goals of care at time of patient diagnosis of a serious illness; (2) considering the benefits versus burdens of treatment options; and (3) attending to the physical, psychological, social, spiritual, and existential needs of the patient/family unit across the lifespan (American Association of Colleges of Nursing, 2016). Patients receiving palliative care often suffer from the symptoms and stress of serious illnesses, including but not limited to cancer, dementia, heart failure, Parkinson's disease, and chronic obstructive pulmonary disease (COPD; National Institutes of Health, National Institute on Aging, 2017). Palliative care teams offer this care

to support curative or other treatment plans of care and help patients and families understand their choices for medical treatment (Mayo Clinic, 2021). Palliative care is not dependent on prognosis and patients do not need to be in hospice or at EOL; patients can receive palliative care at any age and at any time during their illness (National Institutes of Health, National Institute of Nursing Research, 2021).

There are eight domains of palliative care to meet the needs of the whole person and include psychological, physical, spiritual, religious, existential, cultural, structure and processes of care, financial, social, and ethical and legal services (National Quality Forum ([NQF], 2017). When providing palliative care, healthcare professionals should consider the patient population of the person for whom they are caring to provide the best and most appropriate care. Different populations may include adult, pediatric, neonatal, perinatal, and geriatric patients.

Besides physical needs, other issues faced by seriously ill patients may include the following (NQF, 2017):

- Losing independence.
- Maintaining self-determination and a sense of control.
- Decision making about how and where to die.
- Declining functions and related concerns about being a burden.
- Fear of pain and other distressing symptoms.

Population specific palliative care

Pediatric palliative care

Pediatric palliative care is specialized medical care for children of any age that can be provided at any stage of a serious illness, along with treatment meant to cure (Center to Advance Palliative Care [CAPC], 2021). Pediatric palliative care provides relief from distressing symptoms, manages medication and treatment side effects, assists parents with methods to talk with siblings, provides respite care, and finds community resources (CAPC, 2021). Pediatric palliative care, similar to that for the adult population, also aims to meet the emotional, developmental, and spiritual needs of patients and their family members (CAPC, 2021). For example, psychosocial interventions can be offered to adolescents and young adults that range from weekend retreats to transition services when they go back to school, social workers who provide counseling, and expressive arts therapists who help them normalize their situation (Sison, et al., 2017).

A pediatric intensive care unit nurse writes of supporting a mother after the death of her baby and how it can affect a clinician on a personal level. “When it came time to withdraw the life support, it was too much for her to watch. She pleaded with us through tears to please be gentle with him, and then left the room, broken. When it was all done, she returned to hold her baby in her arms one final time. It was the strangest act for me, putting her deceased child in her arms, as if I were all at once giving to her a beautiful but most terrible gift, and then leaving her alone to figure out what to do with it. All I could do was whisper, “’Take as much time as you need’” (Sato, 2017, p. 72).

Perinatal and neonatal palliative care

Despite the medical advances and treatments in neonatology that have improved survival rates, when a neonate is diagnosed with a serious illness, mainly congenital in nature, both perinatal and neonatal palliative care is called upon to prevent and relieve pain and suffering as well as support the needs and choices of the parents (Kilcullen & Ireland, 2017). Perinatal deaths are defined in various ways. Perinatal deaths can include fetal deaths as well as live births with only a brief survival of days or weeks. The definition of perinatal death is “…the death of a baby between 22 weeks of gestation (or weighing 500 g) and 7 days after birth” (Camacho-Ávila & Fernández-Sola, 2019, p.1). The March of Dimes (2021) defines a neonatal death as a live birth that results in death within the first 28 days of life.

Although preterm births, those less than 37 weeks gestation, diminished between 2007 and 2014 (10.41% to 9.54%), new data from the Centers for Disease Control and Prevention (2021) show they have risen for the fifth straight year to 10.23% in 2019. This highlights the need for clinicians who can provide support and comfort to parents when their baby has a life limiting illness or is born premature or stillborn. This specialized type of palliative care helps to guide the decision-making process to anticipate, prevent, and relieve suffering; choices along the spectrum of this care include pregnancy termination (abortion) to full neonatal resuscitation and treatment (American College of Obstetricians and Gynecologists, 2019).

An example of perinatal palliative care delivered is with a mother who shared the experience of her pregnancy scan that led to a diagnosis of a chromosomal abnormality called trisomy 18 and of her child being stillborn at 36 weeks’ gestation (Children’s Project on Hospice and Palliative Care [ChiPPS], 2017). Although the chance of a live birth was very slim, nearing the induction date, clinicians discussed with both parents which interventions they wanted if the baby was born alive and was able to come home, arranged for the parents to talk with a child life specialist to understand how to explain the situation to their 2-year-old son, assisted in choosing a funeral home, and discussed memory making. After the birth of their dead infant daughter, the parents held their baby the entire day in the hospital, introduced her to extended family, baptized her, gave her a bath, made handprint and footprint molds, and took photos. This advance care planning before birth allowed the parents to spend their time making memories when she was born instead of making difficult decisions (ChiPPS, 2017).

Yildiz and Cimete (2017) studied the effects of a grief support program in a hospital neonatal intensive care unit (NICU) in Turkey. Participants in the study were those whose babies in the NICU had a higher risk of dying within 1 year. In the period before the baby’s death, as part of a neonatal palliative care plan, parents were encouraged to touch their babies and call them by name during every visit. The parents were also given a picture of their baby if desired. After the baby’s death, parents were given a chance to see and embrace the swathed baby in a private room. Follow-up interventions included two phone calls and two home visits to assess the bereavement status of the parents. They were given a brochure that explained ways to cope with stress and a guide that listed common grief reactions and ways to explain loss to children. The interventions from this study can provide guidance for clinicians who work in NICUs to consider in caring for those parents whose babies are at high risk of dying (Yildiz & Cimete, 2017). Interventions such as allowing parents to hold the infant, keep the umbilical cord clamp, take photos, keep clothes or foot/handprints, or have the baby baptized can be helpful in allowing parents to grieve (Camacho-Ávila, M. & Fernández-Sola, C., 2019).

Geriatric palliative care

Many terminal illnesses produce shock and grief in their diagnosis, require that someone receive care, and deny a person the prospect of living “to a ripe old age” (Macdonald, 2017). While the delivery of palliative care to the older population is not new, geriatric palliative care is an inter-specialty collaborative approach that “aims to improve the quality of life of elderly persons facing severe and life-threatening illness near the end of their lives” (Voumard, et al., 2019. p.3).

Patients with a primary diagnosis of cancer (32%) had the greatest number of days on palliative care, followed by primary diagnoses of circulatory/heart disease (13.2%) and pulmonary disease (11.3%; Schoenherr, et al., 2019). In addition to these diagnoses, dementia, including Alzheimer’s disease, vascular dementia, and dementia with Lewy Bodies, has been steadily increasing (Endsley, & Main, 2019). According to Endsley and Main (2019), by 2025, the number [of patients with dementia] is expected to grow by almost 35% to 7.1 million, with some projections of 16 million by 2050” (p.456). Regardless of etiology, pain is the most common complaint (50%) of palliative care patients (Endsley & Main, 2019, p.457). This is an important consideration for clinicians who work with geriatric patients and their families to provide quality palliative care.

Healthcare Professional Consideration: More specifically, the geriatric palliative care team can help the patient and family understand each stage of the illness; assess and treat symptoms; make choices that will protect the patient's quality of life; help caregivers establish a daily routine for care; recognize what contributes to troubling behavior; ensure patients have 24-hour support; and help families understand the financial costs of care, including Medicare (CAPC, 2021).

Nearly 20 years ago, Beatitudes Campus, an older adult community in Arizona, created a palliative care program for individuals with dementia that focused on overall comfort and well-being. Namely, Beatitudes Campus maintains that those with dementia should (Comfort Matters, 2021):

- Have access to comfort every day.
- Be offered palliative care well in advance of the end of life.
- Sleep when tired.
- Eat what is appetizing, whenever hungry, by having foods that appeal to them available.
- Receive individualized assistance with personal care.
- Be engaged in meaningful ways, considering unique interests and lifelong pursuits.
- Live in an environment that seeks to promote personal autonomy through balancing sensory, stimulating, and calming events

Just as important as addressing individualized comfort and well-being for patients with dementia is addressing the needs of family members while caregiving. According to MacCourt and colleagues (2017), while giving care, family members feel the loss of the person they knew and may begin their bereavement long before the person they are caring for dies. Although the complexities of family members' offering practical and emotional support to a patient with dementia have been well documented, there continues to be little information about intervention effectiveness, especially in diverse populations (MacCourt et al., 2017). Kathleen Venema (2018) wrote about her mother, who was challenged by the myriad and unpredictable effects of Alzheimer's disease:

> "Mom is confined to a wheelchair, often sounds like an animal in pain, must be fed her meals of puréed food, registers only the barest awareness of others around her. Every Friday I find her bent double over the tray attached to her wheelchair. I hold her hands, stroke her face, tell her I love her, and marvel at the relative ease with which I might breach the infinitesimally thin line – incredibly, the still-thinning line – between living and dying". (Venema, K., 2018, p. 304).

Settings for hospice and palliative care

Palliative and hospice services are provided in settings with various types and domains of care. The most common settings include the following (National Coalition for Hospice and Palliative Care (NCHPC), 2017):

- Hospitals.
- Long-term or chronic care facilities.
- Inpatient hospice facilities.
- The patient's home.

However, as palliative care is supportive care within a medical plan of care, it is also offered across settings such as office practices, cancer centers, dialysis units, assisted-living facilities, home health and hospice agencies, social service agencies, prisons, and homeless shelters (NCHPC, 2017). Regardless of the setting, it is paramount that communication flows among the various settings for optimal health care. This flow of communication among clinicians is important for efficient and successful coordination of care. There are significant incentives for improved integration and collaboration among hospice, hospitals, and community-based programs (Center to Advance Palliative Care [CAPC], n.d.). Hospitals receive penalties for rehospitalizations, unnecessary hospitalizations, and emergency department utilization. Therefore, they are incentivized to find methods to improve community-based palliative care providers (CAPC, n.d.).

Healthcare Professional Consideration: Inpatient palliative care teams assist throughout a health system but play a significant role in intensive care units (ICU). Because 60% of deaths in critical care occur following withdrawal of treatment, hospital-based palliative care teams are essential in providing expertise and support for patients and staff in ICUs (Braganza, Glossop, & Vora, 2017). Life-sustaining procedures that can potentially postpone death include but are not limited to intravenous (IV) fluids for the purpose of hydration, enteral tube feedings, mechanical ventilation, chemotherapy, dialysis, and cardiopulmonary resuscitation (CPR; Coté, et al., 2018). Compassionate care in an ICU that is directed to the patient's family during treatment withdrawal is established through delivery of care and emotional support while maintaining the patient's dignity by controlling symptoms, ensuring patient cleanliness, and removing technical apparatus (Efstathiou & Ives, 2017).

Benefits of Effective Palliative Care-Hospital Partnerships

- Expedites and expands access to a continuum of high-quality palliative care services.
- Extends and strengthens the hospice-hospital partnership through an improved understanding about the resources and constraints of each partner.
- Identifies strategies for improving patient and family satisfaction ratings.
- Provides greater access to professional, community-based bereavement services for families of deceased patients.
- Enhances access to appropriate reimbursement structures for palliative care and hospice services (CAPC, n.d.).

DELIVERY OF HOSPICE AND PALLIATIVE CARE

> *Nurses within the palliative care specialty may practice in designated palliative and hospice teams – our call is for all nurses to take action to transform palliative care across all specialties and care settings.*
> *– American Nurses Association President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN (ANA, 2019).*

Hospice and palliative care include the family, which is defined by the patient (NHPCO, 2020). Spatuzzi and colleagues (2017) studied quality of life in family caregivers of patients with advanced cancer in active treatment centers and hospice care. Caregivers reported that they need more support and information from clinicians when their loved ones are moving from curative oncology treatment settings to other levels of care (Spatuzzi et al., 2017). Therefore, the availability of family/ caregiver support must be in place from the moment of the diagnosis (Spatuzzi et al., 2017). To gain trust of their patients and caregivers, clinicians need to coordinate palliative care to improve a patient's quality of life, understand the significance of providing palliative care across the lifespan, and understand hospice philosophy and central principles (Spatuzzi et al., 2017).

The patient and their caregivers and/or family are involved in the plan of care as appropriate. Usually, the patient is central to decision making, but in some cultures, other members of the family may be designated to make decisions about the patient's care (NHPCO, 2020). Family members are taught how to provide care to the patient, educated about the disease process and how it progresses, and signs and symptoms of the dying process (Capital Caring Health [CCH], 2021).

Interdisciplinary care services

As previously mentioned, hospice and palliative care are both provided by IDT working in coordination to provide patient- and family-centered care (NHPCO, 2020). Patient- and family-centered care take place when the health system's mission and quality-improvement drivers are aligned with a patient's goals, preferences, and cultural traditions, and when the patient, while receiving the right care at the right time, shares information as part of the care team to make informed decisions that result in improved individual health outcomes (Picker Institute, 2021). The core concepts of patient- and family-centered care are dignity and respect for the patient and family; sharing of information and taking part in care and decision making; involvement in care at a level they choose; and collaboration among the patient, family members, and clinicians in developing and evaluating policies and programs (St. Jude Children's Research Hospital, 2021.).

Symptom management

Alleviation of physical and psychosocial symptoms to achieve the best quality of life is the major emphasis of both palliative and hospice care (CCH, 2021). Physical symptoms that may evolve as the disease takes its natural course are pain, constipation, ascites, anorexia, alterations in bowel and bladder functioning, itching, dry mouth, nausea and vomiting, skin breakdown, fever, cough, and altered breathing patterns such as dyspnea (CCH, 2021). As death approaches it is important for both clinicians and family/caregivers to understand symptom progression at the EOL to provide better symptom management for the patient (NHPCO, 2021). Patients and family members are given information by clinicians about what to expect as the disease takes its natural course (CCH, 2021).

During the last 3 months of life, patients may get their affairs in order, sometimes consciously or subconsciously (CCH, 2021). During this time, patients may acknowledge their dying and begin to withdraw and communicate less with those around them, may lose interest in watching television or reading the paper, sleep more than usual, and take naps throughout the day (CCH, 2021). Patients may create a list of items that they want to bequeath to family and friends after they die (Caring Info, 2021). They may begin to or seek advice on how to list financial assets and insurance policies. At this time patients are encouraged to complete a living will, advanced directive, healthcare proxy or power of attorney for medical decisions if it has not been completed.

Despite 90% of American adults agreeing on the importance of outlining and notifying family or friends about end-of-life decisions, only 30% of the same people have documented their preferences (CCH, 2021). An advanced directive is oral or written instruction on how to care for an individual if they are unable to make decisions for themselves. Types of advanced directives are the power of attorney, and a living will. Most advance directives are written by older or seriously ill people (American Family Physician (AAFP), 2021). However, experts agree people should document their wishes at a younger age before a serious accident or illness occurs, when they are in good health (The Conversation Project, 2021). Research shows that, if a person has this documentation, their wishes are more likely to be followed (AAFP, 2021). Many people have difficulty understanding the differences in these documents and how to complete them.

- A power of attorney, or healthcare proxy, is a type of advance directive in which you name a person (family member, friend, guardian) to make medical decisions for you when you are unable to do so (The Conversation Project, 2021).
- A living will is a written, legal document that indicates medical treatments a person would and would not want to be used to sustain life, as well as other medical decisions, such as pain management or organ donation (AAFP, 2021).

In addition to these documents, a do-not-resuscitate (DNR) or allow natural death (AND)) order can be placed in an advanced directive document (CCH, 2021). This legal document can be placed in the medical record and is a request that medical personnel do not perform cardiopulmonary resuscitation (CPR) on a patient if they are pulseless and/or have no respiratory rate/effort (CCH, 2021).

Weeks before death, patients often sleep for most of the day and night. Marked weight loss is common because of poor appetite secondary to lack of hunger, gastritis, nausea, or oral lesions (CCH, 2021). However, as the body shuts down, those who are dying need and want less food; therefore, anorexia is often an unavoidable consequence of an end-stage disease process (NHPCO, 2020). It is also common for patients during these last weeks of life to have a short-lived "rally" and spontaneously ask for a meal or be alert, oriented, and ready for a conversation when previously they were withdrawn or lethargic (NHPCO, 2020).

Towards the last few weeks or days of life, patients may come to terms with dying. Clinicians can explore patients' values, beliefs and meaning in life. McClement and Thompson (2018) found that clinicians who worked in palliative and hospice care were competent in their knowledge about what dying meant to the patient. They also learn what living means– to have relationships and friendships, a belief system, a culture, and a history that meld to form significance throughout one's life (McClement & Thompson, 2018). Clinicians who support patients at the end of life often do not know each patient's detailed personal history, but should be aware of individual characteristics (i.e., relationships and friendships, belief system, culture, etc.) of their lives (McClement & Thompson, 2018). The best method to obtain this information is by asking questions that reflect the patient's roles and accomplishments throughout their lifetime (McClement & Thompson, 2018).

The last days of life, the patient may reduce their physical activity and experience symptoms/ behaviors as described in Table 1 (CCH, 2021). Shortness of breath, which can include labored and noisy breathing, is common in the days before death as respiratory dysfunction and the loss of the ability to swallow occur (CCH, 2021) Cheyne-Stokes respirations (several rapid breaths followed by periods of apnea for up to 30 seconds) can occur along with coughing as the body's fluids begin to build up in the lungs (Hospice Foundation of America ([HFA], 2018). These symptoms can be alleviated with opioids, benzodiazepines, atropine, or scopolamine, along with positioning the patient on their side (HFA, 2018). Pain should be aggressively treated throughout the dying process and especially during the final days and hours before death (American Nurses Association [ANA] & Hospice and Palliative Care Nurses Association [HPNA], 2021). Clinicians should speak with patients and their families about their beliefs and misconceptions about pain management and help patients and family members overcome fears about using narcotics (ANA & HPNA, 2021).

Table 1: End of Life Timeline: Signs, Symptoms, & Interventions as Death Approaches		
	Signs & Symptoms	Interventions
Last three (3) months of life	• Getting their affairs in order. • Less interested in activities or acquaintances outside of family or close friends. • Eating decreases to smaller meals and preferred foods. • Much less active: if active one day, may sleep the entire next day.	• Support the patient and family in decision making. • Provide resources and information. • Encourage patient to talk about needs and end of life goals. • Provide consults as needed (social work, nutrition).
Last week or days of life	• Restlessness/agitation. • May talk about travel or getting ready to "go on a trip". • Sleeping 20-23 hours a day; Awake only brief periods at a time. • Talking to people who have already died; May speak of angels in the room. • Eating little to no food/Taking only sips of liquid. • May have brief periods of alertness and hunger. • Loss of ability to control urine and bowel movements.	• Talk to the patient calmly, light room dimly and use distraction techniques to help reduce restlessness. ○ Consider the use of medications (Haldol, Ativan) if patient agitation causes discomfort (requires order). • Continue to encourage the patient to verbalize thoughts and feelings. • Educate family about the process of dying, including sleeping more, the decrease in eating or drinking, and verbalizing needs and dreams. • Pressure care prevention and positioning is important as the patient becomes more immobile and less able to eat or drink. ○ Elevate head slightly. ○ Turn and reposition patient every 2 hours or as policy requires. ○ Use slide boards/draw sheet when turning to prevent tearing injuries. ○ If wound develops, ensure to document, and treat according to wound type/size and provider order. Consider wound consult if extensive. • Skin care: Keep patient clean via bed bath once a day and provide gentle massage of extremities and back. ○ Can use lotion with massage to help moisturize skin • Use adult briefs for incontinence of urine and feces and change immediately to prevent skin breakdown. ○ Consider foley catheter or rectal tube placement (physician order required) if excessive or required to prevent skin breakdown
Last hours of life	• Body temperature changes. ○ Patient may become febrile. • Irregular breathing patterns can occur. ○ Tachypnea, apnea, Cheyne-stokes (period of deep, rapid breathing followed by slowing or apnea). • Noisy breathing can occur and is typically caused by inability to clear secretions. • Changes in swallowing; Secretions in their mouth. • Slowing pulse and or changes in circulation (cyanosis/mottling). • Confusion, restlessness, or unconsciousness. • Vision changes.	• Counsel family about the signs of impending death so not to be alarmed; let them know their presence helps. ○ Remind the family of the belief that hearing may still be intact until death and encourage them to talk to their loved one. • Monitor body temperature, cover patient with light sheet/blankets depending on value. ○ Consider the use of antipyretics (physician order required) to prevent or treat fever, especially if causing patient discomfort. • Provide oxygen as required for comfort. • If patient becomes anxious or uncomfortable with breathing, consider the use of pain medication (morphine) or anti-anxiety mediation (Ativan; order required). • As mouth breathing becomes more noticeable, provide frequent oral care. ○ Clean and moisten (or remove) dentures as necessary. ○ Provide ice chips or small sips of water. Use moist oral sponges if patient cannot swallow. • Remove any accumulating oral secretions by positioning patient on their side and gentle suction. ○ Consider the use of medication (order required) such as Glycopyrrolate or Scopolamine to dry secretions.

Table 1: End of Life Timeline: Signs, Symptoms, & Interventions as Death Approaches *continued*		
	Signs & Symptoms	Interventions
When death occurs	• The patient cannot be awakened, is unresponsive to stimuli. • The patient stops breathing and their heartbeat stops • Their eyelids may be partially open with the eyes in a fixed stare. • Their mouth may fall open slightly as the jaw relaxes. • Body fluids (urine or stool) may be released as muscles relax.	• Perform assessment of body and pronouncement of death per policy. • Provide comfort and support to family. Encourage family to be with the deceased as appropriate. • Perform postmortem care. • Discuss and inform the family about next steps: (calling funeral home, death certificate, belongings). • Allow for members of the interdisciplinary team to say goodbye to the deceased as appropriate. • Complete all required documentation per policy.
(CCH, 2021; De Swardt & Fouché, 2017)		

As quality of life is the most important goal of hospice and palliative care, having knowledge regarding pain as well as the skill to conduct a comprehensive pain assessment is imperative to the delivery of care. In 2020, the International Association for the Study of Pain revised the definition of pain as "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (Raja, et al., 2020, p.1). In addition, the new definition includes 6 points that provide context to the experience of pain. These are:

1. "Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
2. Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
3. Through their life experiences, individuals learn the concept of pain.
4. A person's report of an experience as pain should be respected.
5. Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
6. Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain." (Raja, et al., 2020, p.1)

In hospice and palliative care, the comprehensive pain assessment is performed and documented by a registered nurse (RN) on admission and then with each visit or patient contact (ANA & HPNA, 2021). In addition to the nurse, all IDT members are trained to assess for pain upon each visit with the patient. For patients who can self-report or who have family present, this includes rating pain on a linear scale (numeric or FACES) and following the PQRST assessment (Table 2).

Table 2: The PQRST Pain Assessment	
Letter	Question(s) to ask patient and/or family member
P= Palliative / Provoking Factors	What causes the pain? What makes it better? Worse?
Q= Quality of Pain	What does the pain feel like? (e.g., sharp, burning, stabbing, dull).
R= Radiation of Pain	Does the pain radiate to other areas? If so, where?
S= Severity of Pain	How severe is the pain on a scale of 0-10? (Other intensity scales can be used).
T= Temporal Factors / Timing	When did the pain start? How long does it last?
(Aus Med, 2021)	

For patients who are non-verbal or cannot answer questions because of cognition or mentation status, clinicians must still assess for pain (ANA & HPNA, 2021). Using tools such as FLACC or PAIN-AD scales can be helpful in addition to clinical observation. The FLACC (Face, Legs, Activity, Cry, Consolability) tool is used to assess pain for children between the ages of 2 months and 7 years or individuals that are unable to communicate their pain (Merkel, et al., 1997). The PAIN-AD (Pain Assessment in Advanced Dementia) tool is used to assess pain in older adults who have either suspected or diagnosed dementia or other cognitive impairment and are unable to reliably communicate their pain (Warden, et al., 2003). Once the assessment of pain is completed, clinicians must include the patient, family, and caregivers in choosing the pain management plan that is most acceptable and inform them that it is possible to control their pain. Interventions should then be implemented as soon as possible to decrease or avoid increasing time patient must tolerate the pain (ANA & HPNA, 2021).

Frequently, pain management includes a combination of treatments. Most frequently, opioid analgesics are used in treating pain associated with advanced illness. Opioid analgesics such as fentanyl, hydrocodone, morphine, and oxycodone are the most commonly used pain-relief medications in hospice and palliative care (American Society of Clinical Oncology, 2017). In combination with pain medication, patients may also benefit from complementary and alternative medicine, incorporating massage, animal-assisted therapy, or mind and body interventions in their symptom management plan (Urden, Stacy, & Lough, 2018). Physical, psychological, spiritual, and existential pain can be treated with biofeedback, relaxation techniques, transcutaneous electrical nerve stimulation, supportive counseling, and spiritual care (ANA & HPNA, 2021). Treatments for pain may also include radiation therapy, nerve blocks, and surgery. Notably, changes in breathing such as dyspnea, coughing, and congestion caused by the patient's inability to clear secretions can be managed by frequent mouth care, positioning the patient on their side, elevating the head of bed, or providing medications such as a opioids and anticholinergics (CCH, 2021).

Self-Assessment Quiz Question #4

What is the most important aspect of delivering hospice and palliative care?

a. Alleviation of pain, providing comfort care.
b. Ensuring the family can make decisions for the patient.
c. Alleviation of both physical and psychosocial symptoms to ensure the best quality of life.
d. Allowing the patient to die at home.

As mentioned in Table 1, the prevention and management of skin tears and pressure wounds are very important to the care of the immobile patient and pain management. Pressure wounds are defined as localized injury "to skin and underlying tissue resulting from prolonged pressure on the skin" (Mayo Clinic, 2021, p.1). These types of wounds most often occur on the bony prominences of the body including heels, ankles, hips, and sacrum/coccyx (Mayo Clinic, 2021). According to the National Pressure Injury Advisory Panel (NPIAP; 2017), there are 4 stages of pressure wounds as described below:

- Stage 1 includes non-blanchable erythema of intact skin "which may appear differently in darkly pigmented skin. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury" (NPIAP, 2017, p.1).
- Stage 2 includes "partial-thickness skin loss with exposed dermis" (NPIAP, 2017, p.1). The clinician can visualize a moist, pink, or red wound bed that may look like an intact or ruptured blister (NPIAP, 2017).
- Stage 3 includes full-thickness skin loss, in which the clinician can visualize ulcer and granulation tissue (NPIAP, 2017). In addition,

slough and/or eschar may be visible as well (NPIAP, 2017). The depth of the wound "varies by anatomical location…Undermining and tunneling may occur" (NPIAP, 2017, p 2).

- Stage 4 also includes full-thickness skin loss; however, it has visible or directly palpable "fascia, muscle, tendon, ligament, cartilage or bone in the ulcer, and undermining and/or tunneling often occur" (NPIAP, 2017, p.2).

Clinicians should also be aware of other types of pressure wounds that can occur in the hospice and palliative care patient population. These include wounds which are considered unstageable or a deep tissue pressure injury (DTI). Unstageable pressure injuries, like stages 3 and 4, also have full-thickness loss; however, slough and/or eschar prevent visualization of the wound bed (NPIAP, 2017). According to NPIAP (2017), if the slough or eschar is removed, "a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed" (p2). A deep tissue pressure injury (or DTI) is considered a wound that is either intact or non-intact and has "persistent non-blanchable deep red, maroon or purple discoloration (NPIAP, 2017, p2.).

In hospice and palliative care, patients sometimes present and are suffering from malignant fungating wounds (MFW). The overall incidence of MFWs is not well documented because of underreporting by patients because of embarrassment and fear (Tilley, et al., 2016). However, among patients with advanced cancers, MFWs "afflict 5% of patients with advanced cancers and 10% of patients with metastasis with life expectancy averaging 6 to 12 months" (Tilley, et al., 2016 p. 514). It is worth noting that these wounds can cause a large symptom burden such as disfigurement, pain, pruritus, malodor, exudates, and bleeding (Tilley, et al., 2016). Caring for hospice patients with MFWs is complex and require a well-planned and interdisciplinary approach as the symptoms patients experience oftentimes lead to a diminished quality of life caused by pain, psychosocial and/or spiritual distress, and isolation (Tilley, et al., 2016).

Management of wounds can vary; however, regardless of treatment choice, the goal of palliative care is comfort. Pain is often the most frequent complaint for patients with wounds and, therefore, selection of the type of dressing and analgesic (systemic or topical) is essential in pain control. Secondly, managing the wound exudate is also important for patient comfort and to diminish odor, which can cause patients and families anxiety. Therefore, choice is important as the selection of a wound dressing which does not need to be changed frequently and can help with pain, anxiety, and absorb odors is preferred. Other interventions for odorous wounds include Metronidazole (systemic and topical), silver dressings, and honey as per provider order. Table 3 provides information on dressing options (Dabiri, et al., 2016, Tilley, et al., 2016). Hospice and palliative care teams, regardless of wound type, should consider consulting with a wound, ostomy, and continence nurse (WOCN) and, according to Tilley, et al. (2016), "preferably with a palliative care background and certification in the hospice and palliative care specialty" (p. 516).

Table 3: Wound Dressing Options

Dressing Type	Details/ Benefits	Type of Wound
Foam dressing	• Multiple shapes and sizes available to fit difficult dressing sites (i.e., heels) and conforms to the body. • Can be left in place for up to 7 days. • Promotes a moist wound environment. • Highly absorbent, prevents strikethrough. • Can be used with topical agents.	• Heavily exudating. • Pressure ulcers. • Surgical wounds. • Venous leg and diabetic ulcers. • Donor sites. • MFWs.
Calcium Alginate	• May be used to cover or fill wound bed. • May act as a hemostatic agent. • Can be left on until saturated. • Interacts with exudate to form a gel, which then works to promote a moist wound environment. • Useful for packing wounds. • Requires a secondary dressing	• Exudating wounds. • Pressure ulcers. • Surgical wounds. • MFWs.
Hydrocolloid	• Can be left in place for up to 7 days. • Promotes a moist wound environment and debridement. • Waterproof and occlusive, which prevents bacterial contamination.	• Exudating wounds. • Pressure ulcers. • Venous leg and diabetic ulcers. • Donor sites. • Dry wounds. • Superficial wounds.
Hydrogel	• Easily removed from wound by irrigation with normal saline/sterile water. • Increases moisture, preventing eschar formation. • Promotes autolytic debridement. • Secondary dressing is required.	• Pressure ulcers. • Surgical wounds. • Venous leg and diabetic ulcers. • Dry wounds. • Partial thickness wounds. • Lacerations. • MFWs.
Honey	• Supersaturated sugar solution with high osmolarity, low water activity. • Bactericidal. • Keeps wound moist while removing necrotic tissue. • Lowers wound pH to promote healing.	• Exudating wounds. • Pressure ulcers. • Surgical wounds. • Venous leg and diabetic ulcers. • Sloughy or infected wounds. • MFWs.
Skin Protectant	• Provides 24-hour protection of intact or damaged skin from bodily fluids, adhesives, and friction. • Does not require a cover dressing.	• Can be used for Stage I and Stage ll pressure ulcers. • MFWs

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Lastly, as families wait for their loved one to die, they may ask clinicians how much time is left because of the symptoms they are witnessing. It is important for the clinician to provide clear, factual, and supportive information during this time that includes noting the signs and symptoms of nearing death (see Table 1). As death approaches, patients will oftentimes have a dramatic drop in blood pressure, drop in overall body temperature, and extremities may become mottled (reddening and pooling of blood in spaces in the body) and/or feel very cold to the touch. The patient may experience severe unconsciousness, agitation, hallucinations, urinary and/or bowel incontinence, and the jaw will drop as the body is held in a rigid and unchanging position (ANA & HPNA, 2021). Hearing and vision may decrease until death (CCH, 2021).

Once death occurs, a person no longer breathes and has no heartbeat. There may be minimal movements from the arm or leg because of involuntary muscle movement and the release of a small amount of urine or stool (CCH, 2021). After a few minutes, the skin turns pale, waxen, and cool to the touch. Within 30 minutes of a patient's heart stopping, the blood supply will stop moving through the body and any part of the body that is on a firm surface will show signs of lividity, which looks like a dark purple discoloration against the skin (AMBOSS, 2021; Harle, 2017). Approximately 2 to 6 hours after the death, rigor mortis occurs and is first seen in the small muscles around the eyes, neck, and jaw (Shivpoojan, 2018).

Self-Assessment Quiz Question #5

The Center to Advance Palliative Care (CAPC) provides action items for nurses and other healthcare professionals and organizations to support equity and access to hospice and palliative care among vulnerable populations. These include:

a. Collaborating with the social worker on your team about any unmet needs in the population you serve.
b. Developing a vision and mission statement that encompasses reducing health inequity.
c. Listening to patients and families about what matters most to them, and about their greatest worries.
d. All the above.

Care at the time of death

The pronouncement of death is a moving and profound time for the family members and clinicians. It is typically defined as the opinion or determination that, based on a physical assessment, life has ceased (National Conference of Commissioners on Uniform State Laws, 1980). Determination of death does not require consent from the patient's family or a surrogate decision maker (Pope, 2018). In most instances, especially in the in the acute care environment, a physician is responsible for the death pronouncement. If the patient's physician is unable to be present within a reasonable time and the death is because of natural causes or the patient is being cared for in the home, the RN employed by hospice can pronounce death (Brent, 2016). Many states have passed laws that allow registered nurses and/or advanced practice registered nurses to pronounce death; therefore it is essential that nurses recognize specific laws and variances in their state that relate to the location of the death, such as a hospital, nursing home, or home; whom the registered nurse and/or advanced practice registered nurse must notify before pronouncing a death, such as the medical examiner or attending physician; the requirement that the registered nurse or advanced practice registered nurse was caring for the patient; and whether they can fill out and sign the death certificate (Brent, 2016). Different hospitals and care facilities may have their own policies regarding the death pronouncement.

Upon the pronouncement of death, the patient must first be correctly identified by two patient identifiers and per facility policy. The person verifying the death notes the general appearance of the body, unresponsiveness to verbal or tactile stimuli, listens for the absence of apical and carotid pulses and breath sounds, usually for one full minute. The time at which the assessment was completed must be recorded; this is the official time of death. The physical examination, time of death, and family response are then documented in the medical record and may include the following:

- The pronouncer's name and license number.
- A brief description of events preceding death.
- The primary hospice diagnosis.
- Notation of the absence of pulses, respirations, and pupil responses.
- Those present in the room and response during the pronouncement of death.
- Any communication provided to staff or others during the assessment, such as releasing the body to a funeral home or the nurse notifying the patient's attending family, pastoral care, social worker, donor services, and coroner.

Additionally, a patient must be pronounced dead for organ and tissue donation to take place and many jurisdictions, along with the 1986 Omnibus Budget Reconciliation Act (OBRA,) require that a patient's survivors be made aware of the option of organ and tissue donation upon death (Elsevier Clinical Skills, 2020).

Postmortem care

After the pronouncement of death, postmortem care can begin. Postmortem care, which can be provided in the home and in healthcare facilities, involves "caring for a deceased patient's body with sensitivity and in a manner that is consistent with the patient's religious or cultural beliefs" (Elsevier Clinical Skills, 2020). Typically performed by nursing staff, postmortem care should be done as soon as possible to prevent tissue damage or disfigurement and should provide a peaceful and respectful presentation of the patient for family and visitors (Elsevier Clinical Skills, 2020). Cultural and religious beliefs can dictate how the body will be handled after death and should be discussed as part of the patients plan of care before death (Table 4; Pyrek, 2017). It is important to remember that cultural practices may vary, and clinicians should ask the patient and family about religion and beliefs. Universal precautions along with any other infection control procedures must be maintained for infection prevention and to limit bloodborne pathogen exposures (Pyrek, 2017).

Table 4: Religious and Cultural Considerations in Care of the Body Near and After Death.	
Buddhism	• Provide a quiet place for death and maintain strict silence after death. • Incense may be requested to use. • When the person has died, cover the body with a cotton sheet. • Leave the deceased's mouth and eyes open. • Autopsy and organ donation are permitted.
Christianity	• Varying practices at time of death; there are not prescribed rituals for body preparation. • Bible texts may be read near or at the time of death. Protestants receive the sacraments of Holy Communion or sometimes baptism. • Roman Catholics often request sacraments of Penance, Anointing of the Sick, and Holy Communion at the end of life. • In most cases, autopsy and organ donation are permissible.
Hinduism	• Prefer to die at home or in a quiet setting and family members prefer to wash the body after death. • Because of a belief in reincarnation, efforts are made to resolve relationships before death. • The head of a person nearing death should face the east with a lamp placed near the head if possible. • If the dying person is unable to chant mantras, a family member can chant them into the right ear. • Passages from Bhagavad Gita are recited. • Hindus prefer cremation of the body.
Islam	• A Muslim reader recites verses from the Qur'an when the person is near death. • Family members usually prepare the body, and non-Muslims should not touch it. • The person's eyes should be closed after death and the arms and legs straightened. • Autopsy or organ donation is generally not permissible, except as required by law.
Judaism	• Confessional, blessings, and readings from the Torah are traditional. • Sometimes a family member will close the person's eyes and remain with the body until burial, which takes place within 24 hours, but not on the Sabbath. • Organ donation prohibitions may exist in Orthodox Judaism, but not for all Jews. • Autopsies may be considered if organs are not removed.
(Perry, et al., 2018)	

Postmortem care begins by putting the patient in a supine position, elevating the head about 30 degrees, placing a washcloth under the chin to keep the mouth closed, and straightening the limbs. If the eyes are open, gently, and repeatedly massage the eyelids downward and outward; if they remain open, use a strip of tape to keep them closed unless they are being donated, which requires covering them with gauze moistened with normal saline (Elsevier Clinical Skills, 2020). If an autopsy is required, IV lines, tubes, and catheters (capped or clamped) should be kept in place rather than removed, unless facility policy states otherwise (Elsevier Clinical Skills, 2020). These can be removed if no autopsy is required and as facility policy allows (Elsevier Clinical Skills, 2020).

Before washing the patient, a waterproof pad or incontinence brief should be placed under the patient's buttocks as well as any areas that are draining and a towel can be placed under the patient's chin to help keep the mouth/jaw closed (Elsevier Clinical Skills, 2020). Place a clean gown on the patient or any clothing requested by the family, then place a clean sheet over the body up to the chin with arms outside the sheet, if possible (Elsevier Clinical Skills, 2020). Remove any medical equipment when possible and turn down lighting to provide a calm environment for family and visitors to be with the deceased (Elsevier Clinical Skills, 2020). If the patient died from an infectious disease, staff should label the body according to hospital or facility policy. After identifying information about the deceased (e.g., patient's name, hospital number, date of birth, date and time of death, name of attending physician) is written on death identification tags, the tags are placed on the patient's toes or ankles per funeral home, morgue, or facility policy (Elsevier Clinical Skills, 2020).

Postmortem care also includes giving the patient's clothing and jewelry to the family. If the family is not present, personal belongings should be bagged and labeled and may be stored or given to the funeral director for later retrieval by the family (Elsevier Clinical Skills, 2020). The body is then left on the bed for the funeral director or before transportation to the morgue (Elsevier Clinical Skills, 2020).

Supporting families coping with dying

One way clinical staff can provide psychological support to families and caregivers following the death of a patient is allowing them to provide postmortem care for the deceased family member if they choose. They can comb their loved one's hair, wash their hands and face, stroke their head, apply lotions to the arms, wash the entire body, and/or dress their loved one in fresh pajamas or clothing before the body is sent to the morgue or funeral home (Elsevier Clinical Skills, 2020).

In 1969, Viktor Frankl argued that the main goal in a person's life is to actively create and find meaning and value in life. This reflective process at the end of life includes emotional, physical, cognitive, behavioral, and spiritual exploration, and helps many to find understanding and positive transformation (Frankl, 1969).

- Emotional component: exploring one's feelings about a diagnosis with a terminal prognosis.
- Physical component: coping with bodily changes and any significant suffering.
- Cognitive component: thinking about adapting to what is and leaving behind what was.
- Behavioral component: conveying wishes to others and personally acting upon those wishes based on personal values.
- Spiritual component: interpreting life's purpose, unraveling its mystery, and leaving a legacy that explains it all.

As individuals face dying, they may attempt to find meaning in their losses, their lives, their illness, and most importantly, in their own deaths (Smith, 2017). For example, they may attempt to find meaning by asking themselves what it means to be near the end of life, or they may attempt to find meaning by exploring what it means to no longer exist (Smith, 2017).

Supporting colleagues following the death of a patient

Providing care for patients with a life-limiting illness can be stressful for clinical staff, yet it has not been well studied (Rodenbach, et al., 2016). As clinicians support those with a life-threatening illness, barriers remain in the care, communication, and relationship with the patient (Rodenbach, et al., 2016). Studies have shown that physicians who personally have a fear of death have patients with longer terminal hospital stays, and those physicians "who have not accepted their own mortality are more likely to focus solely on biomedical issues rather than dying patients' emotional concerns" (Rodenbach, et al., 2016).

Among hospice and palliative care clinicians this is especially relevant, as frequent exposure to death and suffering can evoke intense emotions and can lead to anxiety, disengagement from patients, and compassion fatigue, which impacts clinician burnout (Cross, 2019). However, such exposure also can yield several positive outcomes, such as greater personal fulfillment and enhanced meaning in life (De Swardt & Fouché, 2017). Therefore, clinicians should focus on the relationship that is shared with the patient but also on their own beliefs about death, dying, and suffering (Rodenbach, et al., 2016). To offer effective communication and support, the clinician should understand and be comfortable with their own attitudes about what the patient is going through by asking (Dignity in Care, 2016):

- How would I be feeling in this patient's situation?
- What is leading me to draw these conclusions?
- Have I checked whether my assumptions are accurate?
- Am I aware how my attitudes toward the patient may be affecting them?
- Could my attitudes toward the patient be based on something to do with my own experiences, anxieties, or fears?
- Does my attitude toward my job help or hinder my ability to treat this patient with care, openness, and respect?

In a study by De Swardt and Fouché (2017), nurses reported that safeguarding the integrity of the patient was a priority and that providing professional and quality care to the patient and the family was seen as significantly important. Stress reduction techniques can be helpful for clinicians during this process and delivery of care. Jordan et al., (2016) maintain that nurses can use problem-based educational strategies to promote learning about ways to cope with stress while ensuring personal safety during this complex professional practice situation. Moreover, using a problem-solving approach as a coping strategy can help with finding meaning in the stressful part of the experience (Alsarqri, 2017). Techniques include deep-breathing exercises to reduce some of the stress (American Holistic Nurses Association, 2017). This type of diaphragmatic breath starts in the belly and draws the diaphragm downward into the abdominal cavity; take slow, full breaths instead of short, shallow ones from the chest (American Holistic Nurses Association, 2017). Healthcare professionals can also consider thinking about a soothing activity, positive thinking, or silence to maintain self-control; rather than paying attention to negative feelings, divert bad thoughts (American Sentinel University, 2017). In addition, the practice of mindfulness while focusing attention on the experiences of the present moment can help with coping (American Sentinel University, 2017).

In the same study, nurses reported that while providing postmortem care, they felt detached from some relationships; they specifically detached themselves professionally and emotionally from the dead patient, the family, and the death experience (De Swardt & Fouché, 2017). This detachment, described by the authors as thanatophobia, or an "intense fear of death or dying" (De Swart & Fouché, 2017, p.1), caused some nurses emotional trauma and challenges when it came to caring for their patients. Techniques to help reduce stress in this situation include using visualization to picture each step in the challenging task and see overcoming each to reach the next step in the care being provided and practice telling oneself that they are confident in the skill of providing competent postmortem care (American Sentinel University, 2017).

Theoretical models

In addition to finding meaning, a variety of theoretical perspectives can help guide the way in which clinicians provide support to those coping with death and dying. These theories can be applied from the time of diagnosis to the time of death. Theoretical models of the dying process help clinicians intervene appropriately and offer the best quality of life for these patients. Theoretical models of the dying process include stage-based, awareness-based, task-based, phase-based, landmarks-based, and spirituality-based models.

The stage-based approach to coping with dying is the most familiar among healthcare providers. This groundbreaking work by Elisabeth Kübler-Ross (1969) outlined the emotional stages of the dying process and includes the five stages of grieving, or accepting death: denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969). What this model can teach clinicians is that the underlying philosophy of the stage-based model is not to manipulate and move those with a life-threatening disease through transitions and milestones as death approaches; stages do not occur in a fixed sequence or timeline (Connelly, 2020). More specifically, the Kubler-Ross Five State Model described is:

1. Denial: "I can't believe it", "This can't be happening", "Not to me!", "Not again!". This stage is the initial numbness and shock phase and is usually temporary. It is a "…defense that gives us time to absorb news of change before moving on to other stages" (Connelly, 2020, p.1).
2. Anger: "Why me? It's not fair!" "NO! I can't accept this!", The anger stage reflects how our denial usually turns to anger. Humans then attempt to blame others (Connelly, 2020).
3. Bargaining: "Just let me live to see my children graduate." "I'll do anything if you give me more time. A few more years?" This stage is "an attempt to postpone what is inevitable [and] we start bargaining in order to put off the change or find a way out of the situation" (Connelly, 2020, p1).
4. Depression: "I'm so sad, why bother with anything?" "What's the point of trying?". According to Connelly (2020), this occurs "when we realize that bargaining is not going to work [and] the reality of the change sets in. At this point we become aware of the losses associated with the change and what we have to leave behind."
5. Acceptance: "It's going to be OK." "I can't fight it; I may as well prepare for it." This last stage occurs when a person realizes that "fighting the change is not going to make it go away" (Connelly, 2020, p.1). It is important to note that this is not the same as being happy, but rather a resigned attitude towards the change and a sense that they must get on with it (Connelly, 2020).

Awareness-based theory by Glaser and Strauss (1968) provides a theoretical model for coping with dying that is based on a context of awareness and how the situation is perceived by significant others in the person's life. For decades, the Glaser and Strauss awareness-of-dying model has guided research on patients' awareness of their conditions. The model describes four types of awareness contexts: closed awareness, suspected awareness, mutual pretense, and open awareness.

- In closed awareness, the patient does not know they are, but everyone else is aware. Often, family members keep the news from the patient. In closed awareness, the nurse and social worker do not discuss the patient's illness directly with the patient.
- In suspected awareness, the patient suspects what others know and attempts to find out more information about the prognosis. The patient becomes suspicious as they become increasingly ill. Although the patient may want to know how sick they really are, the patient is not told that they are dying. A patient's context of awareness will influence how they communicate with family members, friends, and clinicians who care for them. Communication depends on the patient's level of awareness. With closed awareness, communication is restricted. The more the patient is aware, the greater the opportunity to share concerns, issues, and needs.
- In mutual pretense, the patient, family members, and clinicians pretend they do not know the prognosis. Unless the patient initiates the conversation about impending death, no one talks about it. Everyone involved acts as though the patient is going to live. Although clinicians can explore a life review and reminisce with the patient, it is difficult to do so if everyone is pretending that the patient is not going to die.
- In open awareness, the patient is aware of impending death and is both preparing for it and discussing it. During open awareness, the patient can talk openly about forgiveness, gratitude, and love. Although open awareness allows those who are dying to become aware of their approaching death, not everyone wants to know when they will die. This awareness allows clinicians to review not only the patient's life, but also the meaning of their dying and death (Glaser & Strauss, 1968).

What this model can teach clinicians who work with those who are living with a life-limiting illness is that the context of awareness will influence how people communicate with their family members, friends, and clinicians who care for them. Any communication about the terminal illness or the dying process with the patient depends on the patient's level of awareness. If the patient has closed awareness, communication will be restricted. Conversely, the more the patient is aware, the greater the opportunity to share concerns, issues, and needs.

While dealing with each phase that brings the patient closer to death, there are certain tasks that need to be accomplished while living with life-threatening illness. In 1992, Charles Corr created a model that focuses on how people with a life-threatening disease cope with dying by completing four areas of taskwork (Kilcrease, 2021). These dimensions include physical, psychological, social, and spiritual tasks (Kilcrease, 2021).

- Physical tasks involve managing bodily needs and minimizing physical distress, such as by controlling pain and constipation.
- Psychological tasks maximize psychological security, autonomy, and richness in living.
- Social tasks enhance significant attachments and address the social implications of dying.
- Spiritual tasks address meaningfulness, connectedness, and transcendence.

This model teaches clinicians who work in palliative care and hospice care that as individuals find ways to manage their bodily changes, attempt to maintain a healthy mental perspective, and cherish their relationships, they are also exploring what is sacred to them in the time they have left.

The phase-based theory of dying was developed in the late 1970s by Pattison for people with a life-limiting disease. This theoretical model of the dying process focuses on the living-dying interval that occurs from when the patient learns that death is imminent to the actual death, during which the patient oscillates between denial and acceptance of the prognosis (Pattison, 1978). Three clinical phases take place during the living-dying interval phase: acute, chronic, and terminal. As the patient moves through each of the phases, the dying process is determined by their feelings and reactions, which can continually change (Pattison, 1978). What this model can teach clinicians who work in palliative care and hospice care is to recognize how the varying changes emotionally affect the patient from the very first moment of learning of the terminal illness to the moment of death (Pattison, 1978).

- During the acute crisis phase, the patient is challenged by understanding that a dying process beyond their control influences the death. Close friends and family help the patient deal with the reactions to the news.
- During the chronic phase, the patient has a keen awareness of concurrently living and dying. Friends and family help the patient respond appropriately to what is happening.
- During the terminal phase, the patient withdraws from the outside world and becomes aware of the need to conserve their internal energies. Friends and family compassionately prepare the person to move into this last phase

Doka (1996) describes another theory of life-limiting illness that includes the prediagnostic, acute, chronic, terminal, and recovery landmarks. Each landmark then has an associated task of coping. In the prediagnostic landmark, individuals suspect an illness and seek out medical attention (Doka, 1996). The acute landmark, initiated by the diagnosis, is when individuals attempt to understand the disease, maximize health, develop coping strategies, explore the effects of the diagnosis, express feelings, and integrate the present reality into their sense of past and future (Doka, 1996). The chronic phase involves managing the symptoms and side effects while carrying out health regimens, normalizing life, maximizing social support, expressing feelings, and finding meaning in the suffering (Doka, 1996).

Those who have a life-threatening disease can inform a family member or close friend of the location of insurance documents and important papers, contact people in their address books, renew old friendships, and express their love to others. By addressing unfinished business, whether practical or emotional, dying individuals feel in control. In the terminal phase, individuals cope with dying by managing pain, symptoms, health procedures, and related stress. Dying persons prepare for death by saying goodbye and finding meaning in life and death. Some individuals experience a recovery phase during which their disease is cured or in remission.

What Doka's model (1996) can teach clinicians who work in palliative care and hospice care is that there are tasks to complete in each phase of dying, from setting up the first appointment with a physician to learning how to adjust to the new reality to managing the physical, emotional, cognitive, behavioral, and spiritual changes and preparing for death. Landmarks and taskwork for the end-of-life clinicians who work with patients who have a life-threatening disease can help them to review their lives, find meaning in their lives, complete important tasks, and accept the reality of death. This approach is based on the work of Ira Byock (1996), who identified the importance of patients with a life-threatening disease attaining certain landmarks before death. At each landmark, individuals have taskwork to complete. These landmarks include completing one's affairs, resolving relationships, finding a sense of meaning in one's life, experiencing love of self and others, acknowledging the finality of life and a sense of a new self, and letting go. A patient's spiritual perspective across the dying trajectory stems from their belief system; faith; values; life's purpose; and perception of the meaning of their existence in relation to others, including family members and close friends, nurses, physicians, social workers, and pastoral counselors (Fitch & Bartlett, 2019). Spiritual distress is just as critical as body and mind distress (Fitch & Bartlett, 2019). A spiritual approach to coping with dying can enhance the patient's life and can be instrumental for those who have a life-threatening disease and for their family members (Fitch & Bartlett, 2019)

What this model can teach clinicians who work with those who are coping with life-threatening illness is that spirituality is woven throughout a person's beliefs about their illness, even if the term spirituality or religion is never mentioned. Clinicians can begin to assess the spirituality of patient by asking "Does spirituality play a role in your life?" Once addressed, clinicians can focus on the wholeness of the patient, which includes the patient's body, mind, and spiritual essence. Additional spiritual questions to explore with patients are as follows:

- What items of special meaning do you want in your room?
- What can you tell your spiritual companion about the people you want – or don't want – around you?
- How do you want God to be present with you as you go through your death?
- Dying often takes days or weeks. How do you like to be comforted and reassured?
- Do you want or expect to have visions of loved ones as you prepare to die? If so, who might you see?
- What spiritual insights have you recently had?
- What are the spiritual understandings you feel you have lived your life by?
- What are your beliefs about the afterlife?
- What do you think will happen to yourself/your soul in the afterlife?
- Do you have special prayers/readings you want said?

(Anderson & Sacred Dying Foundation, 2017)

Although chaplains, community-based clergy, and pastoral counselors recognize and explore spiritual distress, all professional care providers can inquire into this significant part of the patient's being (CCH, 2020). Bowman (2016) notes that spirituality is now routinely included in palliative care and that spiritual care is not synonymous with religious practice. This difference may cause tension for those providing end-of-life care because, all too frequently, patients near the end of life may reveal things when ready to clinicians with whom they experience comfort; clinicians need to be ready to address any spiritual and grief concerns when voiced (Bowman, 2016). Accordingly, a palliative care team may help patients and families move toward acceptance and peace if they are challenged by the illness and are looking for spiritual support (Ernedoff & Cox, 2017; Moestrup & Hvidt, 2016).

Theoretical models of the dying process help clinicians see that there is not only one way to provide support at the end of life (ANA & HPNA, 2021). Each patient faces terminal illness and dying in their own unique way. Clinicians can use these models as a guide while providing care at any point in the dying trajectory. Clinicians must realize that they need to individualize their approach to end- of-life care with patients based on the patient's awareness level, what is sacred to them, and what struggles they may be facing (NHPCO, 2021). Clinicians can note how the principles of the theories are reflected in their practice and focus on how they can adapt or modify the concepts of the coping-with-dying theories to meet the needs of those they help. Moreover, they can promote a discussion with those they help about the principles noted in the theories (ANA & HPNA 2021).

Case study 1

Mrs. Osmani is an alert and oriented 88-year-old White woman who was recently diagnosed with heart failure with an ejection fraction of 20%. It has been 10 years since the death of her beloved husband and all of her children are deceased. Most of her friends are also deceased or living in nursing homes. In addition, her best friend Carol has Alzheimer's disease. Mrs. Osmani lives in her own home and is cared for by a live-in assistant, Marina. Mrs. Osmani has been under the care of Dr. Frimet for the past 4 years.

Marina takes Mrs. Osmani to see Dr. Frimet, who explains to Mrs. Osmani that her heart failure is not curable, and her life expectancy is limited. With a compassionate tone and in language the patient understands, the physician explains that she probably has less than 6 months to live. With Marina by her side, Mrs. Osmani listens as Dr. Frimet tells her about hospice care and she agrees to an introductory meeting with the interdisciplinary team, which is quickly arranged.

The next day, Mrs. Osmani and Marina meet with the hospice nurse, Sandra, and the social worker, Tim. They spend the next 2 hours discussing the philosophy of hospice care and services that can be provided through the HMB. Sandra explains the guidelines for determination of appropriateness for hospice services. After Sandra conducts a patient assessment, she explains how hospice can provide care in Mrs. Osmani's home. Marina states that she is fearful that hospice wants to take her job away. Tim makes it clear that Marina will still be Mrs. Osmani's primary caregiver, and the hospice team will support Marina as she cares for her.

Mrs. Osmani appears anxious about the home visits and asks what Sandra will do during visits. Sandra attempts to alleviate any fears and explains that during each visit she will perform a physical assessment, discuss any problems, and update the plan of care according to Mrs. Osmani's wishes. In very simple language, Sandra explains that the assessment at each visit will focus on any physical symptoms that Mrs. Osmani may report. Sandra discusses the questioning and listening that she will perform regarding expected symptoms such as pain, changes in appetite, and bowel and bladder function. Sandra offers a detailed explanation of the physical assessment she will perform for common respiratory issues as well as alterations in skin integrity, urinary elimination, and cardiac/circulatory function. She explains everything in nonmedical language and frequently asks Mrs. Osmani and Marina if they understand or have any questions or concerns.

Sandra also discusses her role in managing Mrs. Osmani's medications and consulting with Dr. Frimet. She describes a symptom management comfort pack that will be kept in the home and includes medications for pain or other distressing symptoms that Mrs. Osmani may develop. Sandra explains that she will visit weekly to oversee Mrs. Osmani's care, but Marina will remain her primary caregiver. If Mrs. Osmani or Marina believe they need further help, hospice can provide an aide several times a week to assist with Mrs. Osmani's care. Tim, the social worker, then recommends certain safety measures to prevent falls, including adequate lighting, adequate phone access, and removal of area rugs.

Supplemental oxygen is also discussed because it is commonly prescribed for patients with heart failure. Tim explains to Mrs. Osmani that he will be responsible for ordering home medical equipment, such as a hospital bed and a wheelchair, should they be needed. During this conversation, Mrs. Osmani asks for a walker. Tim tells Mrs. Osmani and Marina that if either of them has any problems coping, he, along with the bereavement and spiritual counselors, can help with emotional support.

When Tim asks about advance directives, Mrs. Osmani gives him a copy of her living will and states that her neighbor and close friend, Ida, is her healthcare surrogate and understands her end-of-life wishes. Mrs. Osmani mentions that a few weeks before, Ida expressed a belief that hospice providers euthanize all their patients. Tim explains that hospice does not euthanize people. He goes on to explain that the overriding objective of hospice care is to develop a working partnership with the patient. Tim will help Mrs. Osmani in identifying any problems with her care and developing goals to address these care problems.

Mrs. Osmani expresses concerns about the role of Dr. Frimet in her care. She says that she trusts Sandra and Tim, and although she wants to begin hospice care, she does not want to lose her physician-patient relationship with Dr. Frimet. Tim assures her that Dr. Frimet can remain her primary care physician, and Sandra explains that she will make frequent reports to Dr. Frimet, who will continue to provide medical orders for her care.

At the end of the meeting, Tim schedules a meeting for Mrs. Osmani and Marina with the bereavement and spiritual counselor for next week. Sandra gives Marina a magnet with the hospice contact phone numbers and Marina later places it on the refrigerator for easy access. Before leaving, they each schedule follow-up home visits and ask if Mrs. Osmani and Marina have any further questions.

Questions

1. How did Dr. Frimet present hospice care to Mrs. Osmani? Why was hospice care a good choice for Mrs. Osmani?
2. What are the actions of the nurse and the social worker in explaining hospice services? Were their explanations helpful?
3. Were all of Mrs. Osmani's concerns and emotions adequately addressed during this visit?
4. How could the social worker have better addressed the feelings and concerns of Mrs. Osmani and her caregiver?

Responses

1. Dr. Frimet informed Mrs. Osmani that she has a limited life expectancy. He did not seem uncomfortable informing her of her terminal illness, and he did not neglect to explain hospice care as an alternative to her current treatment. Hospice can be offered to patients only when the attending physician determines that the patient has a time-limited prognosis and curative care is no longer appropriate. During their initial meeting, the hospice nurse and social worker spent extensive time discussing hospice care with Mrs. Osmani and Marina, her caregiver Mrs. Osmani and Marina understands that hospice is not going to take over Mrs. Osmani's care. Although an aide can come in several hours a week and a nurse will oversee the patient's care, the primary responsibility of care remains with Marina. This is a good option for both Mrs. Osmani and Marina.
2. When Mrs. Osmani appeared worried about her home visits with hospice staff, Sandra took the time to alleviate any fears and explain in detail what services she would perform each week as Mrs. Osmani's hospice nurse. This dialogue encouraged Mrs. Osmani's trust in Sandra and the rest of the hospice team. When learning about Mrs. Osmani's fear that patients under hospice care are euthanized, Tim, the hospice social worker, clearly explained that hospice does not euthanize patients. Mrs. Osmani seemed reassured by hearing that Tim's role includes identifying any problems that Mrs. Osmani may have and helping to alleviate her suffering.

3. Although Tim recommended appropriate safety measures, he neglected to discuss Mrs. Osmani's many losses. In fact, both Sandra and Tim failed to address Mrs. Osmani's potential emotional concerns. Her husband and both children have died, she has lost many friends, and her best friend has Alzheimer's disease. Clearly, she may have bereavement issues because of her losses.
4. Although it is not Tim's primary job as the social worker to address bereavement issues, as an illustration, he could have taken the time to see how much of a concern Mrs. Osmani's losses are to her and whether they are compounding any other losses she may be experiencing. Although he did recommend an initial visit with the bereavement and spiritual counselor, he did not take the time to discuss the counselor's role. Because Marina cares deeply for Mrs. Osmani, her anticipatory grief needs should be examined as well.

Common myths and barriers

Although hospice and palliative care allow patients the autonomy in dealing with their own illness, there are still misconceptions that contribute to fear and resistance. These misconceptions then cause barriers to care delivery (NHPCO, 2021). Many people consider hospice synonymous with death, giving up hope, euthanasia, or assisted suicide (Landers, 2017). Zimmermann and colleagues (2016) found when palliative care was introduced to patients, they reported feeling shock and fear, resistance to it, and a lack of relevance to them. The American Hospice Foundation (n.d. -a) identified common myths of hospice and palliative care that are listed in Table 5.

Table 5: Common Myths of Hospice

Myth #1: Hospice is a place.	False: Hospice is a philosophy and hospice care takes place wherever the patient calls home.
Myth #2: Hospice is only for people with cancer.	False: More than one-half of hospice patients have diagnoses other than cancer. Hospices serve many HIV/AIDS patients and the end-stages of chronic diseases such as COPD, Alzheimer's, cardiovascular, and neuromuscular diseases.
Myth #3: Hospice is only for old people.	False: Although most hospice patients are older, hospices serve patients of all ages. Many hospices offer clinical staff with expertise in pediatric hospice care. Almost 20% of hospice patients are under 65 years of age.
Myth #4: Hospice is only for the dying person.	False: As a family-centered concept of care, hospice focuses as much on the grieving family as on the dying patient. Most hospices make their grief services available to the community at large, serving schools, churches, and the workplace.
Myth #5: Hospice can help only when family members are available to provide care.	False: Recognizing that terminally ill people may live alone or with family members unable to provide care, many hospices coordinate community resources to make home care possible. Or they help to find an alternative location where the patient can safely receive care.
Myth #6: Hospice is for people who don't need a high level of care.	False: Hospice and palliative care is serious medicine and can be quite high-level. Most hospices are Medicare-certified, requiring that they employ experienced and highly skilled medical and nursing personnel. There are four levels of hospice that reflect the changing needs patient may have while under care. Hospices also offer state-of-the-art palliative care, using advanced technologies to prevent or alleviate distressing symptoms.
Myth #7: Hospice is only for people who can accept death.	False: While those affected by terminal illness struggle to come to terms with death, hospices gently help them find their way at their own speed. Many hospices welcome inquiries from families who are unsure about their needs and preferences. Hospice staff are readily available to discuss all options and to facilitate family decisions.
Myth #8: Hospice care is expensive.	False: Most people who use hospice are entitled to the Medicare Hospice Benefit. This benefit covers virtually all hospice services and requires little, if any, out-of-pocket costs. This means that there are no financial burdens incurred by the family, in sharp contrast to the huge financial expenses at the end of life that may be incurred when hospice is not used. Medicaid and most private insurances also have hospice benefits where services are covered.
Myth #9: Hospice is not covered by managed care plans.	False: While managed care organizations (MCOs) are not required to include hospice coverage, Medicare beneficiaries can use their Medicare hospice benefit anytime, anywhere they choose. They are not locked into the end-of-life services offered or not offered by the MCOs. Those that do have MCO plans may have hospice coverage that is detailed in their plan.
Myth #10: Hospice is for when there is no hope.	False: When death is in sight, there are two options: submit without hope or live life as fully as ever until the end. The gift of hospice is its capacity to help families see how much can be shared at the end of life through personal and spiritual connections often left behind.

(American Hospice Foundation, n.d. -a, p.1)

Other barriers to the delivery of hospice and palliative care include both the education and training of healthcare providers in this specialty area. The National Consensus Project for Quality Palliative Care (NCP) aims to formalize and delineate evidence-based processes and practices for the provision of safe and reliable high-quality palliative care in all care settings (National Coalition for Hospice and Palliative Care, 2018). The overview and scope of the 4th edition of the NCP Clinical Practice Guidelines for Quality Palliative Care is to:

- Improve access to palliative care for those with serious illness in all care settings by integrating palliative care principles and best practices into routine assessments and care.
- Formalize evidence-based practices for palliative care for seriously ill adults and children in all care settings.

- Provide guidelines to assist in developing palliative care reimbursement mechanisms that are linked to standardized care, as payers (e.g., Medicare Advantage plans) are exploring ways to pay for better access to palliative care (National Coalition for Hospice and Palliative Care, 2018).

In 2017, Kilcullen and Ireland studied the palliative care perceptions of eight Australian neonatal nurses, each with at least 5 years of experience in neonatal nursing. The nursing staff reported factors that supported the delivery of neonatal palliative care, including leadership; clinical knowledge; morals, values, beliefs, and themes related to family emotional support; communication with parents; and unit practices (Kilcullen & Ireland, 2017). Among this same group, barriers to the delivery of quality neonatal palliative care included level of staff education, lack of privacy, isolation, staff characteristics, and systemic issues (e.g., policy and procedures; Kilcullen & Ireland, 2017).

The American Nurses Association (ANA) and Hospice and Palliative Nurses Association (HPNA; 2017) maintain there are educational challenges associated with palliative care practice in nursing that include a lack of preparatory education and exposure to palliative care principles within nursing curricula, palliative nursing clinical practicum experiences, and professional mentoring. In response, hospice and palliative care competencies were created by the American Association of Colleges of Nursing (AACN, 2016) for undergraduate nursing programs. Competencies include the "promotion of need for palliative care for seriously ill patients and their families, identify the dynamic changes in population demographics, health care economics, service delivery, caregiving demands, and financial impact of serious illness on the patient and family, recognize one's own ethical, cultural and spiritual values and beliefs about serious illness and death, demonstrate respect for cultural, spiritual and other forms of diversity for patients and their families in the provision of palliative care services, and educate and communicate effectively and compassionately with the patient, family, health care team members, and the public about palliative care issues" (AACN, 2016). The full list of competencies is available at the AACN website.

Because palliative nursing specialty practice, including hospice, is usually overlooked within healthcare institutions, nursing academic, and professional development curricula, the ANA and HPNA recommend that the End-of-Life Nursing Education Consortium (ELNEC) curricula should be the standard for primary palliative nursing education for prelicensure, graduate, doctoral, and continuing education for nurses (2017). The ELNEC project is a national and international end-of-life educational program administered by the City of Hope and the American Association of Colleges of Nursing and designed to enhance palliative care education in nursing (AACN, 2021). ELNEC recognizes that nurses need to be educated in ways to improve the quality of care and focus on palliative nursing care, pain and symptom management, ethical issues, cultural considerations, communication, loss, grief and bereavement, and the patient's final hours (AACN, 2021). As of April 2021, over 40,127 nurses and other healthcare professionals across the United States and internationally have completed an ELNEC train-the-trainer course (AACN, 2021). The ELNEC curricula is divided into specialty areas: Undergraduate/ New Nurse Graduate, Graduate, Core, Critical Care, Geriatric, and Pediatric (AACN, 2021). The value of both the AACN competencies as well as ELNEC is that they contribute to the education and training of healthcare professionals, but also assist acute, post-acute, and community organizations to achieve and maintain the delivery of high-quality, coordinated hospice and palliative care (AACN, 2021).

Case study 2

Robert is an 87-year-old male patient who was diagnosed several weeks ago with pancreatic cancer that was found to be advanced. Robert has been undergoing radiation therapy to shrink the cancer, control his symptoms, and prolong his life. His medical oncology team has also referred Robert for chemotherapy after his radiation therapy is complete. Robert is informed that his pancreatic cancer is "locally advanced," meaning that the cancer has not yet spread to distant locations in the body but has extended into local areas around the pancreas. Robert understands that his type of pancreatic cancer is very difficult or impossible to surgically remove completely. In addition, Robert has been losing weight and appears slightly jaundiced. He explains to his primary care nurse that he feels "so weak" all the time. Robert reports that he was experiencing some pain, but the radiation therapy has been helping with relieving his pain somewhat.

Robert's oncologist, Dr. Rupert, calls a family meeting to discuss Robert's status and goals of care, and to introduce the integration of palliative care into his treatment plan. Robert's wife, Mary, and his two middle-aged daughters show great concern for Robert's condition and prognosis during the meeting. Dr. Rupert explains that, although he cannot predict Robert's life expectancy, he does not expect Robert's condition to permanently improve or his symptoms to completely disappear. When Robert states that he does not want treatment to extend life given his condition, his family agrees with this decision. They also do not want to continue Robert's suffering given his prognosis. Dr. Rupert clarifies the decision to write a do-not-resuscitate order with Robert, who gives his consent to write the order.

Dr. Rupert then introduces Diane, the palliative care nurse in the hospital. Diane explains that she will assess Robert and his family to determine their level of distress and functioning so that an appropriate plan of care to support everyone's needs can be developed. The integration of palliative care into Robert's current treatment plan is being offered to Robert to improve his quality of life. Quality of life is improved by providing prevention and relief of suffering and early identification and treatment of pain. Diane describes how palliative care goes on even after Robert and his family may decide to stop treating his pancreatic cancer. Diane then schedules a time with Robert and his family to conduct a palliative care assessment of their physical, psychological, social, and spiritual needs.

Questions

1. What will Diane review and discuss with Robert and his family during the hospital-based palliative care assessment? Which decisions will be addressed?
2. What might Robert's palliative care routine and services include?
3. How will Robert's quality of life improve by receiving palliative care?

Responses

1. During the palliative care assessment, Diane will assess Robert's and his family members' quality of life. To do so, Diane will assess their physical, psychological, social, and spiritual aspects of suffering. Assessment and treatment of pain, as well as support for any other issues identified during the assessment, will be provided. Discussion and decisions about Robert's and the family's goals of care are paramount. The benefits and risks of any treatment options will be considered before making any determination about treatment choices. Diane will conduct a thorough assessment of any psychological, social, spiritual, or existential needs of Robert or the family unit. Stress is a common symptom of patients with serious illness, and Diane will address any reports or symptoms of stress in Robert or the family unit. A decision point that might come up is when to stop treating Robert's pancreatic cancer. This will be a very difficult decision and should include Robert, his family, perhaps close family friends or religious/spiritual leaders, and his healthcare team.
2. The integration of palliative care in Robert's plan of care will begin with an assessment of the quality of care that is currently being provided. Diane will emphasize that palliative treatment does not mean ending care for Robert. In addition to Robert's current care providers, it is also routine practice for palliative care specialists to co-manage the patient's care. Palliative care services for Robert may include the following:
   - Providing relief from pain and other physically distressing symptoms.
   - Providing a caring approach that embraces psychological, social, and spiritual support for Robert and his family members.

- Offering a support system to help Robert live as actively as possible until death and to help his family cope in their bereavement
- Incorporating services as early as possible in Robert's course of illness, in conjunction with other therapies that are intended to prolong life, to better understand and manage clinical complications

3. By using a palliative care team approach to address the needs of Robert and his family, including bereavement counseling if indicated, quality of life is improved for Robert and his family. Multiple care providers, including oncologists and other medical providers, primary nurses and nursing assistants, chaplains and other religious leaders, and social workers, will all work together to meet Robert's needs, reduce distress, and minimize suffering.

Case study 3

Baby Brooke suffered a prenatal hypoxic injury of unknown etiology, was born at 37 weeks' gestation at a local hospital center and had Apgar scores of 3 at 1 minute and 6 at 5 minutes. She was intubated, provided ventilation support, and transferred to a neonatal intensive care unit (NICU) outside the hospital facility 90 minutes away from the family home. Baby Brooke developed seizures on day 1 of life and was in the NICU for 2 months until seizures were controlled with Phenobarbital (initial), then Levetiracetam (maintenance) and she was extubated and breathing independently and effectively. She was discharged to home with her parents, Kelly (19 years old) and Jim (21 years old) with an apnea monitor, which both parents and all grandparents received training on. Kelly and Jim currently do not have full time work and live with Jim's parents. Kelly's parents are involved in the care of Brooke, however, they are not supportive of Kelly and Jim's relationship, as they are not married.

At 3 months of age, after suffering from several apneic episodes that required Kelly and Jim to stimulate Brooke along with more frequent and longer lasting seizures at home, Brooke's pediatrician sent her to the emergency room (ER) for further medical evaluation, treatment, and to admit her to the pediatric intensive care unit (PICU). At the same time, he referred the family to the hospital's palliative care team to be evaluated for the potential of a life-limiting brain injury. Jim's parents were supportive; however, they were concerned about the distance (90 miles away), the cost of this type of consult, and what it means to have palliative care. Brooke is covered by Medicaid for her medical care.

Upon admission to the ER, Brooke was crying and inconsolable. Her mother was cradling and rocking her to try to soothe her. Brooke's vital signs were stable, except for her respiratory effort; it was tachypneic, yet weak, and her oxygen saturation (SaO2) was 88% on room air (RA). The RN provided Brooke with 4LPM of oxygen via a nasal cannula, which increased her SaO2 to 92% and reduced her inconsolability. After evaluation by the ER, PICU, and pediatric surgical teams, Brooke was admitted to the PICU where the palliative care team provided a consult. A few days later, the infant received a tracheostomy and g-tube placement because of her apnea and her ineffective swallow; there were no complications. Parents and grandparents were informed of this plan. Three weeks later, she was sent home with her parents and required to be on home ventilator support and intermittent tube feedings, which required around-the-clock home care nursing. The palliative care team also provided a home care plan to help manage Brooke's comfort.

At 8 months of age, Brooke was referred to hospice care by the palliative care team after multiple referrals to the ER by the pediatrician and extended re-admissions to the PICU for seizures. After being evaluated by the PICU team, child life, social work, nutritional services, and multiple ancillary services, requests were made to nursing to help with advanced care planning. Brooke's pediatrician, however, did not initially agree that Brooke was suffering from a life-limiting or terminal illness and informed the family of his opinion. Two weeks later, after Brooke suffered from more seizures and deteriorated neurologically with loss of consciousness, further meetings occurred without the palliative care team; however, the team agreed with the terminal prognosis and diagnosis.

Unfortunately, Brooke's parents did not agree with the healthcare team and the family didn't agree among one another. Mom wanted to do everything possible and did not believe Brooke was deteriorating nor did she believe the prognosis. She believed the PICU team was providing too much morphine, which was causing her not to wake up. Dad did believe Brooke's health status and prognosis and wanted to move forward with hospice care. Brooke's grandparents (Kelly's parents) sided with Jim and wanted the best care possible, recognized the need for hospice care, but didn't want Brooke to die at home. When approached by the family, the pediatric nurse was unable to provide any information on options regarding advanced directives or hospice care. The nurse requested a social work consult, but no one was available. The family could not come to an agreement and Brooke was not admitted into hospice care. Brooke remained in the PICU until her death 6 days later. Her parents and grandparents planned on being in the hospital that day but were unable to be with Brooke when she died.

Questions:

1. Brooke's care was complex from the beginning and most likely was impacted by what factors?
2. When would have been the best time to refer Kelly and Jim to the palliative medicine team?
3. What is the biggest barrier to hospice care in this case and among many other pediatric patients?

Responses:

1. Brooke's care was complex from the beginning because of multiple factors, including having multiple disciplines involved in her care, including several subspecialty care teams. In addition, the care professionals, including the nursing staff and social worker, most likely did not have the skills or tools to educate and help the family be more involved in the decision-making process. Lastly, Brooke's parents were young and reliant on their own parents, and quite possibly limited in their understanding and capabilities.
2. Understanding that Brooke suffered a prenatal event, a palliative care consult would have been optimal during the prenatal period. An additional opportunity would have been during Brooke's time in the NICU, instead of waiting until finally receiving this service in the PICU. There were several lost opportunities to help the family become comfortable and confident in this type of care. One of these opportunities missed by the PICU team itself was notifying the palliative care team when conflict arose; instead of calling that team, the nurse called the hospital social worker, who was unavailable. Calling the palliative care team to assist would have improved the communication and possibly the acceptance of hospice care.
3. There were several confounding factors in Brooke's hospice referral. The couple's age, poor socioeconomic status, living in a rural area with limited access to healthcare providers that delayed identification of health challenges and difficulties. These factors all led to a delay in admission to hospice care and the acceptance of a terminal condition by her family.

Conclusion

This course provided an overview of hospice and palliative care and illuminated the importance and recent growth of this specialty area. It also included a focus on hospice services as defined by the Medicare hospice benefit, quality metrics, and the delivery of care. Increased understanding by nurses and other clinicians is crucial to providing compassionate care. The goal of hospice and palliative care is to reduce the patient's distressing symptoms (physical, psychological, social, and spiritual), no matter how young or how old they are, and to improve their quality of life. Making appropriate and timely referrals for hospice and palliative care is one way that clinicians can prevent needless suffering for patients with life-limiting conditions.

Resources

- Aging With Dignity
  - https://agingwithdignity.org
- American Academy of Hospice and Palliative Medicine
  - http://aahpm.org
- American Association of Colleges of Nursing End of Life Nursing Consortium
  - https://www.aacnnursing.org/ELNEC
- CaringInfo (National Hospice and Palliative Care Organization)
  - https://www.caringinfo.org
- Center to Advance Palliative Care
  - https://www.capc.org
- Centers for Medicare and Medicaid Services
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice#:~:text=Hospice%20Levels%20of%20Care,enrolled%20in%20the%20hospice%20benefit.&text=A%20patient's%20home%20might%20be,patient%20isn't%20in%20crisis
- Dignity in Care
  - https://dignityincare.ca/en/
- Hospice and Palliative Nurses Association
  - https://advancingexpertcare.org
- Hospice Foundation of America
  - https://hospicefoundation.org
- National Association for Home Care & Hospice
  - https://www.nahc.org
- National Hospice and Palliative Care Organization
  - https://www.nhpco.org

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HOSPICE AND PALLIATIVE CARE FOR HEALTHCARE PROFESSIONALS

Self-Assessment Answers and Rationales

1. The correct answer is B.

Rationale: Hospice and palliative care are not the same. Palliative care is the overarching care of those with serous or advanced illness, in which hospice is a subset. Hospice is not only paid for by private insurance. Other sources of payment for hospice services are veteran's benefits, self-pay, charity, Medicaid, or the Medicare Hospice Benefit.

2. The correct answer is A.

Rationale: The 4 levels of hospice care are routine, continuous, general inpatient, and respite care.

3. The correct answer is C.

Rationale: Only patients who have been diagnosed with an advanced or life-limiting illness and determined by a physician to have 6 months or less to live can qualify for hospice care. Having a family is not part of the hospice certification process.

4. The correct answer is C.

Rationale: Both hospice and palliative care delivery center around quality of life and working towards relief of physical and psychosocial symptoms.

5. The correct answer is D.

Rationale: CAPC recommends a, b, and c as ways for healthcare providers to support access and equity for the delivery of hospice and palliative care to minority, vulnerable, or underserved populations.

Managing Difficult Patients for Healthcare Professionals

5 Contact Hours

Release Date: August 24, 2021 **Expiration Date:** August 24, 2024

Faculty

Karen S. Ward, PhD, MSN, RN, COI, received BSN and MSN degrees in psychiatric-mental health nursing from Vanderbilt University and a PhD in developmental psychology from Cornell University. She is a professor at the Middle Tennessee State University School of Nursing, where she has taught in both the undergraduate and graduate programs. Dr. Ward's work has been published in journals such as *Nurse Educator, Journal of Nursing Scholarship, Journal of Emotional Abuse, and Critical Care Nursing Clinics of North America*. She has also presented her work at local, regional, and international conferences. Dr. Ward's research interests include child and adolescent maltreatment, mental health, and wellness issues (stress and depression), leadership variables, and survivorship.

Karen S. Ward has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Debra Rose Wilson, PhD, MSN, RN, IBCLC, AHN-BC, CHT, received an MSN in holistic nursing from Tennessee State University School of Nursing and a PhD in health psychology with a focus in psychoneuroimmunology from Walden University. She has expertise in public health, psychiatric nursing, wellness, and disease prevention. In addition to being a researcher, Dr. Wilson has been editor of the International Journal of Childbirth Education since 2011 and has more than 150 publications with expertise in holistic nursing, psychoneuroimmunology, and grief counseling. Dr. Wilson has a private practice as a holistic nurse and is an internationally known speaker on stress and self-care. Dr. Wilson was named the 2017-2018 American Holistic Nurse of the Year. She is on the faculty at both Austin Peay State University School of Nursing and at Walden University.

Debra Rose Wilson has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Reviewer:

Cindy Parsons, DNP, ARNP, BC, is a Psychiatric Mental Health Nurse Practitioner and educator. She earned her Doctor of Nursing Practice at Rush University, Illinois and her Nurse Practitioner preparation from Pace University, New York. Dr. Parson's is an Associate Professor of Nursing at the University of Tampa and maintains a part-time private practice. She is board certified as Family Psychiatric Nurse Practitioner and a Child and Adolescent Psychiatric Clinical Specialist and her areas of specialization are full spectrum psychiatric mental health care with a focus on family systems, community health and quality improvement. Dr. Parson's currently serves as the chair of the QUIN council, is the membership chair for the Florida Nurse Practitioner Network, and in 2009, she was inducted as a Fellow of the American Association of Nurse Practitioners.

Cindy Parsons has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

Healthcare professionals will encounter difficult or hard to manage patients during their career. Examples of these difficult encounters include workplace violence, non-adherence to medical treatments, and manipulation of caregivers. This course explores how healthcare professionals can avoid potentially violent situations and work with difficult patients by being prepared and recognizing the signs and risk factors for these occurrences. De-escalation skills, diagnosis, preventative measures, training, and planning are all presented in this course to help healthcare professionals respond to difficult patients and ensure a healthy environment for everyone.

Learning objectives

After completing this course, the learner will be able to do the following:

- Interpret the early warning signs of workplace violence in patients who are aggressive.
- Apply healthcare professional interventions for managing patients who are assaultive or have the potential to engage in workplace violence.
- Differentiate risk factors associated with nonadherence.
- Compare healthcare professional interventions that may be used when caring for patients who are nonadherent.
- Distinguish ways in which manipulative behavior can be identified.
- Choose effective healthcare professional interventions for patients who demonstrate manipulative behaviors.

How to receive credit

- Read the entire course online or in print which requires a 5-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

CE Broker reporting

Elite, provider # 50-4007, reports course completion results within 1 business day to CE Broker. If you are licensed in Arkansas, District of Columbia, Florida, Georgia, Kentucky, Mississippi, New Mexico, North Dakota, South Carolina, or West Virginia, your successful completion results will be automatically reported for you.

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Activity director

Lisa Simani, MS, APRN, ACNP

Disclosures

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Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

INTRODUCTION

Hospitalization can sometimes be frightening, disorientating and may even cause a patient to resort to behaviors that include hostility, noncompliance, and manipulation. Healthcare professionals working in a general hospital setting may not have been given specific instructions in handling such situations. In acute care settings, security staff frequently manage the occasional behavioral incident associated with patient aggression. However, psychiatric healthcare professional personnel are trained in the management of aggressive behavior and crises.

Healthcare institutions must take necessary precautions to protect healthcare professional personnel from workplace violence. The Occupational Safety and Health Act of 1970 requires that employers ensure each employee has a place of employment that is free from recognized hazards that are causing, or are likely to cause, death or serious physical harm (Occupational Safety and Health Administration [OSHA], 2017).

Healthcare professionals may experience difficulty with patients who are noncompliant or nonadherent treatment. The concept of noncompliance, or nonadherence, is a subject of debate in healthcare. At issue is the right of the patient to choose a treatment course that is different from the recommendations of the healthcare team. Discovering the cause of nonadherence is a necessary first step. If it can be determined, then patient education or problem solving by the healthcare professional - may assist in future adherence. Helping patients truly understand the risks of not following the treatment regimen can go a long way toward achieving better adherence.

Another way patients may demonstrate difficult behavior in a hospital setting is through manipulation. The term manipulate means to influence the behavior or emotions of others, often at their expense, for one's own purposes. The stress of hospitalization may cause a patient to resort to manipulation in an effort to meet needs that are absent in a hospital setting. Patients who demonstrate manipulative behaviors are typically trying to gain power over the healthcare professional to get what they need/want. This behavior can evoke a negative response towards the patient from healthcare professionals and other clinicians.

FACTORS THAT MAY INCREASE THE RISK OF WORKPLACE VIOLENCE

Workplace violence ranges from offensive or threatening language to homicide. Incidents of violence are episodes or outbursts that involve hitting, choking, or assaulting another person; damaging property; throwing cups; smashing glassware, and so forth. One of the difficulties with providing a safe environment is that sickness and potential life-threatening factors cause stress in patients, their family members, and personnel in healthcare workplaces. Such stress can aggravate factors that lead to violence, which is reportedly on the increase (American Nurses Association [ANA], 2017).

Research demonstrates that among healthcare personnel, nurses are the most likely victims of workplace violence (OSHA, 2017). According to one report (Dwyer, 2017), 21% of nurses have experienced some form of violence, verbal assault, physical assault, or rape. The risk factors for violence vary with each healthcare facility, depending on location, size, and type of care. It is a problem that the American Nurses

Association has considered high priority (ANA, n.d.) and the ANA has been instrumental in sponsoring appropriate legislation to address it. Common risk factors for workplace violence in healthcare settings include poor or inadequate security measures, poorly lit public areas of the facility, and long waiting times in areas that are overcrowded or otherwise uncomfortable. Healthcare facilities are also places where drugs and money are viewed as easily available. Patients, their visitors, and healthcare staff are all at risk for involvement with violence for many reasons. Staff may lack training in recognition and management of violent behavior. Patients may feel extreme anxiety because of their medical condition and react in violent ways. Distraught family members and other visitors may think they are not getting the information they want or getting it quickly enough. Factors that may influence the risk for violence in healthcare settings are listed in Table 1.

Table 1: Factors That May Increase the Risk of Violence in Healthcare Settings

Patients and Visitors	Staff	Environment
Patients who are acutely agitated, violent, or volatile.	Lack of training in recognition, early intervention, and management of escalating, hostile, and assaultive behavior or patients who are potentially volatile.	Poor or inadequate security measures.
Patients with a history of violence or certain psychotic diagnoses.	Low staffing levels during times of specific increased activity, such as mealtimes, visiting hours, and shift changes.	Poorly lit corridors, rooms, parking lots, and other areas.
Patients who are on criminal holds by police and the criminal justice system.	Solo work, particularly in remote locations.	Highly accessible worksites with little or no privacy.
Patients with a history of trauma.	Interventions demanding close physical contact, such as examinations, treatments, or transporting patients.	Unrestricted movement of the public in clinics and hospitals.
Patients who abuse drugs or alcohol, are under the influence of these substances, or are withdrawing from substances.	Shift work, including commuting to and from work at night.	Long waits in emergency or clinic areas that are overcrowded and uncomfortable.
Distraught family members.	Demanding workloads.	Availability of drugs or money at hospitals, clinics, and pharmacies, making them likely targets for robbery.
Presence of gang members.	The use of temporary and inexperienced staff; working alone.	Prevalence of handguns and other weapons; home visiting, with its associated isolation.

Based on National Institute for Occupational Safety and Health. (2017). Occupational violence. Centers for Disease Control and Prevention. https://www.cdc.gov/niosh/topics/violence/training_nurses.html

Occupational Safety and Health Administration. (2017). Workplace violence. U.S. Department of Labor. https://www.osha.gov/SLTC/workplaceviolence

Townsend, M. C., & Morgan, K. (2017). Essentials of psychiatric mental health nursing: Concepts of care in evidence-based practice (7th ed.). F. A. Davis.

Workplace violence is destructive and has a profoundly negative impact on healthcare professionals. Nurses may experience physical injuries, psychological trauma, anxiety, or even death. Feelings such as anger, depression, fear, self-blame, and powerlessness might take over the healthcare professional's life. This can affect the institution by causing loss of job satisfaction, low worker morale, increased job stress, and increased staff turnover rate (Mento et al., 2020; OSHA, 2017).

Members of the healthcare professional staff need guidelines for dealing with workplace aggression, just as they do for a fire or dangerous situations. These guidelines should be based on a team approach with security staff because both groups have their own perspectives and skills to offer. In particular, healthcare professionals who work in long-term care facilities should have training in the management of patients who are potentially aggressive; both the frequency of incidents and the delicate nature of some patients' conditions increase the likelihood of violent incidents. The areas of a hospital where violence is most likely to occur are the emergency department, psychiatric services, and geriatric units (ANA, 2021). Ideally, all healthcare professionals should receive education on how to handle violence in their workplace.

INCIDENCE OF WORKPLACE VIOLENCE IN HEALTHCARE SETTINGS

Hospital workers are at high risk for experiencing violence in the workplace (National Institute for Occupational Safety and Health [NIOSH], 2017). Data collected between 2002 and 2013 revealed the incidence of nonfatal assaults on hospital workers was 8.3 assaults per 10,000 workers. This rate was much higher than the rate of nonfatal assaults in private sector industries, which was two per 10,000 workers. Healthcare workers are four times more likely to experience workplace violence than individuals in other professions. It continues to be a critical issue for all hospital workers. Individual states have enacted legislation to help curb this problem. Through these efforts, emergency departments in particular have added secure entry systems and, as much as possible under current budget restrictions, additional security personnel.

PREVENTION OF WORKPLACE VIOLENCE IN THE HEALTHCARE SETTING

Nurses in all healthcare settings should expect training in dealing with patient aggression. Being prepared for situations that may escalate allows healthcare professionals and other staff to defuse potentially violent situations before injuries occur. Areas where patients are most likely to become violent require higher staff-to-patient ratios to decrease incidents of violence. Suggested prevention strategies include maintaining a means of escape from the threat until help arrives, consistent enforcement of prevention policies, and fostering good working relationships with security personnel (Martinez, 2016; Edward, et al., 2016).

Patients are not the only individuals responsible for workplace violence. Family, other visitors, staff, and vendors are all potential aggressors. Nurses educated in de-escalation techniques may be able to help any of these individuals calm down rather than create a violent episode. Everyone benefits when an emotionally charged situation does not end in violence of any sort.

Evidence-based practice! Although most healthcare professionals work in places that have some sort of building that contains staff, patients, their families, and the supplies needed to administer care, home health healthcare professionals are out in the community. This requires some additional considerations when it comes to working safely. For one thing, home healthcare professionals are usually on their own – there is just one of them! Although history has shown that the public has a soft heart for healthcare professionals, it is imprudent to count on that alone. Nurses going out into the community and rural countryside must be cognizant of the norms for the area. They need to follow the policies and procedures of their workplace. Keeping safe practices in mind, such as making sure all car maintenance is up to date, is important. Consulting other home care workers and reading articles about current safety issues (Marrelli & Rennell, 2020) that focus on the unique needs of in-home providers help prepare for safe and successful visits.

DIAGNOSTIC ASSESSMENT

The following are the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) diagnoses and North American Nursing Diagnosis Association (NANDA) nursing diagnoses that might be applicable to patients with potentially aggressive behavior. Of course, circumstances may warrant additions to the list of diagnoses for any specific patient, but those listed here are likely for anyone experiencing potentially aggressive behavior and mental health issues.

DSM-5 psychiatric diagnoses

Patients considered more at risk for becoming aggressive are those who have had a previous violent outburst: The highest predictor of violence is a previous violent episode. Patients with the following DSM-5 mental disorders may exhibit aggression (American Psychiatric Association, 2013):

- Neurocognitive disorders
- Alcohol and other substance use disorders, intoxication, or withdrawal
- Bipolar disorder and/or mania
- Schizophrenia
- Borderline personality disorder

NANDA nursing diagnoses

The NANDA nursing diagnoses that are often considered with patients who are at risk for violence include the following (Herdman & Kamitsuru, 2018):

- Confusion (acute, chronic)
- Coping (ineffective, readiness for enhanced, defensive)
- Fear
- Hopelessness
- Memory, impaired
- Nonadherence
- Self-esteem (chronic low, risk for low)
- Self-mutilation or risk for self-mutilation
- Social interaction, impaired
- Suicide risk

PREVENTION AND EARLY DETECTION

Nurses need to be aware of how they deal with patient anger. For example, becoming angry in response to anger will not be therapeutic and will actually create a situation in which the healthcare professional is unable to defuse a patient's aggression. Such behavior will more likely intensify the patient's emotions. Overly controlling behavior may lead to a power struggle with the patient. Simply withdrawing from an angry patient will almost always be ineffective. If the patient's angry feelings are escalating, the patient is communicating loss of control and needs help regaining composure (Townsend & Morgan, 2017).

Nurses should not overlook personal feelings of anxiety during an interaction with a patient. If their intuition gives them a message that a patient may become dangerous or that the situation may be getting out of hand, healthcare professionals should do the following:

- Seek help early.
- Use healthcare professional skills to establish and maintain a trusting relationship with the patient.
- Conduct a thorough psychosocial and mental status assessment.
- Be a good monitor of a potential crisis.
- Pay attention to "gut" reactions.
- Inform the patient that violent or aggressive behavior is not acceptable.
- Use calming statements to lower the patient's anxiety and decrease the likelihood of aggression.
- Encourage the patient to talk things through rather than acting out.
- Ask very simple, short-answer questions and not broad questions in these situations.
- Anticipate potential problems; have a plan for obtaining help from security and/or other staff members, as well as an escape route out of the patient's room.
- Know each patient's history and current problems. Consider obtaining an order for medication to calm a patient who has a history of aggressive behavior (if this appears in the patient's history or if the patient's behavior suggests loss of control and emotional escalation).
- Be alert to patients whose primary or secondary diagnoses are associated with a high degree of potential for violent occurrences (e.g., patients experiencing delirium or dementia, and patients with certain substance use disorders).

Nurses should request a psychiatric consultation for any patient who demonstrates violent behavior. A thorough assessment is crucial in making a correct diagnosis so that appropriate treatment may be initiated (Townsend & Morgan, 2017).

EARLY WARNING SIGNS

Considering the source and target of the patient's anger, as well as the likelihood of escalation, is important. Patients who are potentially violent are often demanding, argumentative, hostile, and perhaps challenging and blatantly threatening in all their interactions. This behavior may be directed toward staff members, other patients, or the patients' family and friends, depending on the situation. Authority figures are often the recipients of verbal and other abuse, although anyone who is "in the way" may be the target of patients who cannot control themselves.

A history of previous violence is the highest predictor of future violence. Patients who are at risk for violence often have a history of recent acts of aggression or violence and might exhibit the following behaviors (NIOSH, 2017):

- Becoming extremely loud, shouting, and making menacing verbal or physical threats.
- Becoming physically tense and appearing rigid and tight.
- Clenching their teeth and hands or wringing their hands.
- Becoming quite agitated, anxious, and restless; pacing around if mobile; seeming quite jittery.
- Exhibiting a labile mood but mostly anger.

PRELIMINARY ACTIONS

The healthcare professional staff should carefully manage patients who are agitated and seem to be at risk for violence. The following steps are important for healthcare professionals to remember in these situations (NIOSH, 2017; OSHA, 2017):

- Maintain a demeanor that helps defuse anger. Present a calm, caring attitude.
- Give patients who exhibit irritability choices and options, but make sure they are valid, true choices and options.
- Do not be demanding and argumentative; perhaps some rules or procedures can be waived temporarily. Patients who are angry and potentially violent generally feel helpless and powerless. They need help with their self-control.
- To avoid power struggles with these patients, do not confront them. This approach will help de-escalate the patients' behavior and the situation.
- Open and consistent communication should be ongoing among staff members and between the patient and the staff. Talk to the patient. Try to find out what is precipitating this crisis.
- Do not match the threats. Do not give orders. Acknowledge the person's feelings (e.g., "I know you are frustrated."). Ask the patient what they would like done (e.g., "How can the staff help?" "How can I help?").
- Decrease the stimuli for the patient. The loud and unfamiliar noises of the hospital may be particularly stressful, and bright lights may be bothersome.
- Avoid any behavior that may be interpreted as aggressive (e.g., moving rapidly, getting too close, touching, or speaking loudly). Physical touch can be a trigger. Patients may misinterpret the contact and feel threatened with bodily harm, and they may feel the need to defend themselves. Delay procedures that may escalate a patient's potentially violent behavior.
- Before the situation gets out of control, check the environment. Look for potentially dangerous objects and remove them if possible. Items such as glasses, scissors, food utensils, and other breakable or sharp objects can be used as weapons.
- Avoid being alone and vulnerable with a patient who is potentially violent or being trapped in a room away from the exit; stay between the patient and the door. Team up with another member of the staff when encountering such a patient; there can be safety in numbers.
- Alert other members of the healthcare professional staff of a potential problem. Do not call on new and inexperienced staff members. Additional personnel should be available to help with a crisis.

WHEN VIOLENCE ERUPTS

If the risk for violence escalates and a patient is behaving in a threatening manner, the healthcare professional staff must act quickly. This may mean administering medication against the patient's will. In such situations, following the textbook protocols may not be possible. The best rule of thumb is to follow hospital policy and state laws, protect the patient, and provide for the safety of all present. Careful and timely evaluation of the situation means containing any violence using the least restrictive means possible. Rigid adherence to precise procedure may not result in the desired outcome.

Healthcare Professional Consideration:
All healthcare professionals are taught how to give an intramuscular injection – carefully measuring the amount, "mapping" out the site, wiping the area clean, inserting the needle, aspirating, and then proceeding to inject the liquid. Admittedly, some of these steps have been brought into question, but when dealing with a patient who is agitated or possibly combative, the focus needs to be on the outcome, which is that the patient safely receives the calming agent. How does this translate to an actual patient setting? As a patient is crawling down the hallway, trying to get away from the four healthcare professional assistants who are holding him down, the healthcare professional needs to intervene quickly. In this situation, the healthcare professional should try to calm the patient and create a safe environment as soon as possible. The use of restraints is desirable before medication to control difficult behavior is administered.
On some occasions, restraint provided by staff may be all that is initially available. Once the staff has the patient's movements under control, the healthcare professional must act swiftly and decisively in administering the medication, even if this means giving a non-textbook injection. Those holding the patient can only do so for a certain period. Any such interventions should be in keeping with state laws and institution policy.

Nurses should always seek assistance in an emergency. They should get help from the security staff, other available healthcare professionals, or any other hospital personnel. A patient who has a weapon should be disarmed by persons who are trained to do so. If the patient cannot be disarmed easily, the safety of healthcare personnel and that of others in the area must be considered. Shields and barriers may protect against knives but not against a patient with a loaded gun. Other patients and visitors should be moved to safe and secure areas, and local police should be engaged in such a situation.

If the patient is unarmed, antianxiety or antipsychotic medication, physical restraints, or possibly both may be needed. This is often the decision that needs to be made by appropriate medical staff, quickly and with assurance, based on existing protocols and appropriate training. Erring on the side of caution is the best choice because the safety of all in the area is a priority. At the same time, the lowest level of effective restraint is desirable. Knowledge of the hospital's policies, state laws and regulations, the patient, and appropriate and available interventions is necessary for successful resolution of a violent episode.

RESTRAINTS

Each healthcare institution has, or should have, some guidelines for the use of chemical or physical restraints in potentially violent situations, and all healthcare professionals should be aware of the procedures used in their institution.

Chemical restraints

The medication protocol generally consists of giving a patient who cannot be "talked down" an initial, low dose of a high-potency antipsychotic (such as haloperidol) or a short-acting antianxiety medication (such as a benzodiazepine). Oral medications may be offered first, but if escalation is rapid, an intramuscular medication may be required. The patient is observed at 15-min intervals or possibly on a continuous basis. In some instances, medication may be given as often as every half hour until the violent episode is in check or the maximum dose is reached.

The healthcare professional responsibilities involved in handling a violent episode by medicating a patient with a potent pharmacologic agent include the following:

- Checking for or obtaining a healthcare practitioner's order to administer medication.
- Preparing the medication: capsules, tablets, or liquid; intramuscular injection, intravenous drip, or butterfly infusion.
- Assessing the patient's vital signs before giving the drugs if this can be done safely.
- Informing the patient of the procedure that will follow and providing reassurance and support if needed.
- After the medication has been administered, observing the patient, assessing for a decrease in signs and symptoms of aggression, and noting any untoward side effects of medication given.
- Periodically checking the patient's vital signs.
- Documenting the incident and the medications given by recording the information in the patient's medical record or as the institution directs.

Mechanical restraints

As with protocols for using medications, each healthcare institution should have a procedure to follow for mechanically restraining a patient. Without an order for an involuntary commitment, however, the patient cannot be held against their will (Tamura et al., 2015).

When a patient in a general hospital setting is at high risk for harm, the number of staff members needed to restrain the patient depends on the patient's size, strength, and potential for violence (Francis & Young, 2017). The general recommendation is that one staff member needs to be available to hold each extremity, and an additional staff member must be available to apply the restraints; if six staff members are available, one person can support the patient's head.

The patient is held by the arms and legs and walked, carried, or placed in as comfortable a position as possible (usually in a hospital bed with side rails up) and put in wrist and ankle restraints. These restraints may be cotton, gauze, cloth, or leather, depending on the patient's size and strength.

Ideally, one person (one of the registered healthcare professionals) should be in charge of a group of five or six staff members. If no one is in charge, the possibility of miscommunication can produce a disjointed effort. Consequently, the patient may escape and be harmed or do harm. The confusion that ensues when no one is in charge invariably adds to the patient's sense of being out of control and thus escalates the situation. The decision as to which staff member will be in charge should be made before any action is taken. A "show of force" of five or six staff members may be enough to defuse the situation.

The best approach toward the patient is a uniform one. All staff members should move or walk toward the patient together. Sometimes, this simple show of force subdues a patient. Before the approach is undertaken, to avoid confusion, the team leader should assign which staff member will hold which extremity. Staff members should try to be calm themselves. They should not speak loudly; instead they should be firm and speak slowly, clearly, and precisely. A soft voice may have a quieting effect on the patient.

The healthcare professional responsibilities involved in handling a violent episode by mechanically restraining a patient include the following:

- Staff should monitor the patient frequently, according to the facility's protocol.
- At least every 2 hr, the restraints should be untied and the patient's position should be changed (Francis & Young, 2017). Although the patient may not need to be restrained this long.
- Staff should not negotiate with the patient.
- Staff should not confuse the patient with options.
- Staff should remember that this patient is out of control.
- Staff can say something like the following: "We feel you are not in good control of yourself right now. We will help you calm down."

The room should be checked for potentially dangerous objects. Nurses should remove any watches, eyeglasses, jewelry, shoes, belts, and other items that could be a hazard. No place is absolutely free of danger. Patients have broken light bulbs and cut themselves with the shards or used pajama waist cords to hang themselves. Nurses should be cautious and aware. Nurses should look around the area from the patient's eye level so they can see what the patient sees.

The safety of the patient and the staff should be considered at all times. The goal is to demonstrate no tolerance for the violence and to present the intervention as not punitive but an attempt to help the patient regain some self-control over violent behavior. Patients should be shown respect and allowed to maintain their dignity. The staff should know the patient's name and use it.

Nurses should use calming statements or phrases and always explain step-by-step to the patient what is happening. They should be firm and provide information on why the staff is acting the way they are. For example, if giving an injection, the healthcare professional should say tell the patient that the injection is intended to relax and calm the patient. While putting on restraints, the healthcare professional should acknowledge that they may not be comfortable but that they will be removed as soon as possible. Providing these brief explanations will take away the unknown and, ideally, help the patient accept the interventions a little more calmly.

HEALTHCARE PROFESSIONAL INTERVENTIONS FOR PATIENTS WITH POTENTIALLY AGGRESSIVE BEHAVIORS

The role of the healthcare professional in the management of a patient's aggressive behaviors will be found within the protocol, policy, or procedure manual of each institution, as well as in the scope of practice or mental health act of the state. Nurses need to remain nonconfrontational. A calm, quiet approach that acknowledges the patient's anxiety and probable dislike of the situation will provide the best possibility of de-escalating the patient's aggression. By acknowledging the patient's feelings and providing the patient with an opportunity to talk, the healthcare professional establishes rapport and offers an opening for the patient to vent verbally rather than resorting to violence. Becoming aware of the potential of a violent episode before the situation escalates is a skill healthcare professionals should master. When a situation has arisen that requires intervention, healthcare professionals must carefully document all that happened, including any precipitating factors, attempted interventions, and the length of time it took to resolve the situation. Within this framework, the healthcare professional interventions in Table 2 may apply.

Table 2. Independent Healthcare professional Interventions and Their Rationale for Patients Who Exhibit Aggressive Behaviors	
Independent Healthcare professional Interventions	Rationale
Use good interpersonal skills. Be nonconfrontational.	Establishing rapport can help decrease the likelihood of aggression.
Assess for potentially violent occurrences.	Maintaining alertness to possibilities of violence allows the healthcare professional to be prepared.
Acknowledge the patient's feelings (e.g., "You seem angry."). Listen actively.	Providing an opening for verbal discussion can decrease possible violent episodes.
Anticipate a potential problem.	It is important to stay aware of environmental cues for escalating violence.
If a patient's anger is escalating, communicate verbally with then in a soft but firm voice.	Attempt to foster a therapeutic relationship by conveying empathy, acknowledging the patient's feelings.
Encourage patients to express anger verbally rather than by "acting out" their feelings.	Dealing with anger in this way will create a safe environment and help the patient learn more effective coping skills.
Be respectful of a patient's personal space.	Allowing a patient plenty of room sometimes keeps anger at a lower level.
Teach stress reduction techniques (e.g., deep breathing).	Providing alternative outlets for anger is good patient education.
Continuously observe patients who are potentially dangerous to themselves or to others.	Evaluation is part of the healthcare professional process.
Assess the patient's coping skills and ability.	Crisis intervention techniques may work to prevent violent eruption.
Help the patient maintain control by offering choices, talking, or walking.	Physical activity can sometimes defuse angry outbursts.
Initiate or collaborate on a plan that includes a team approach to restraining a patient.	Prepare ahead of time for potential violence.
Alert others of the potential problem. Do not approach an aggressive patient alone.	Use of a team to demonstrate a show of force is often all that is needed to defuse a potentially violent situation.
Monitor the situation for the safety of others and the staff.	Ask those who can to leave the area if violence is erupting.
Based on Halter, M. J. (2018). Varcarolis' foundations of psychiatric mental health nursing: A clinical approach (8th ed.). Elsevier. Townsend, M. C., & Morgan, K. (2017). Essentials of psychiatric mental health nursing: Concepts of care in evidence-based practice 7th ed.). F. A. Davis.	

HOLISTIC CONSIDERATIONS

Healthcare is one of the professions where the incidence of workplace violence is particularly concerning to governing agencies such as the ANA (2017), OSHA (2017), and, within the Centers for Disease Control and Prevention, NIOSH (2017).

Nurses need to educate themselves on how to identify institutional policies that might put them at higher risk for workplace violence. They should learn how to recognize warning signs and behaviors and how to develop a workplace violence-prevention program. The Centers for Disease Control and Prevention offers a free online course, Workplace Violence Prevention for Nurses (https://www.cdc.gov/niosh/topics/violence/training_nurses.html). Developing an awareness of changes in the environment involves paying attention, intentionally. As both witnesses to and recipients of workplace violence, healthcare professionals can campaign this cause at their facility to increase the care and safety of all staff. The healthcare profession does not tolerate violence of any kind, from any source (ANA, 2021).

The best way to deal with any patient's violent behaviors is to defuse the agitation during the early stages of escalation. Nurses need to watch for early warning signs and try to avoid dangerous outbursts. When this fails, their own safety and that of other patients and staff members, as well as that of the patient, must be considered.

Case study 1

Martha, who is a newly graduated nurse, is working on a detox unit. Susan is her lead nurse. Susan has asked Martha to go quickly and administer an injection to a newly committed patient who is trying to get out of the hospital. Martha has drawn up the medication and goes to where she finds the patient on the floor, physically restrained by four coworkers. The patient is constantly trying to get away by moving along the floor in a crawling manner, keeping his hips in motion. The staff is getting tired. Several minutes go by while Martha is attempting to give the injection. Susan comes to the group and realizes the difficulty Martha is having.

Self-Assessment Quiz Question #1

What should Susan do immediately?

a. Quietly tell Martha to "go ahead and give him the injection."
b. Announce loudly to all, "Carefully lift him up and carry him to his room."
c. Ask Martha, "Why can't you just give this medication as you were asked?"
d. Take the syringe from Martha, and give the injection herself.

Self-Assessment Quiz Question #2

WWhat action should Susan take later?

a. Tell Martha that she is not working out on this unit and will need to transfer to another one.
b. Ask Martha to submit her resignation as she does not seem to be doing a good job.
c. Take some time with Martha to explore her feelings about the situation and why she failed to give the injection.
d. Meet with the staff, who were holding the patient down, and explain to them that Martha is just inexperienced.

Case study 2

Erik Nilsson is admitted to a large general hospital for a surgical procedure scheduled for early the next morning. He is 68 years old, and English is his second language. Although he can understand some words and phrases, his ability to speak in English is extremely limited. Erik is accompanied to the hospital by his daughter, Astrid, who can translate for Erik during the admission process. She tells Jackie, the healthcare professional conducting the interview, that her father lives with her and her family. Astrid says that she does not think he is especially worried about his surgery but did add that lately she has noticed that her father exhibits mood swings.

Self-Assessment Quiz Question #3

What would Jackie's best response be to this information?

a. Make a note to ask Erik about his "mood swings."
b. Ask Astrid to describe what she means by "mood swings."
c. Tell Erik that Astrid said he had "mood swings."
d. Inform the doctor that Astrid reported Erik having "mood swings."

Case study 3

That evening, Erik speaks in an agitated manner, in Swedish, to another patient. Jackie, his evening healthcare professional, goes to Erik's bedside to calm him down and see what is wrong. He is gesturing and muttering to himself, quite loudly at times. Jackie notifies the physician on call. When the physician examines Erik, he still appears agitated but somewhat calmer. The attending practitioner orders a sedative and informs Jackie that he will check with her again in an hour. Erik falls asleep in a short while. The rest of the evening shift progresses unremarkably.

Self-Assessment Quiz Question #4

Based on the information presented, what healthcare professional actions should Jackie take at this point?

a. Arrange for security to send someone to stay right outside Erik's room.
b. Locate some restraints and place them in Erik's room.
c. Check on Erik at frequent intervals throughout the night.
d. Treat the patient the same as any other patient.

Case study 4

Jackie wakes Erik at about 6:00 a.m. and administers his preoperative medications. Erik is taken to surgery at 7:00 a.m. The surgery goes well, with no complications. Erik has an uneventful recovery and is returned to his unit at 2:00 p.m. His daughter and son-in-law are waiting to see him.

Although he appears somewhat sleepy, Erik is mumbling to himself and gesturing with his hands. Neither his daughter nor his son-in-law can understand what he is saying. They try to visit with him briefly but finally leave, telling him to get some rest and they will return later.

Erik dozes off, but when he awakes, the unusual behaviors seem to increase. Erik's voice becomes louder. He then begins to appear very tense, grimacing and clenching his fists. When Jackie approaches him, he seems angry with her, and she is confused as to why. The nurse reports her concerns to her unit manager: "I'm not sure what's going on with Erik, but I feel somewhat frightened of him."

Self-Assessment Quiz Question #5

What is the best action for the nurse manager to take at this time?

a. Instruct Jackie to pass information on to the next shift regarding Erik's behavior.
b. Remind Jackie that she is expected to act independently, not rely on her supervisor.
c. Go with Jackie to visit Erik and see if together they can figure out what is going on.
d. Make sure that Jackie did nothing to anger Erik while caring for him.

Case study 5

Jackie and the nurse manager decide that they both will go to Erik's room together to conduct a postoperative assessment. As they approach Erik's bedside, he begins shouting, trying to pull out his intravenous line and catheter, and attempting to leap out of the bed. He picks up a water bottle that was on his over-the-bed tray and throws it at the healthcare professional unit manager. It hits her on the arm, stunning her but not hurting her.

Self-Assessment Quiz Question #6

Of the following, which is the best choice for the nurse manager to do first?

a. Initiate a call for help from the rest of the staff.
b. Ask for an interpreter to be sent to the unit.
c. Have someone call Erik's surgeon.
d. Call Erik's family.

Self-Assessment Quiz Question #7

Which of the following would be the best response to Erik following his behavior?

a. "You know this kind of behavior cannot be tolerated here."
b. "No one here is deserving of your violent actions."
c. "You seem to have lost control. We are going to help you calm down."
d. "Now why would you do something like that?"

Case study 6

Staff arrive on the scene ready to assist in restraining Erik. In the meantime, a Swedish-language interpreter has come to the unit. After the interpreter is introduced, Erik seems to calm down considerably.

Self-Assessment Quiz Question #8

The nurse manager asks the interpreter to convey to Erik which of the following?

a. "You seem to be upset. Tell us what's bothering you."
b. "Why are you behaving so poorly?"
c. "What are you thinking? Throwing things is not allowed here."
d. "Were you really trying to hurt someone?"

Case study 7

The on-call healthcare practitioner responsible for Erik's care arrives and, after reviewing the situation, orders medication to calm Erik. The interpreter tells Erik, in his own language, about the medication and why he is receiving it. Erik responds favorably to this and accepts the medication. A staff member is assigned to remain at Erik's bedside until he falls asleep. Soft restraints are made available at the bedside in case they are needed.

After this incident is under control, the unit manager, Jackie, and the other staff involved go to a conference room to review the episode. A plan is made to confer with the family about Erik's reported "mood swings," request a psychiatric evaluation, use Swedish-speaking personnel when available, and maintain close observation of the patient. Jackie asks the team why Erik behaved in this way.

Self-Assessment Quiz Question #9

What response is most likely accurate and helpful to Jackie?

a. "We really can't say."
b. "It's hard to know. What do you think?"
c. "Some people are just that way."
d. "It is not possible to say accurately why Erik is behaving in this manner."

Case study 8

The nurse manager may also tell Jackie, "Often patients will react aggressively, and the staff has no sure way of knowing why this happens. It could be that the 'mood swings' mentioned by the daughter are connected to Erik's current behavior. It might be the unknowns of the hospital process or of what the findings from his surgery will indicate. The fact that Erik does not speak English well may increase what might be normal anxiety to a frightening level."

Self-Assessment Quiz Question #10

What guided everyone on the staff and facilitated the positive outcome?

a. No one person tried to tell others what to do.
b. Everyone on staff liked and felt sorry for Erik.
c. Jackie had had a lot of experience dealing with aggressive patients.
d. The staff all kept in mind that the most important thing is to provide a safe environment.

NONCOMPLIANCE

There is some debate among healthcare professionals regarding the concept of noncompliance. Healthcare professionals have argued that a diagnosis of noncompliance labels the patient negatively, arguing that it places the emphasis on the patient's behavior instead of on a mutual process with the healthcare professional and other healthcare providers. At the heart of this argument is the issue of the right of the patient to choose a treatment course that is different from the recommendations of the healthcare team.

Treatment adherence is usually associated with optimal health. The most obvious result of nonadherence is that the disorder may not be relieved or cured. For example, when patients with glaucoma fail to take their prescribed medications, optic nerve damage and blindness may be the result. For patients with an erratic heart rhythm, failure to comply with suggested treatment can lead to cardiac arrest. Stroke may be the outcome when people with high blood pressure ignore prescribed treatment. Failing to take prescribed doses of an antibiotic can cause an infection to flare up and may contribute to the emergence of drug-resistant bacteria. These failures to follow healthcare suggestions are not only frustrating but are also costly because of the undesired patient outcomes.

Healthcare Professional Consideration: Sometimes, patients who need to take medication regularly are the ones who are the most worried about addiction. In some cases, the family is also worried that their loved one will become addicted. In many cases, prescribed drugs are reducing symptoms, not curing the disease. Many psychiatric medications reduce symptoms, but, from the patient's perspective, the side effects seem to be worse than the symptoms. When patients begin to feel better, they stop taking their medication. After a period of time without the medication, the symptoms return, and the patients must start the cycle all over again. Education of patients and their families is critical in helping them understand why they are taking their medications, the expected side effects, when there is reason to be concerned about developing tolerance or dependence, and that continuing the medication is what will make them continue to feel better. A similar situation exists in the frequent nonadherence with antibiotic treatments. Although patients are told to take the entire prescription, they often stop once they feel better. Again, education is the key to patients' adherence to treatment. Verbal instruction followed by giving the patient a written pamphlet is often necessary to achieve adherence.

INCIDENCE

Although it is almost impossible to correctly determine statistics related to nonadherence, estimates have been made. It is estimated that 125,000 deaths and up to 10% of hospitalizations could be prevented, as well as between $100 and $289 billion saved, if patients took their medications as prescribed (Boylan, 2017; Cutler et al., 2018). That represents between 3% and 10% of total U.S. healthcare costs.

One meta-analysis (Cutler et al., 2018) examined the economic impact of numerous different disease processes and found the average cost of nonadherence per person was up to $44,000 a year.

Medication nonadherence leads to poor health outcomes, increased health costs, and increased health risks for individuals and populations. Misuse and overuse of antibiotics have contributed to the emergence of antibiotic-resistant strains of bacteria (U.S. Food and Drug Administration, 2020). Population health is affected by medication nonadherence; an example of this is persons with tuberculosis who did not adhere to treatment protocols, creating the antibiotic-resistant tuberculosis strain now evident (Centers for Disease Control and Prevention, 2017).

Patients fail to take medications as prescribed approximately 50% of the time, which often leads to hospitalization and emergency room visits (Brown & Sinsky, 2017). One of the recommended means of improving adherence is to involve the patient in the development of the treatment plan (Brown & Sinsky, 2017).

Patients with mental health disorders are frequently nonadherent with medications. Some psychiatric medications do have intrusive side effects that may seem to the patient more difficult to bear than the illness itself. Patients who are nonadherent with medications may also be nonadherent with interventions such as rehabilitation, relaxation, counseling therapy, quitting smoking, or losing weight.

HEALTH BELIEF MODEL

Many attempts have been made to create a conceptual model of adherence that will enable healthcare providers to predict and understand patients' behavior. The Health Belief Model offers some understanding of the phenomenon of adherence. The model proposes reasons for people's varied and unique responses to illness (Jones et al., 2015). The significance of this model is that it suggests that patients' choices depend on their beliefs, not necessarily on the medical evaluation of the situation.

The Health Belief Model proposes that changes in beliefs about the severity of and susceptibility to a health outcome and its consequences are associated with the motivation to take action. Once an individual feels threatened, a decision is made from among alternative actions based on a cost-benefit analysis. This model also emphasizes the concept of self-efficacy. Patients must feel capable of mastering their environment and behavior to risk trying to make behavioral changes. If they do not feel capable, assistance may be offered by healthcare providers through skill practice and positive reinforcement so that the patients come to see that they are capable of change.

The model postulates that people choose healthcare actions when they are faced with a threat to their health. The actions they choose depend on their perceptions of the situation. They decide how much of their personal goals they might be risking and compare it with how severe the threat is to their health. Then a further determination is made as to whether the costs to their lifestyle are worth the potential benefits. Unfortunately, a lot of this "balance sheet" is based on personal viewpoints and not on medical facts. Even when patients decide on a course of action that is adherent, they struggle with long-term habits that must be overcome. Lifelong habits are difficult to change, and the ease of continuing a previous pattern of behavior works against making healthy lifestyle changes (Jones et al., 2015). For many patients, nonadherence may be the perception that the illness is less of a problem than the treatment. Some changes are much more difficult than others as well.

LEGAL AND ETHICAL ISSUES

Healthcare professionals face increasingly complex situations in which the patient's wishes may deviate from the treatment recommendations. Some ethical guidelines can help healthcare professionals choose a response to a patient who is nonadherent. In addition, to practice within the law, healthcare professionals must be aware of legal guidelines. This area of healthcare is changing quickly. Healthcare professionals need to be clear about their obligations to patients and be knowledgeable about patients' rights.

Rights of the patient

Inviolability is the fundamental right of every individual to be left alone. The US Constitution and Bill of Rights are based on this principle. The individual has authority over what happens to their body. In practice, however, the situation is not always so clear. In some instances, individual rights may interfere with the rights of others. In addition, fluctuations in public sentiment may affect the decisions made by practitioners and institutions.

Ethicists differ in their perceptions about the dilemmas that healthcare professionals face. The concept of personal freedom becomes unclear when the perspective is one of social responsibility. Some ethicists believe that people can have both individual autonomy and responsibilities to one another.

The issue of mandatory testing for communicable diseases illustrates the dilemma of conflicting principles. Inviolability would guarantee the individual the right to refuse such testing. The principle of social responsibility would support mandatory testing because the individual has the obligation to participate to protect others.

Legal concerns

One legal issue that affects Healthcare Professional when discussing patient adherence to treatment is the issue of competence. A patient is considered competent if they are able to participate in making decisions, which means the patient has the ability to comprehend information, understand choices, and communicate their decision verbally or nonverbally to the healthcare team. For example, patients must be able to understand the nature of their illness and the available treatment alternatives. Equally important is an understanding of the consequences of any decision the patient might make about these alternatives.

Patients are presumed to be competent. This assumption means that the burden of proving incompetence belongs to parties other than the patient. Unless otherwise indicated, patients are assumed to be making competent choices about their healthcare.

At times, however, patients may be caught in a frustrating contradiction between the issues of adherence and competence. A patient may refuse a treatment recommendation. Healthcare professionals may label the patient incompetent because of the refusal. In this situation, a cognitively capable patient has made an informed decision. However, because the patient has made the decision, which opposes that of the treatment team, healthcare professionals view the patient as incompetent.

Special cases

Rights of Women Who Are Pregnant

Pregnancy offers a unique slant to the issue of patients' rights. For some people, the fact that the fetus is affected by the mother's behavior alters the mother's right to personal freedom. The legal system has increasingly overridden the right of the pregnant mother to disregard medical advice. The legal basis for these decisions is weak. However, societal support for protecting the unborn fetus can result in a disregard for the rights of the pregnant woman. The ongoing debate over the rights of the unborn fetus versus the rights of the mother evokes intense emotions on both sides of the issue.

Withholding Nutrition

There is little consensus on the ethics of withholding or withdrawing nutrition from patients. When a patient chooses to refuse nutrition, it is often difficult for healthcare providers to honor this wish. Healthcare professionals may be concerned about participating in behavior that will lead to hunger or thirst in the patient. The American Nurses Association (2015) maintains the position that the decision to withhold artificial nutrition and hydration should be made by the patient or the patient's surrogate after consultation with the healthcare team.

In some ethical deliberations, a distinction is made between allowing a patient to die and killing a patient. The difference lies with the intent of the actions. Nutrition may be withheld on the premise that, if given, it will prolong life and thus prolong suffering. This is different from starving a patient with the intent to kill them. Others argue that the finality of the act of withholding nutrition makes the act untenable.

It is imperative that every healthcare professional be familiar with the legalities surrounding the patients' right to refuse treatment. They should find out if there are advance directives that have addressed this issue. In addition, careful thought concerning the healthcare professional's ethical position on these issues is necessary. The answers are not always clear in the increasingly complex environment of healthcare today. Although it may be difficult for healthcare professionals to act on patients' wishes that are contrary to their own beliefs, they are usually mandated to do so by the policies of the

institution where they work. Although they may be free to operate on their own principles and beliefs, they should be fully aware that by doing so their job might be in jeopardy in some situations.

The Patient Who Signs Out Against Medical Advice

Leaving the hospital against medical advice (aka AMA) may be an extreme example of nonadherence. It is rarely a spontaneous act. There are often warning signals or repeated conflictual interactions with staff members before the patient actually signs out of the hospital.

Healthcare professionals and physicians react strongly when a patient leaves against medical advice. Healthcare providers may attempt to cajole or coerce the patient into staying, since there are often concerns about the patient's safety and the providers' obligations to the patient. Healthcare professionals may also feel a personal failure when a patient's choice is to leave against medical advice.

Patients should be free to leave against medical advice as long as they are competent and not endangering their lives. It is not appropriate to medicate a patient who is nonpsychotic and threatening to leave against medical advice. Using drugs as chemical restraints in this manner is battery from a legal standpoint.

RISK FACTORS

Nonadherence has meaning in the patient's life. The healthcare professional must be able to carefully assess the patient's situation to understand this meaning. In this way, the healthcare professional can uncover and deal with obstacles to adherence. Patients' individual characteristics and living conditions will influence the likelihood of their being compliant or noncompliant. For example, if the patient's home has no running water, then maintaining cleanliness will be more problematic for them than it will be for someone living with modern plumbing. Knowledge of risk factors can help healthcare professionals be more aware of the possibility that patients may have difficulties following their treatment plans. This knowledge is most helpful when it is used to prevent possible problems with compliance.

Psychological and cognitive risk factors

The most important psychological risk factors include the following:

- Cognitive abilities
- Mental status
- Denial and anxiety
- Addictions
- Depression
- Past experiences

Psychological and cognitive factors influence adherence to treatment. To be able to comply, patients must understand the information presented to them. Teaching should be brief and focused. Complex information should be broken into smaller and more understandable parts whenever possible. It is helpful to simplify teaching material as much as possible. Use of written materials that reflect a fourth- or fifth-grade reading level is appropriate so that the patient's level of health literacy is not overestimated.

Patients with cognitive deficits may not be able to learn. Patients must have an adequate attention span to be capable of concentrating and learning new behaviors. If the patient has little focus or scope of attention, the healthcare professional should attempt to consult with a family member or other support person and determine who should receive healthcare information because the patient is not capable of understanding it.

Similarly, patients with changes in mental status may be unable to integrate new learning material effectively. Their judgment may be significantly impaired. A thorough mental status examination is needed if there is any indication that a patient's mental status is compromised.

Some patients may be in denial, a defense mechanism used to guard against uncomfortable feelings. They may be too frightened by their illness to be able to accept it. This can cause them to feel their treatment recommendations are unnecessary. They need time to adjust and an opportunity to discuss these difficult feelings.

Denial is a normal part of grieving and sometimes occurs in people when they find out they have a terminal illness. Illness and hospitalization involve losses for people regardless of the prognosis, and denial may be part of any patient's presentation. Sometimes giving patients time to adjust to their new status is sufficient and they will be ready to accept and, ideally, adhere to their new treatment needs.

Anxiety reduces the ability to process information or to make decisions. An anxious patient might exhibit a number of different emotions and behaviors, including anger, complaining, demanding, withdrawing, or even crying. When a patient's anxiety is reduced, it will help the patient in adhering to the treatment regimen. Many patients are fearful of the unknown. Education often allays these fears.

Dependence on medications and illegal substances affects adherence because these drugs may be the priority in the individual's life. If the treatment regimen interferes in any way with the behaviors surrounding the need to maintain the drug to avoid withdrawal, the patient will not be adherent until the substance use disorder is treated. The classic example of this is the patient with an alcohol use disorder who has cirrhosis. The recommended treatment is abstinence from alcohol, but few patients who misuse alcohol can accomplish this without professional intervention.

A person who suffers from a depressive disorder will not take in information or make decisions as well as one who is not depressed. Individuals who are depressed are more likely than others to be nonadherent to treatment plans. They commonly have low self-esteem and feelings of hopelessness that can interfere with their ability to follow a regimen to better their health. To a large degree, they lack the energy to comply. Although depression is the most common mental health problem in the United States and one of the easiest to treat, it is the least treated; thus, patients who are depressed are often overlooked. Patients with depression often have other physical inflammatory illnesses such as heart disease, diabetes, or chronic obstructive pulmonary disease.

Finally, patients enter the healthcare system with ideas and beliefs that affect the course of their current hospitalization. Previous experiences that were negative can affect a patient's expectations. If a patient enters the system expecting the worst, chances are good that healthcare recommendations will not be viewed in a positive light. Healthcare professionals can influence these patients to take a more positive outlook by building trust and meeting their expectations as much as possible. When healthcare professionals cannot meet these expectations, it can be helpful for them to explain why.

Age

The estimated rate of nonadherence for older adult patients is 50%. They are more at risk for nonadherence than other adult patients. Because of their unique needs, older adult patients present a challenge in adherence. Their hearing, vision, and cognitive functioning are likely to be impaired in some way. These impairments, as well as years of ingrained habits, make changes in behavior more difficult.

Most patients 60 years of age or older require vision correction of some sort. These impairments make self-administration of medications particularly difficult. Almost one third of all people aged 65 to 79 years have significant hearing impairment. In older adult patients, recall is best when material is given verbally. Information must be delivered slowly and audibly. Reinforcing verbal instruction with written materials is essential and teach back will assess understanding. Print materials with large-type fonts and pictures are most effective.

Depression is common in older adult patients. It often goes undetected and untreated. Depression lessens the ability of older adult patients to adapt to changes in lifestyle. Seemingly simple tasks such as picking

up a pill become difficult. Plans for self-management must take this loss of dexterity into account.

Older adults often find that their social support systems are shrinking. Friends and relatives may be ill, dying, or making changes in living arrangements. This resulting isolation can affect adherence.

The number of medications prescribed for older adult patients can be a problem. At least one fourth of older adult patients recently discharged from hospitals have six or more prescriptions that require self-administration. Medication costs must be considered, as well as the ability to obtain the medications if transportation and mobility are issues (Townsend & Morgan, 2017).

It is easy to see why the nonadherence rates for older adult patients are high. This population is also less likely to be assertive about their needs with healthcare providers. Older adult patients constitute a major part of general care patients today. Healthcare professionals need to be sensitive to the unique needs of this age group.

Social and economic risk factors

The social spheres that most affect a patient's health behaviors are:

1. Family and significant others
2. Relationships with healthcare providers
3. Cultural or ethnic groups
4. Religious community or beliefs
5. Economic status

Patients are more likely to adhere with their treatment plans if their family or significant others are supportive of it and encourage them to follow it. They are also more likely to be adherent if they have a positive relationship with their healthcare team, are included in the decision-making process, and are acknowledged for being adherent.

A patient's cultural or religious beliefs and practices may prohibit adherence with a treatment regimen. In some religions, use of certain types of medical interventions is regarded as a lack of faith in God, and those interventions are therefore prohibited. Some cultures have lay healers, and the patient may wish to combine the healer's cures with medical treatment. Many cultures view healing as a family affair; therefore, the family will always need to be present and involved in the patient's care. Healthcare professionals must try to understand and appreciate the importance of these practices to help patients be adherent.

A significant concern related to nonadherence is limited income. Patients may have hospitalization coverage but lack sufficient funds to follow through on recommendations after discharge. A patient who must choose between feeding their family and buying blood pressure medicine has no choice at all. This is particularly true for older adult patients who are frequently on fixed, limited incomes. Choices between food and medication are not easy ones, and healthcare professionals can help access as much assistance as is available to older adult patients. It is helpful to examine older adult patients' finances with them and plan realistic healthcare choices together.

Environmental risk factors

The healthcare setting can influence patient adherence. The most common factors are comfort issues and ease of access, including transportation. The needs of patients who are physically impaired must be considered carefully. For example, an older adult who has been directed to return to the clinic after a surgical admission may not keep this appointment. The patient may not have transportation, the parking may be remote and require walking a long distance between the parking lot and office, or the stairs may be too much to handle. If there is little to motivate patients' return, then when they are feeling well, environmental obstacles will result in nonadherence.

Determining risk factors early in treatment enables healthcare professionals to intervene effectively. Healthcare professionals are in the best position to use their skills to develop a care plan with the patient that maximizes adherence. In the same way, knowledge of risk factors affecting compliance can enhance discharge planning and make it more effective.

Situational factors are best dealt with through anticipatory planning. A conversation with the patient about the possibility of these events occurring and how to deal with them can ensure their adherence. A patient on a restricted diet, for example, is asked to consider eating at home until they are familiar with the diet. The patient is also given ideas about what to order in a restaurant that would be allowed on this diet. The patient may feel uncomfortable explaining their diet to friends. Role playing can be helpful in these situations.

Case study 9

Bill is a 32-year-old, single African American man diagnosed with bipolar disorder who stopped taking his medications 3 weeks ago. His family brought him into the emergency department because of his manic behavior.

Self-Assessment Quiz Question #11

The healthcare professional caring for this patient knows that:

a. Most drugs for psychiatric illnesses have few side effects.
b. The severity of side effects for antipsychotic drugs varies according to their gender.
c. A bipolar patient often stops taking their medication when they are manic.
d. Medications for bipolar disorder have few side effects.

Self-Assessment Quiz Question #12

To avoid medication noncompliance in the future, the healthcare professional should:

a. Limit disclosure of the severity of the illness to the patient and family.
b. Encourage the patient to purchase needed medications at their own expense.
c. Teach the family some of the symptoms (rapid speech, change in energy level) that would show medication nonadherence early.
d. Use scare tactics wherever necessary to obtain compliance.

DIAGNOSTIC ASSESSMENT

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) diagnoses and the NANDA nursing diagnoses that might be applicable to patients who are nonadherent are detailed in this section. Of course, circumstances for any specific patient who is nonadherent may warrant additions to the listings.

DSM-5 psychiatric diagnoses

Medication treatment nonadherence, as it is referred to in the DSM-5, can occur in patients with any diagnosis. However, especially for patients with psychiatric diagnoses, the effects of nonadherence can be unsafe. Patients with the following DSM-5 diagnoses may be particularly at risk for nonadherence (American Psychiatric Association, 2013):

- Neurocognitive disorders.
- Substance-related disorders.
- Bipolar disorder.
- Schizophrenia.
- Feeding and eating disorders.
- Personality disorders.

NANDA nursing diagnoses

The following are NANDA nursing diagnoses that are associated with patient nonadherence (Herdman & Kamitsuru, 2018):

- Anxiety (e.g., mild, moderate, severe).
- Coping (ineffective, defensive).
- Family processes (e.g., dysfunctional, interrupted).
- Self-care deficit (e.g., bathing, dressing, feeding).

THE HEALTHCARE PROFESSIONAL'S REACTION TO THE PATIENT WHO IS NONADHERENT

Healthcare professionals' willingness to examine their attitudes and feelings toward the patient is of primary importance in working with patients who are nonadherent. The identity of a healthcare professional is closely tied to the concepts of helping, caring, and service. When a patient appears to reject a healthcare professional's expertise in promoting wellness, the healthcare professional must deal with many intense and conflicting emotions.

Many healthcare professionals state that they would prefer to spend their time with motivated patients who want to get well rather than with patients who do not comply with their treatment plan. They express anger that the patients are "wasting" a bed, precious resources, or the healthcare professionals' time. It is important to understand that many patients who are nonadherent are not deliberately working against the treatment team.

Sometimes anger can lead to withdrawal of services. A healthcare professional may avoid going into the patient's room or omit teaching the patient because "the patient isn't going to do it anyway." The healthcare professional should deal with these feelings in another way because it is obviously not helpful to punish the patient with these behaviors. Discussing the patient's case with the healthcare team and getting suggestions for new approaches to handling the patient can be helpful. Discussions may need to focus on the degree to which care is patient-centered, so that patients feel they are active, respected partners in healthcare decisions. Patients will resist interventions if they feel that their needs are not being heard or respected. When they do resist and appear to be nonadherent, this may be a signal to the healthcare team that an internal assessment of the system's approaches to patient care should be conducted (see Box 1).

At times, healthcare professionals may feel unable to "allow" a patient to be nonadherent. This situation might occur when the healthcare professional has some commonality with the patient, such as being the same age as the patient or having a parent who died of the disease the patient has. Healthcare professionals who feel powerless in the face of a patient's nonadherence may push the patient to adhere while assuming decision-making responsibilities that belong to the patient.

Box 1. Cycle of Nonadherence Between Patients and Healthcare professionals

Depending on the reasons for nonadherence, the patient may be quite happy to be left alone or to be overly dependent on the healthcare professional. More likely, however, the patient will feel that their real healthcare needs are going undetected. This behavior may become a cycle.

Nonadherence Cycle

- Patient is nonadherent
- Healthcare professional feels angry, powerless, and so forth
- Healthcare professional withdraws or overreacts
- Patient's needs go unmet

Healthcare Professional Strategies to Stop This Cycle

- Becoming aware of feelings
- Performing a healthcare professional assessment
- Using care planning as a mutual process

INDEPENDENT HEALTHCARE PROFESSIONAL INTERVENTIONS

Healthcare professionals can be key players in enhancing adherence on the part of their patients. By establishing rapport and creating trust, they present themselves to their patients as informed and knowledgeable persons who can answer questions and offer ways to adhere to plans of care. Healthcare professionals can reassure patients that it is not always easy to change long-term behaviors and gently reinforce why some changes may be necessary. Providing their patients with education as to the reason for certain treatment regimens is something healthcare professionals are well equipped to do. Often patients are more likely to follow through on their treatment requirements when they fully understand the reason and importance of what they are doing.

Patients benefit from the help of family and friends; healthcare professionals can assist their patients in obtaining support from these individuals. If there is a particular part of the treatment that goes against the patient's belief system in some way, the healthcare professional can help explain this to the healthcare team and together they (including the patient) can try to come up with an alternative intervention. Healthcare professionals implement their role as a patient advocate when they assist in these situations.

In addition to being professionals with a job to do, healthcare professionals are also individuals with their own belief systems. When patients are nonadherent, healthcare professionals can take it personally and react poorly in the situation. It is helpful for healthcare professionals to examine their reactions and why the patient may be acting in this way. Table 3 provides some suggested healthcare professional interventions along with their rationale for working with patients who are nonadherent.

Table 3. Independent Healthcare professional Interventions for Patients Who Are Nonadherent and Their Rationale	
Independent Healthcare professional Interventions	Rationale
Develop awareness of feelings toward patients who are nonadherent with their treatment regimens.	If unaware of personal feelings toward patients who are nonadherent, there is the possibility to be unaware of feelings of anger and/or powerless toward patients. This may a withdrawal from the patients and thus their needs will go unmet.
Develop a trusting relationship with patients.	Trust is basic to a therapeutic relationship. The quality of the healthcare professional-patient relationship has been shown to be a powerful predictor of adherence.
Assess patients' mental status.	Several studies have shown that clinical depression is a risk factor for nonadherence (Brown & Sinsky, 2017).
Explain clearly why the treatment is necessary and what to expect (e.g., delayed benefits, general side effects). Ask the patients to identify benefits of treatment, and how likely they think it is that there will be consequences of the current illness or health problem (perceived susceptibility and perceived severity).	A complicated or demanding treatment plan is an ordeal for even the most motivated patients. Patients need to understand why the plan is necessary; otherwise, they have little incentive to follow through with it.
Include the patients in setting goals and planning care. Ask the patients to identify potential barriers to adherence (e.g., social, economic, or environmental factors).	The mutuality of expectations of patients and healthcare professionals makes it more likely that patients will be adherent with the treatment plan. Encourage patients to ask questions and express their concerns regarding their illness and the advantages and disadvantages of a treatment regimen. Addressing issues and strategizing with the patients as to how best to deal with these issues will help with adherence and help to reinforce the importance of the treatment plan.
Teaching should be aimed at the patients' learning level.	To be able to adhere, patients must understand the information presented to them: • Teaching should be brief and focused. • Complex information should be broken into smaller, more understandable parts whenever possible. • Teaching material should be simplified as much as possible. Aim for a reading level of fourth or fifth grade with few words with more than three syllables.
Encourage patients to report problems with their treatment regimen, such as any unwanted or unexpected side effects, before adjusting or stopping it.	Patients often have valid reasons for not following a treatment plan. The better the understanding of patients' concerns about their treatment regimen, the more likely its importance will be explained (Jones et al., 2015).
Encourage patients to request the support and help of family or friends.	If family members or other caregivers are not providing direct care to patients, and if patients are having difficulty following through on taking medications or other therapies, family members may be helpful in reminding patients to take their medications.
Communicate concerns about the patients' nonadherence with other members of the healthcare team. Revisit the facility's philosophy about patient-centered care.	The healthcare team may detect and help solve nonadherence problems, including health system problems as well as patient issues.

HOLISTIC CONSIDERATIONS

Patients do have the right to choose their own treatment and make their own decisions unless their choices will harm themselves or others. However, healthcare professionals and other clinicians may have a better knowledge base about treatment options. The healthcare professionals' role is to educate patients so that they can make an informed choice and not to assume patients do not know what is best for themselves. Walker (2017) outlined four basic philosophical orientations for clinician-patient relationships related to adherence.

Paternalism

The paternalism model is based on the expertise of the clinician, coupled with a grounding in beneficence (the doctor or healthcare professional knows what is best for the patient). This framework often conflicts with the concept of patient autonomy. This model is most acceptable in emergency situations and to value-neutral, technical decisions. There has been a shift in healthcare in recent decades toward more patient-centered, autonomous decision making.

The Radical individualism model

The patient has absolute autonomy and absolute rights over decisions regarding their body. The patient is capable of assessing alternatives, and healthcare staff members are obligated to adhere with these wishes.

The consumer model

This relationship model is market based. Healthcare is seen as a commodity with the patient as a consumer. This relationship model tends to undermine the caregiver ethos by encouraging emotional disengagement.

Shared Decision-making model

Also known as the reciprocal model or negotiated contract model, the shared decision-making model lies between the extremes of paternalism and radical individualism. It is rooted in the concept of shared humanity in all participants. It emphasizes the relationship to the patient, not the disease.

Holistic healthcare professionals, understanding the experience from their perspective, work with the patient. They recognize that the burden of responsibility for the ultimate decision and change belongs with the patient. The healthcare professional's duty is to educate and empower the patient.

Case study 10

Michael Longfellow is a 60-year-old male patient who was admitted to the hospital after he fell and broke his hip. He had been helpless at home for several hours after the fall because his wife was away from the house. When she returned and found him, he was immediately brought to the hospital by ambulance. On the day of admission, surgical repair was performed.

After surgery, Michael was disoriented for several days. He was confused, belligerent, and had visual hallucinations. Medication for agitation was required some of the time. Michael's blood pressure and pulse rate were high. Eventually, his mental status cleared, and the remainder of the postoperative period went smoothly. Michael's incision began healing, and his vital signs became stable.

Pain management, however, remained a problem for Michael; it was difficult to develop a pain management regimen that enabled Michael to experience pain relief. He was unwilling to practice coughing or deep breathing as recommended because of reported pain. It was a constant struggle to assist him with ambulation exercises, although he had been informed of the dangers from immobility many times. He developed pneumonia, and his hospitalization continued.

His wife and adult children rarely visited and were unwilling to talk with staff members. Michael reported that he had not worked for years and relied on his wife for much of his care and support. He gave vague reasons for this situation, stating that he had been laid off and that there were never any jobs in his field of employment.

The healthcare professional staff began to be concerned as time passed and Michael did not appear to be assuming responsibility for his recovery. He, on the other hand, was eager to return home and pressured his physician to let him go prematurely. The staff called a patient care conference to discuss the discharge plans for Michael.

During the conference, several of the healthcare professionals on the evening shift expressed concern that Michael would not be well taken care of if he were to return home at this time. They had met his wife because she visited in the evening after work. They described her as "cold" and "mean." They were sure that she would provide no assistance to Michael, who would be forced to fend for himself at home.

The night healthcare professionals described ongoing episodes of insomnia that the patient had experienced since his admission. One of the healthcare professionals had found Michael attempting to smoke in his room. She stated that he drank cup after cup of coffee whenever he could. She thought that he was simply a patient who was nonadherent with his treatment plan and should be discharged as soon as possible with home care assistance.

One of the healthcare professionals mentioned the possibility that Michael might have an alcohol use disorder. She cited his delirious episode after admission, his low pain tolerance, and the dysfunction in the family as possible indicators that he might have a substance use problem. The physician added that the hypertensive episode after surgery and the insomnia supported that assessment.

The social worker remembered that Michael's wife had bitterly discussed with her Michael's lack of employment and his previous falls. The social worker admitted that she had focused on the wife's hostility instead of on the possibility of an alcohol use disorder. She added that the behavioral habits of smoking and excessive coffee drinking have been linked in the literature to problem drinking.

It was agreed that the social worker would meet again with Michael's wife and discuss the possibility that Michael has an alcohol use disorder. With the information from that interview identifying Michael with a pattern of problem drinking, it was easier to approach Michael about his problem, and he was, in fact, assessed and referred for treatment of an alcohol use disorder.

Questions

1. What are the staff's issues regarding Michael's nonadherence to his treatment plan?
2. What are some approaches that the healthcare professionals can use when caring for patients who are nonadherent?

Discussion

1. The evening staff healthcare professionals who described the patient's wife as cold and mean were clearly angry. If they had examined their feelings closely, they might have discovered that they were angry with the patient for his unwillingness to participate in recovery. It is often easier to be angry at a healthy, and distant, family member than to be angry with the patient. It can be difficult for healthcare professionals to accept their anger toward a patient who is ill and with whom they interact on a daily basis.

   It seems like the night healthcare professionals felt little compassion for this patient. They were most likely dealing with feelings of powerlessness. Michael was a patient who ignored the rules and the healthcare advice offered to him. Powerlessness is difficult for anyone to experience and is most often masked by anger and rejection. When staff learn how to use techniques of brief assessment and intervention with patients who have alcohol problems and see their role in patient-centered care more clearly, they will feel less powerless.

   Most of the issues of nonadherence in this case study may be attributable to the patient's unrecognized alcohol use disorder. Michael was unwilling to adhere to treatment recommendations because of his as-yet-untreated alcohol use disorder. His wanting to leave the hospital may be, in large part, motivated by his desire to have easier access to alcohol. If he had been discharged to home without treatment of this problem, his chances of a successful recovery would have been low. In addition, his alcohol use would have placed him at risk for more falls and other physical problems.

   In this example, the staff needed to learn to look beyond Michael's nonadherent behavior and find out what was really occurring. He was certainly not following the treatment plan, but it was not simply negativity. There was an unidentified problem beneath the surface that needed resolution before Michael could address his nonadherence.

   Family issues in this case study should not be overlooked. The wife and adult children should be included in discussions, with some focus on their own possible health issues, needs, and feelings as well. Further assessment and referral may be appropriate for the entire family. Because adherence to the treatment plan will be critical for a successful outcome for Michael, paying attention to family issues interfering with adherence is important.

2. Much of the time, the healthcare team is asking the patient to make significant changes in a lifelong pattern of behavior. This is not easy for anyone. Creating attainable short-term goals for which the patient can experience success is helpful in ultimately reaching long-term goals. The healthcare professional provides thorough and appropriate education and training on any aspect of the patient's care plan to enhance cooperation with the recommended treatments and interventions. Use of Internet or smart phone resources can help remind and educate the patient. Teaching family and friends to be alert for signs of changes in

behavior is part of a holistic approach. Establishing a strong sense of rapport is essential to teaching being effective.

It is also useful to discuss with the patient why adherence is difficult for them. Finding the root of the problem and addressing it directly can help with optimizing the patient's ability to carry out the plan of care and achieve the desired health benefits. For example, the patient may not remember to take a prescribed medication because it is effectively working and there are no symptoms triggering the need to keep taking the drug. The healthcare professional can assist the patient with finding other reminders as to when the medication should be taken. Many people have cell phones equipped with alarm features, so teaching the patient how to use this alarm function may be a constructive way to gain adherence to medication use.

Healthcare professionals who acknowledge their own problems make it less likely that those problems will interfere with helping the patient. Healthcare professionals, just like patients, may find it difficult to follow many health-related behaviors. Adherence on the healthcare professionals' part helps patients see congruence in what is practiced by others and what is asked of them. However, examining their feelings is not always the easiest thing for healthcare professionals to do. Because patients present with many different issues, it is likely that situations will arise when the patients' problems match ones that healthcare professionals, themselves, are experiencing. Self-awareness is critical for successful interactions in these situations. Healthcare professionals are not perfect, and they may have unsolved problems and issues, but knowing what they are is important.

There is also the recognition that patients do have the right to nonadherence. Sometimes the patient is making choices for reasons the healthcare professional has not considered. It is essential to examine why the patient stopped (or never started) the treatment as prescribed. There is also a time when patients will have to live with the consequences of their own actions. The self-aware healthcare professional knows that there are limits to what teaching and explaining can do to change the health behaviors of others.

Evidence-based practice! Some technology-based interventions, such as reminder apps on a cell phone or digital patient education are becoming more common, but do they really work? Some clinical trials have been examining the effectiveness of smart phone reminders and education for mental health patients. One meta-analysis (Linardon & Fuller-Tyszkiewicz, 2020) examined numerous clinical trials, and the adherence and improvement in behavior was not consistently improved. Mental health patients often drop out of programs or trials, and low levels of adherence are seen as common for this population. Healthcare professionals can only continue to offer education and support for the patient and their family.

MANIPULATIVE BEHAVIORS

Illness poses a severe threat to a person's security, self-esteem, and autonomy. It results in a loss of self-control and a fear of becoming helpless and dependent. The healthcare system may also place patients in childlike positions. The resulting anxiety may prompt a regression to manipulation as a coping mechanism even in patients who do not typically demonstrate manipulative behaviors.

A DEVELOPMENTAL VIEW OF MANIPULATIVE BEHAVIORS

Before healthcare professionals can intervene effectively, they must understand not only what manipulation is and how they respond to it but also where it begins. How does manipulation become entrenched as a need-gratifying mechanism?

The use of manipulation as an adaptive, need-gratifying mechanism starts early in life. It is defined as an automatic behavioral pattern that infants use to get their basic needs met. They manipulate without any regard for the needs of others. In newborns, who are utterly dependent on others, the use of manipulation is acceptable and, in fact, vital. It is a matter of survival.

As children grow and develop, they test a variety of adaptive maneuvers to manipulate the environment to gratify their needs. If a child's unacceptable behaviors are met with clear and consistent limits delivered by primary caretakers with unconditional love and acceptance (of the child if not of the behavior), then the child will gradually develop a sense of self-esteem and self-control. Slowly, children learn to replace manipulation with more independent, adaptive behaviors.

If, on the other hand, a child's first limit-testing manipulative efforts are met with inconsistent limits or with no limits at all, with conditional love, and with lack of acceptance of the child, then the child will not learn how to fulfill their needs and how to gain love and acceptance from others (Townsend & Morgan, 2017).

ADAPTIVE MANIPULATION VERSUS MALADAPTIVE MANIPULATION

Manipulation, learned early in life, is a process that occurs consciously or unconsciously in virtually all interpersonal interactions.

When manipulation is used in an adaptive sense, it is just one of many behaviors that a person can call on to ensure that their needs are fulfilled. It is neither the only need-gratifying behavior nor the dominant one.

For manipulation to be considered maladaptive, it depends on the

- extent to which it is used as a dominant need-gratifying mechanism.
- degree to which a person is aware of using it.
- degree to which the person is self-oriented and not oriented to others.
- degree to which others are treated as objects.
- effect on others, such as the person who has been manipulated feeling angry but not necessarily being certain as to why.

Unquestionably, the word *manipulator* has taken on a derogatory or pejorative connotation. However, the fact is that everyone manipulates at times as a way of ensuring that needs are met. It is important to understand that isolated instances of manipulation do not make a person a manipulator. It is when manipulation as a need-gratifying mechanism becomes an adult behavioral pattern that it is viewed negatively. When it is adopted as the primary means of decreasing anxiety without the opportunity of learning or experiencing personal growth, then it is problematic.

Healthcare Professional Consideration: For the same reasons younger patients are prone to manipulation, anxiety, lack of control in their environment, low self-esteem, and feelings of insecurity, the elderly are also likely to use such behavior to meet their needs. Although healthcare professionals working with geriatric patients may understand why it is happening, it is no less frustrating to manage. It is important for the healthcare professional to provide information to this population about reasonable expectations and then make every effort to meet those expectations. If something has been promised that cannot happen, the healthcare professional should explain to the patient why this change must be made. Open and honest communication is important in establishing trust and modeling straightforward behavior. One healthcare professional (Kemerer, 2016) notes that consistent therapeutic communication and remaining accountable serve to decrease the likelihood of allegations of neglect or abuse.

IDENTIFYING MANIPULATIVE BEHAVIORS

Healthcare professionals may overuse the term manipulative. After a difficult day or after caring for a string of patients with particularly taxing behaviors, a healthcare professional may be prone to assign the label manipulator to the patient who makes that one final demand that sends the healthcare professional over the edge or to the patient who is just a little too insistent in their self-advocacy. Patients who use manipulation have many requests that begin to seem unreasonable. Asking for a fresh beverage is understandable but asking for another within an hour and then needing more ice, then a pain pill, and then wanting to have a pillow fluffed becomes too much (Riley, 2020). Healthcare professionals who work in correctional or psychiatric settings often experience this manipulation as a stressor (Schoenly, 2017). If the term manipulative is to have clinical meaning, its characteristics must be understood.

Manipulation is not always easy to recognize

Patients who use manipulation are often charming, entertaining, and intelligent. They rarely see themselves as having a problem and are unlikely to seek help on their own. In fact, many individuals who demonstrate manipulative behaviors are loathe to change even when confronted because these behaviors get their needs met (Townsend & Morgan, 2017). When the harmful effect on others is pointed out, these patients may feign guilt or remorse because they are aware that these are the socially acceptable responses. They will not actually feel those feelings, however. Patients with dominant manipulative traits do not have a superego (concerned with moral behavior) strong enough for pangs of conscience to be genuine.

The reaction of healthcare professionals faced with such situations is, understandably, negative. It is sometimes possible to detect manipulation by virtue of a negative reaction to a patient's interaction or request. Sensing that something does not ring true can assist the healthcare professional to suspect manipulative behavior. Universally, healthcare professionals, like most of the population, want to avoid interaction with patients who regularly use manipulation.

Cycle of manipulation

A person has needs to be met but cannot trust the environment to meet them consistently. The ensuing anxiety causes the person to fall back on the earliest need-gratifying mechanism – adaptive maneuvering and manipulation to ensure that their needs are met. If the manipulative behavior is effective, then the anxiety temporarily decreases. The person's needs have been met. However, the pattern of manipulation has been reinforced.

When the same person gets a negative response, they may become angry and frustrated, and anxiety skyrockets. The person again tries desperately to manipulate the environment in an effort to regain control. The pattern is set, especially when the manipulative behaviors work.

Lacking basic trust, the person is caught in an endless cycle of having to resort to manipulative behaviors to ensure that their needs are met. In the process, however, individuals are likely to alienate those around them and generate mistrust from other people. The issue of this loss of trust is key to understanding the pathology of manipulation. The patient who uses manipulation in a maladaptive way has little concern for the wants and needs of other people. Because individuals who use manipulation do not trust their own feelings, they cannot trust others. This lack of trust leads to a sense of loss of control, and the individual tries to regain a sense of self-mastery by controlling others.

Evidence-based practice! There are a variety of measurement tools available to attempt to decipher personality traits. Exploring manipulative behavior is of interest to many, especially because of its apparent connection with delinquent and/or criminal behavior later in life. Bergstrom and Farrington (2018) investigated whether the use of one or more scales could be predictive of psychopathology in adulthood. The data were supportive of a connection between high scores on callous-unemotional traits combined with high scores on daring-impulsive ones pointing to a higher risk in childhood and outcomes as adults that were below normal.

THE HEALTHCARE PROFESSIONAL-PATIENT CYCLE OF MANIPULATION

The patient who exhibits manipulative behaviors is uncannily adept at seeking out the unique weaknesses and vulnerabilities of others and using those weaknesses and vulnerabilities to gain control. Their manipulative behavior can be active or passive.

Active manipulation may involve any of the following behaviors:

- *Making demands*: "I want my medication at 9 o'clock, not 8 o'clock. I don't care about your rules!"
- *Violating rules and routines*: "Oops! I forgot I was supposed to be measuring my urine. Guess I'll need to stay another day so you can get a complete sample."
- *Making threats*: "If you don't get that guy and his obnoxious family out of my room this minute, I'm going to tear up this place – and you along with it!"

Manipulative behaviors can also be passive and more subtle:

- *Eliciting pity*: "Can't you understand how hard it's been for me lately? My husband is leaving me for another woman, my two kids are out every night until 1:00 a.m., and my son wrecked a brand-new car last weekend. Wouldn't you drink too?"
- *Ingratiating and flattering*: "You're the only one on this unit who can possibly understand me. I don't even know why you're working here – you're so much smarter than the rest of them. And prettier too."
- *Evoking guilt feelings*: "Well, if you had come in here to talk to me at 2:15, when you said you would, I wouldn't have gotten so depressed, and I wouldn't have had to cut my wrist."
- *Abusing compassion*: "You said you understood how hard it was for me to be in this hospital, so I was sure you'd understand why I needed to sneak out this morning. I'm back now, so take it easy. Why do you have to search me? You said you trusted me!"
- *Attempting to exchange roles and become the helper's helper*: "I heard you tell one of the healthcare professionals that you're having trouble with your son. I can't believe he doesn't appreciate having a mother like you. I'm about his age, I'll bet. Tell me what he's doing. Maybe I can help."
- *Pitting staff members against each other*: "I couldn't get that other healthcare professional to understand why she should persuade the doctor to discharge me tomorrow. She said not to discuss it with you because you're too new to understand the rules yet. But I know you understand my situation. Will you explain it to my doctor? And pick a time when she's not around to interfere."
- *Questioning competence or authority*: "My doctor said that I could have another sleeping pill if the first one didn't work. Can't you even read a chart? Well, you're not in charge around here anyway. We'll see what happens to your job when the unit manager comes in tomorrow."

In each of the foregoing examples, patients seized on a particular need of the healthcare professional (the need to be professionally competent; to maintain a safe, consistent environment; to be viewed as empathic and understanding) and geared their behavior to exploit the healthcare professional's weaknesses or therapeutic vulnerability.

When healthcare professionals realize they have been successfully manipulated, their likely response is a range of negative feelings and behaviors, including anger, frustration, indifference, and withdrawal. Although patients with manipulative behaviors will enjoy these

responses as signs of their power, they will also feel an inward sense of increasing anxiety because once again they have successfully managed to manipulate someone. Can no one be trusted? Will no one ever be able to see through them and give them what is truly needed – a sense of realistic limits and a genuine feeling of self-control? The vicious cycle of manipulation can play out repeatedly between healthcare professional and patient when manipulative behaviors are not accurately identified, and healthcare professional interventions are not put in place to halt the cycle. It is essential that firm, realistic limits be set and then followed with all patients. The limits should be communicated clearly and openly, with an appropriate rationale. Although there should be consequences for nonadherence, they should not be punitive but should be set to reflect the best interests of the patients. Table 4 summarizes steps that are helpful in setting limits for patients who act in a manipulative manner.

If healthcare professionals are to stop the cycle, self-awareness is vital. If they have difficulty with their own self-esteem, they will be vulnerable to manipulative behavior. The key is for healthcare professionals to be aware of their needs so they will know when they are being exploited. They also need to be aware of their own responses, such as feelings of anger, need to withdraw, frustration, or loss of objectivity, as indicators that they are being manipulated. Only then can they be effective in helping patients find more adaptive ways of getting their needs met.

Table 4. Ten Steps to Setting Limits with Patients Who Exhibit Manipulative Behaviors

1. Define clear expectations.
2. Communicate expectations positively and firmly.
3. Limit only those behaviors that clearly impinge on the well-being of the patient or others.
4. Make sure that the limits are in the patient's best interests and are not punitive.
5. Offer a brief rationale for the limit but do not engage in a debate about its fairness or justification.
6. Define the consequences of exceeding the limit, and make sure that they are consequences that can be fulfilled.
7. Hold all discussions related to limit setting on a one-to-one basis, in private. (This limits the opportunity for the patient to involve an "audience" in determining whether the limit is "fair.")
8. Make sure that all staff members understand the limit and its consequences as they were communicated to the patient.
9. Stand firm in the face of the inevitable testing of the limit.
10. Provide positive reinforcement every time the patient is able to meet the limit.

Based on Reach, G. (2016). Patient education, nudge, and manipulation: Defining the ethical conditions of the person-centered model of care. Patient Preference and Adherence, 10, 459-468. https://doi.org/10.2147/PPA.S99627; and Townsend, M. C., & Morgan, K. (2017). Essentials of psychiatric mental health nursing: Concepts of care in evidence-based practice (7th ed.). F. A. Davis.

DIAGNOSTIC ASSESSMENT

The following are the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) diagnoses and North American Nursing Diagnosis Association (NANDA) nursing diagnoses that might be applicable to patients who demonstrate manipulative behaviors. Of course, circumstances may warrant additions to the list of diagnoses for any specific patient, but those listed here are likely for anyone with manipulative behaviors.

DSM-5 psychiatric diagnoses

As noted earlier, manipulative behaviors are ubiquitous. Healthcare professionals may encounter manipulation in any patient, on any unit, and in any circumstance. However, patients with the following DSM-5 diagnoses are more likely than others to show characteristics of manipulation (American Psychiatric Association, 2013):

- Conduct disorders
- Feeding and eating disorders
- Personality disorders
- Factitious disorders
- Substance use disorders

These DSM-5 diagnoses provide "red flags" to the possibility of the use of manipulative behaviors by patients. Any healthcare professional assigned to a patient with one of the diagnoses in this list should be on the alert for manipulative behavior. However, it would be an error to rely on the DSM-5 diagnoses as a sole indicator.

Many patients who have one of these diagnoses may not be maladaptively manipulative. The opposite is also true. Many patients who do not fit one of these diagnostic categories may use manipulation as a primary need-gratifying mechanism. A thorough healthcare professional assessment will help the healthcare professional identify manipulative behaviors regardless of the patient's diagnosis.

NANDA nursing diagnoses

The NANDA nursing diagnoses that are most often associated with manipulative behaviors are the following (Herdman & Kamitsuru, 2018):

- Impaired social interaction
- Coping (e.g., ineffective, compromised family, defensive)
- Self-esteem (e.g., chronic low, situational low, risk for low)
- Anxiety (e.g., mild, moderate, severe)
- Fear
- Risk for loneliness

INDEPENDENT HEALTHCARE PROFESSIONAL INTERVENTIONS

Patients who use manipulation as a means to have their needs met present a challenge for healthcare professionals. Patients may be unable and unwilling to recognize their maladaptive manipulative coping mechanism. Even when the healthcare professional points it out, the patient may not be willing to change. As noted previously, manipulation is inherently rewarding. However, manipulation also has a way of alienating others and making it impossible for the patient to form meaningful relationships. The healthcare professional who can help patients recognize the effects of their manipulative behavior and find alternative need-gratifying mechanisms will do much to improve their patients' quality of life. Role-modeling straightforward behavior is an effective way to encourage patients to lessen their manipulative behaviors.

Gaining the patient's trust, although difficult, and sometimes not possible, is something the healthcare professional should work toward. Trust-building behavior includes being on time for treatments or other appointments with the patient, never promising something that cannot be delivered, and remembering things the patient has related. In addition, healthcare professionals must accept that patients may say hurtful things and not take them personally; patients who use manipulation make such remarks to everyone. Self-confidence on the part of the healthcare professional is important because patients who use manipulative behaviors will try their best to gain power by undermining the healthcare professional's knowledge, skill, and competence.

Consistency will help gain rapport with patients using manipulation. All staff members must agree on a plan and follow through with it. Individually, healthcare professionals must remain consistent day to day in their expectations and responses. See Table 5 for healthcare professional interventions that may be useful in caring for patients who use manipulative behaviors.

Table 5. Healthcare Professional Interventions and Rationale for Managing Patients' Manipulative Behaviors	
Independent Healthcare Professional Interventions	Rationale
Establish a trusting relationship.	Establishing a trusting relationship is as difficult as it is vital. ● Deception is a way of life for the patient who uses manipulation, but every healthcare professional intervention is based on the foundation of a trusting healthcare professional-patient relationship. ● It may be the first trusting relationship that the patient has ever had in their life. Allow time for trust to develop.
Help patients recognize their manipulation and potential causes of their behavior.	Patients cannot be helped to find more adaptive ways of living if they do not recognize their current behavior as a problem and take responsibility for the circumstances in which they find themselves.
Provide a consistent environment.	Inconsistent caretaking is at the root of the development of maladaptive manipulation as a coping mechanism in early childhood. ● The goal of manipulation is to somehow make the environment safe and secure. ● Knowing what to expect decreases the patient's anxiety and helps them learn to trust others and the environment. ● In addition, consistency reduces the patient's opportunity to divide the staff by manipulating them.
Formulate short- and long-term goals to ensure that every member of the staff carries out the care plan as consistently as possible.	Consistency is vital to ensuring that the patient cannot manipulate by "splitting" the staff – all team members should provide input in setting goals. Short-term goals include the following: ● Recognize and verbalize feelings of anxiety, frustration, or powerlessness. ● Recognize instances of manipulative behavior. ● Gain insight into the effect of manipulative behavior on others. ● Distinguish between wants and needs and learn to delay immediate gratification of both. ● Verbalize acceptance of responsibility for own actions. ● Limit manipulative behavior and determine and practice alternative methods of gratifying needs. Long-term goals include assisting the patient to achieve the following: ● Determine and express needs in a clear, direct manner that does no harm to others. ● Demonstrate responsibility for their own actions.
Recognize and refuse to respond to manipulation.	Refusing to support the manipulative behavior tells patients who are manipulative that you the healthcare professional cannot be used as an object. They will have to find another way to get the healthcare professional to meet their needs.
Do not accept the behavior but accept the patient.	Patients who manipulate are in desperate need of acceptance and positive regard. The healthcare professional should recognize the patient's behavior as manipulative rather than label the patient as a "manipulator."
Help the patient to understand the impact of their behavior on others.	Do not assume that empathy comes naturally to patients who manipulate. Help them develop an awareness of their impact on others by being honest about how it feels to be manipulated.
Set limits that are reasonable, clear, firm, and consistent.	Although patients will most likely rail against limits, they will be enormously relieved by them. Limits will provide the external control patients need until they can develop internal control.
Provide positive reinforcement every time the patient is able to: ● communicate needs directly, ● take responsibility for their own actions, or ● accept limits.	The patient needs to recognize not only unacceptable behavior but also acceptable behavior. Reinforcement of positive behavior is likely to elicit more of the same.
American Nurses Association, American Psychiatric Nurses Association, & International Society of Psychiatric-Mental Health Nurses. (2014). Psychiatric-mental health nursing: Scope & standards of practice (2nd ed.). Townsend, M. C., & Morgan, K. (2017). Essentials of psychiatric mental health nursing: Concepts of care in evidence-based practice (7th ed.). F. A. Davis.	

HOLISTIC CONSIDERATIONS

Manipulation tactics can include flattery, interest, or praising one healthcare professional while degrading another healthcare professional. This attempt at control is usually the means to an end; there is some goal in mind for power, entertainment, or privileges. Manipulation is so prevalent in some settings that healthcare professionals have developed theories and strategies to better manage the difficulties associated with these patients' behaviors (Schoenly, 2017).

Intentionally developing social maturity, which includes the emotional strength and ego to recognize and deflect manipulation, is an important goal for healthcare professionals. Healthcare professionals' benefit from learning to recognize intrinsic rewards such as knowing they have made a difference and helped someone else transcend to a higher level of functioning. For patients who use manipulation, healthcare professionals must clearly set the healthcare professional-patient relationship with appropriate professional boundaries and maintain those boundaries (Schoenly, 2017).

Patients often use a combination of charm and manipulation to disturb the flow of care on a healthcare professional unit. These patients can be difficult. One moment one healthcare professional will be the only healthcare professional who can care for the patient, then the patient will refuse to see that healthcare professional (Schoenly, 2017). Reflection on each experience with a fellow team member can be helpful for healthcare professionals. Meeting frequently to ensure all staff members (even non-healthcare professional staff) are applying the same rules to patients who manipulate is recommended. It is critical to understand that the underlying aspect of this personality trait is stable and enduring. It is difficult to change a pattern of behavior, but consistency and a caring and professional approach must be maintained to begin to make a change.

The management of "difficult" patients leads to frustration, stress, and burnout for healthcare professionals. The team needs to work cohesively and reflectively and offer support to all team members. Training to work with patients who use manipulation will reduce burnout and increase job satisfaction, while continuing to provide care to all those who need it. Mentoring healthcare professional colleagues is highly recommended for situations involving patients with manipulative behaviors.

Case study 11

David Andrews, a single, 32-year-old White man, has been admitted to the general surgery unit for a hernia repair. His healthcare professional, Bonnie Blake, introduces herself and welcomes him to the hospital. Bonnie is a recently divorced 28-year-old and has been a registered healthcare professional (RN) for about 6 months. She explains to David that she will need to ask a series of questions, some of which he may already have answered, but that she would like to hear his answers herself. David says he will be very happy to answer questions asked by such a cute healthcare professional. He tells Bonnie that he hopes she is his healthcare professional the whole time he is in the hospital and will meet his "every need, if you get what I mean!"

Self-Assessment Quiz Question #13

How should Bonnie interpret David's last remark?

a. David is probably very nervous about being admitted to the hospital.
b. David is a big flirt.
c. David is probably guilty of sexual harassment in his work situation.
d. It is hard to be sure of how to interpret his remark at this point.

Case study 12

Bonnie begins her assessment by asking David ordinary questions such as his name, address, date of birth, and marital status. Each time he answers, David adds a short comment such as, "Yes, I already answered that one" or "Seems like you people could pass along information better; are you people all incompetent?"

Self-Assessment Quiz Question #14

Which would be the best response for Bonnie to make to David's comments?

a. "I told you these questions may have already been asked."
b. "I agree that all this makes things very repetitious."
c. "I do understand your frustration, there aren't too many more items."
d. "I really wish you'd stop interrupting, then we'd get done sooner."

Case study 13

When asked the question about marital status, David replies, "I'm single, who wants to know?" and gives Bonnie a wink. He then asks her what her marital status is.

Self-Assessment Quiz Question #15

What is the best response for Bonnie to make at this point?

a. "That's really none of your business."
b. "Hey, I'm asking the questions here!"
c. "That is not the purpose of this interview."
d. "If I tell you, will you start just answering what I ask?"

Case study 14

Bonnie is becoming increasingly uncomfortable and decides she needs to take a short break from this interaction. She tells David she needs to check on something and will be back as soon as she can. As she leaves the room, David calls out, "You hurry back, you sweet thing, I'll miss you while you are gone!"

Questions

1. Why is Bonnie feeling so uncomfortable?
2. Why is David behaving the way he is?
3. Is Bonnie making a good decision to "take a break"?

Discussion

1. More than likely, Bonnie is uncomfortable because David is behaving inappropriately, and she is unsure what to do about it. Although David is cooperating by answering the questions, he is making remarks that undermine Bonnie's confidence in her ability to provide competent care. He is putting their relationship on a personal, rather than professional, level, and is treating her as a potential date, not his healthcare professional. As a new RN, it is normal that Bonnie does not yet have complete confidence in her abilities. On top of that, as a recently divorced woman, she possibly has doubts about her desirability as a woman.

Because his behavior is inappropriate for the setting, Bonnie cannot be sure what David means by his flirtatious remarks; does he actually find her attractive, or is he teasing her? With the ambiguity and Bonnie's lack of experience, it is not unusual that she would become anxious in her interaction with David.

2. David may be nervous about having to be admitted to the hospital. The behavior he is exhibiting might demonstrate an attempt to gain control of an unfamiliar situation. He is manipulating his healthcare professional in such a way that gives him the upper hand, in his opinion at any rate. Or David might simply be used to this sort of interaction under any circumstance. Whatever his reasons for this manipulative behavior, David will have difficulty getting his needs met in this manner. Instead of gaining the support and help he needs, he alienates people and causes them to avoid him.
3. Given the fact that Bonnie is becoming extremely anxious and feels like she is losing control of the interview, taking a break is not an inappropriate decision. Although there are other ways to deal with the situation, Bonnie has found a way to interrupt the seemingly downward turn that the interaction was taking.

Case study 15

Bonnie finds her supervisor and tells her that she is very uncomfortable with David. She asks if she can be reassigned to a different patient and let Joe, another RN on the unit, take over for her with David. The supervisor tells Bonnie that it would be better if she learned to manage patients with manipulative behaviors and that, for now, the assignments remain as they are. The supervisor does spend a bit more time with Bonnie and asks her what, specifically, is making the interview so uncomfortable and what she thinks would be the best thing to do about her discomfort.

Question

Is the supervisor making the right decision in having Bonnie continue to work with David?

Discussion

At least for the present, the supervisor seems to be making the right decision. Bonnie will encounter all sorts of people in her career as a healthcare professional and will not have the luxury of changing assignments every time she is uncomfortable with one of them. She needs to develop the skills to work effectively with all types of behaviors exhibited by patients. Given his manipulative behaviors the patient has made her uncomfortable, but her supervisor sees this as a good learning experience and offers support by talking over the difficulties Bonnie is encountering.

Self-Assessment Quiz Question #16

On hearing her supervisor tell her that she will continue as David's healthcare professional, Bonnie's first reaction is to plead her case and ask her supervisor to reconsider. What is the supervisor's best response?

a. "Tell me more about your feelings of discomfort."
b. "All new healthcare professionals are a bit uncomfortable at first."
c. "No, I can't reassign you to another patient."
d. "What if everyone wanted to switch assignments?"

Self-Assessment Quiz Question #17

Which of the following would be the best way to resume the interview once Bonnie has returned to the assessment room?

a. "Sorry for the delay, let's start where we left off."
b. "OK, David, let's try to stay on track now that I'm back."
c. "I'm back to continue where we left off – if you can cooperate by simply answering my questions."
d. All right, we'll continue with your assessment. I hope you can avoid any more inappropriate remarks."

Conclusion

Healthcare professionals should never underestimate the potential for violence; assaults by patients – young or old, male, or female – can occur for many reasons. This course explored how healthcare professionals will encounter difficult or hard to manage patients during their career, including workplace violence, non-adherence to medical treatments, and manipulation of caregivers and the treatments and skills needed. This course demonstrated how healthcare professionals can avoid potentially violent situations and work with difficult patients by being prepared and recognizing the signs and risk factors for these occurrences. It also explores how healthcare professionals must deal with their own feelings toward difficult patients while treating them. De-escalation skills, diagnosis, preventative measures, training, and planning are all presented in this course to help healthcare professionals respond to difficult patients and ensure a healthy and safe environment.

Glossary

Adherence: The term adherence describes the degree to which a person's behavior corresponds with the agreed recommendations from a healthcare provider. Adherence acknowledges that the patient is part of the decision-making process. To promote adherence, hospitalization must become an experience in which patients maintain control over most of what happens to them. Healthcare providers are finding new ways to alleviate the dilemmas that patients face when hospitalized. An example is the patient-controlled analgesia pump for self-administration of pain medication. Use of this device reduces the patient's dependence on the healthcare professional for comfort and, in many cases, reduces anxiety about pain control.

Compliance: The term compliance is used to describe the degree to which patients follow their healthcare providers' recommendations. It implies a patient-healthcare provider hierarchy, or a power differential in the relationship, in which the patient is relegated to a subordinate role. Some healthcare professionals believe this has a negative influence on patient compliance with the healthcare provider's recommendations.

Noncompliance: The North American Nursing Diagnosis Association (NANDA) definition of noncompliance is when the actions of the patient do not follow the health-promoting or therapeutic plan agreed on with the healthcare team (Herdman & Kamitsuru, 2018). A plan of action for involvement and agreement with the management plan is needed.

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MANAGING DIFFICULT PATIENTS FOR HEALTHCARE PROFESSIONALS

Self-Assessment Answers and Rationales

1. The correct answer is D.
Rationale: The important thing is to get the medication in the patient quickly.

2. The correct answer is C.
Rationale: Martha will likely feel like a failure because her supervisor had to give the injection. Susan can explain to Martha that it is difficult to ignore some of what she was taught in school, even in emergency situations. Susan shares that with more experience, it is easier to do this simply because she has given "millions" of shots and can better determine where to place the needle from her experience.

3. The correct answer is B.
Rationale: While Astrid is available, it would be important for Jackie to get this information from her. Asking Erik directly about his "mood swings" and informing the doctor about what Astrid reported are actions Jackie could take later.

4. The correct answer is C.
Rationale: Even though Erik is sleeping now, it does not eliminate the possibility that he might become disturbed.

5. The correct answer is C.
Rationale: This is a situation that needs attending to as soon as possible and it may take more than one person to handle it.

6. The correct answer is A.
Rationale: Although all actions are needed, the priority is the safety of Erik and the staff. Getting other staff to the room to help calm Erik would most quickly accomplish that goal.

7. The correct answer is C.
Rationale: Stating the facts about the situation first followed by letting Erik know the staff are there to help calm him will not come across as accusatory or belittling to Erik.

8. The correct answer is A.
Rationale: This approach provides Erik with an opportunity to tell the staff in his own words what has been bothering him.

9. The correct answer is D.
Rationale: Jackie is seeking answers to help her understand Erik's behavior. At this point, there is not a definitive answer to Jackie's question. The interventions in plan will help the team to gather more information to better understand Erik's behavior.

10. The correct answer is D.
Rationale: Preventing harm to the patient and staff and providing a safe environment is important. This is precisely what the nurses and other staff in this scenario did. They focused on the needs at hand and implemented appropriate interventions based on the observed behavior.

11. The correct answer is C.
Rationale: Patients who are experiencing mania feel highly energized and motivated during this phase of their illness. They believe they feel well, although they often have anxiety and inappropriate behaviors such as compulsive spending or numerous unfinished products.

12. The correct answer is C.
Rationale: As much teaching as possible is needed for both this patient and his family. It would not be unusual for a patient to try to hide the nonadherence to medications prescribed from his family.

13. The correct answer is D.
Rationale: Any of the other responses might be true, but it is a little early to make any definitive judgments.

14. The correct answer is C.
Rationale: Answer c acknowledges that the process is cumbersome without taking sides or "scolding" David.

15. The correct answer is C.
Rationale: Answer c is the appropriate response so as not to be rude or flirty or create a bargaining situation.

16. The correct answer is A.
Rationale: This will help Bonnie to focus on the feelings she is having about the situation and, hopefully, what is at the root of her discomfort.

17. The correct answer is A.
Rationale: At least to begin with, it would be best for Bonnie to start with a clean slate and not address David's previous behavior. If it continues, then Bonnie will need to say something, but it would be best to first wait and see how things progress from the new starting point.

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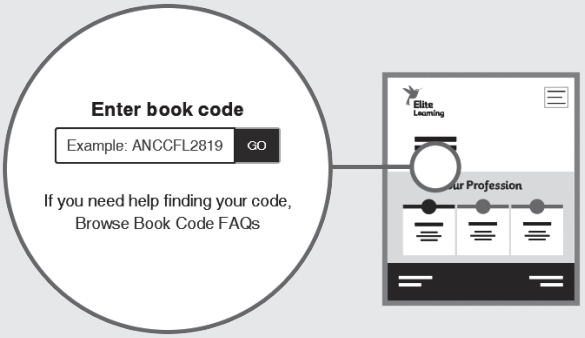

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