ROUTLEDGE

Nursing Older People

Realities of Practice

Edited by Heather Fillmore Elbourne and Andrée le May

NURSING OLDER PEOPLE

This practical guide helps student and practising nurses to understand the impact of their care when working with older people. With stories from older people who have had varied experiences of health care and nursing, chapters are underpinned by five key principles: providing patient-centered and dignified care, shared decision-making involving family and friends, multidisciplinary care, improving well-being through companionship and a sense of value, and an appreciation of both the challenges and rewards of working with older people.

This book offers:

- Stories which reflect the complexity of care and health experienced by older people and their journeys.
- Topic-oriented chapters which provide a series of evidence-based readings which use the most up-to-date research evidence merged with national and international policy and practitioner experience.
- Practical tips and key messages for working with older people.

The volume can be used to help nursing students and practising nurses to understand better how their care might impact positively on older people's health and well-being. This situates the reader within the world as experienced by older people.

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1 About this book

Andrée le May and Heather Fillmore Elbourne

This book is guided by the following principles:

- Older people should receive dignified care; in order to do this care must centre around the person.
- Families and friends need to be included in care and care decisions to minimise isolation either of the older person or of the family member/friend.
- Older people require care from multidisciplinary teams, and nurses need to form an integral part of these teams.
- Companionship and feeling valued can increase feelings of mental well-being, and these are important parts of nursing care.
- Nursing older people can be challenging but also vastly rewarding.

Our aim is to help nursing students and practising nurses to understand better how their care might impact positively on older people's health and well-being. To do this, we have decided to first situate the reader within the world as experienced by older people by describing key facts about the ageing population, their health, and nursing (Chapter 2) and telling some stories based on older people's experiences of health and social care (Chapter 3). We believe that this approach will make it easier for readers to understand the impact of nursing and how nursing can be best structured if nurses start from the client's and their family's perspectives. Stories are a powerful way of showing what life is like for people in different circumstances, and we use them in the remaining chapters to develop empathy and understanding related to clinical situations. We have deliberately chosen stories that focus on the common difficulties of older age and emphasise that nurses form part of a team of health- and social-care workers.

One of the greatest fears expressed by older people is what will happen to them as they become functionally, physically, mentally, and/or socially more dependent on others as they grow frailer and less able to do the things they used to do. For many older people, and their families, friends, and carers, this change in independence brings with it unfamiliar risks and challenges. Understanding and managing such risks may be one of the most daunting aspects of ensuring that care is truly person-centred and works for the benefit of each individual person. In Chapter 4 Imogen Blood explores risk taking and risk management. We have deliberately situated this chapter early in the book since we believe that understanding and managing risk sensitively is crucial to the provision of high-quality care and the promotion of increased quality of life.

This book is not a comprehensive textbook of elderly care/geriatric nursing; rather we have picked commonly occurring consequences of the ageing process to explore how nurses might provide evidence-based, person-centred, responsive care to older people in these circumstances. In Chapter 5 we focus on the notion of staying healthy in older age by covering topics such as exercise, mental agility, and social interaction. This is complemented by Chapter 6 where Khim Horton focuses on common difficulties experienced by older people including falling, incontinence, loneliness, and pain. In Chapter 7 Samuel Searle and Ken Rockwood discuss frailty as an independent geriatric condition that includes both physical and psychological decline and too often goes unnoticed as symptoms are attributed to the ageing process. This chapter is essential to nurses as the ability to identify frailty in its early stages is key to developing specific interventions that may delay or prevent further functional decline and other negative outcomes—such as acute illness, falls, hospitalisation, and death. Catherine Evans and Caroline Nicholson discuss end-of-life care in Chapter 8 making the critical point that dying and death are integral components of living in older age.

In these issue-specific chapters (4–8) experts have provided evidence-based readings using the most up-to-date research evidence merged with national and international policy and practitioner experience to highlight the best practice that a nurse can deliver in conjunction with the patient, their family, and the multidisciplinary/multi-agency team. We have deliberately used a blend of evidence sources—from patients, families, and clients; from the research literature; from policy directives and clinical guidelines, and from best practice and education to reflect the ways through which practitioners learn and function. Our thoughts on what comprises good practice are based on the concept of 'mindlines' (Gabbay and le May, 2004, 2011)—internalised, multiple sources of evidence, which are collectively reinforced, partly tacit, guidelines-in-the-head that clinicians use to flexibly guide and develop their practice.

We conclude in Chapter 9 by drawing together key points from the previous chapters which we believe will help nurses to understand better how their care might impact positively on older people's health and well-being.

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2 Thinking about the ageing population

Heather Fillmore Elbourne and Andrée le May

Introduction

As more and more people live longer their chances of needing care increase. There are several reasons for this which largely focus on the individual older person, their lay carers/families, and/or their environmental/social circumstances. An older person may need more care when acutely ill than they did when they were younger; or they may be generally frailer in older age and need more help and support with activities of living and staying physically and mentally well; or they may not have familial or social support readily available; or they may be living with long-term, often multiple conditions that require continuing care and support. Each of these circumstances, taken individually or together, will impact on a person's physical and mental wellness.

Knowing more about ageing and its impact can help nurses to positively affect the health and wellness of older people (Andrews et al. 2015, Nunnelee et al. 2015), so before we think more about providing care and support to this group there are a few key facts that we need to consider. First, changing demographics means that there are more older people than ever before in almost every country in the world—older people are the fastest growing demographic cohort in the world (WHO 2015a). Second, older people are not only living longer, but they are also living longer with more complex health- and social-care needs (Wolff et al. 2002, Abellan van Kan et al. 2010, Rockwood and Mitnitski 2011). Third, there is both subtle and blatant ageism around us all in our work and everyday lives, and nurses need to understand how that might impact on older people and their care and how to minimise or, preferably, erase ageism by challenging negative stereotypes (Martin et al. 2009, Officer et al. 2016). Fourth, increased numbers of older people, with more complex health- and social-care needs, require increased levels of skilled nursing care; however, finding such nurses in sufficient quantities is becoming increasingly challenging. This chapter is largely about these four things.

Population ageing

Worldwide our population is ageing at an unprecedented rate. Globally, there is an increasing number of older adults alive, and they are living longer than at any other time in the history of humankind (Rechel et al. 2009, WHO 2017). Evidence from the World Health Organization (WHO 2009a) tells us that, on average, most people can expect to be alive and healthy into

Box 2.1 Some population facts (WHO 2009a, WHO 2015b, 2017)

The world's population is growing and ageing:

- Between 2000 and 2015 global life expectancy rose by five years—this is the fastest rise in human lifespans since the 1960s.
- Globally average life expectancy is 71.2 years. For women, it is 73.8 years, and for men, it is 69.1 years.
- Actual life expectancy varies amongst adults and countries, with Japan having the most extended lifespan at 84 years and Africa having the shortest life expectancy of 50 years (although this is increasing).

Simultaneously, at the opposite end of life:

- Fertility rates have declined in most countries around the world due to social changes such as the emancipation of women, growing economic prosperity, the availability of birth control, medical advancements, and public health campaigns.
- Worldwide, although a minority of nations have increasing fertility rates, globally fewer babies are being born.

their 60s and beyond (Box 2.1). Our global population is ageing *and* growing due to a reduction in global death rates and birth rates: this has social, health, and economic consequences that we have not faced before.

Whilst the significant increase in life expectancy means that there has been an overall improvement in health and living conditions around the world it brings with it several challenges for those involved in making health- and social-care policy and delivering care.

'Population Ageing' has become a standard idiom of our time and refers to the entire population growing older. Unlike individual people who age with each passing birthday, populations age when the percentage of young people in the population is less than the percentage of older adults in the population i.e. when fewer children are born than there are adults alive. Population ageing results in:

1 an increasing number of older people in our societies;
2 a reduction in the proportion of children;
3 a decline in the proportion of people of working age (~16–60 years) who can support those who do not work (WHO 2009a).

This demographic shift influences many of our societal, moral, and economic trends. For instance, it is unlikely that the increased numbers of older adults needing care and support will be matched by an adequate increase in the amount of resources (financial and human) that are available for this group to use (Kingma 2007, World Health Assembly 2011, Humphries et al. 2012, Nuernberger et al. 2018). Any shortage of working-aged, tax-paying

adults is likely to result in less public money to support care *and* means that there will be fewer people to provide that care either in paid or in voluntary employment. This may be compounded by the reduction of familial care associated with the break-up of the nuclear family, easier national and international migration resulting in increased geographical distances between family members and less informal social support within communities (World Health Assembly 2011, Abhicharttibutra et al. 2017). These population changes and their resultant challenges have been building steadily since the post-World War II baby boom ended in the late 1960s (Butler 1969, WHO 2011, Beard et al. 2016) and are unlikely to change barring any unexpected or catastrophic occurrence. Meeting these challenges requires widespread progress in redefining and constructing health- and social-care systems to meet the complex needs of this group of people (Abhicharttibutra et al. 2017, Blood 2013, Buchan et al. 2015)—a group of people that spans 40 years and the various experiences and norms of those four different decades: for instance, the experiences and needs of the oldest old will be very different to those of the latest generation to enter older age—the baby boomers (see below).

Think about this …

Economics is important!

Conceivably one of the driving forces behind increased attention to older people is that the latest generation to enter older age have money to spend! In general, the baby-boomers are entering their senior years financially stable with disposable income, thus resulting in an unprecedented, vast and relatively untapped market. Perhaps this is why stakeholders (peripheral to those attentive to health- and social-care service needs) e.g. in the field of commerce, appear to have quickly accepted the burgeoning importance of the increasing number of older people in our societies and have swiftly adapted to target this group as consumers from increasing attention to leisure opportunities to capitalising on life-style improvements. Next time you go to newsagents check out the magazines targeting older people you can see on the shelves. Flick through them and see what articles and features there are.

However, we remain ill-prepared to meet the needs and demands of what will quickly become one of the world’s new population ‘norms’(Marengoni et al. 2011, Conference Board of Canada 2013, Elbourne et al. 2013, Hominick et al. 2016) (see Preparing for the “Big Day”).

***Think about this …* Preparing for the “Big Day”**

For a moment think about the following analogy:

The lack of preparation, and thus the situation older adults and those in health-and social-care services currently find themselves in might be equated to an all too familiar scenario. Pick your favourite yearly event or holiday i.e. a national holiday, Christmas, Hanukkah, Kwanzaa – any event that requires some forethought and planning. Now

think about the day prior to that event and picture the scenario in which some people fill the shops on the eve of the holiday scrambling to purchase the perfect present or celebratory food, and find themselves left thinking "Wow how did this happen, it has just snuck up on me?!". Well, it did not! We all knew it was coming. It happens at the same time every year and thanks to our calendars and perhaps advertising we've been reminded continuously for weeks that the countdown to the event was on. Inevitably, there are always those left in a tizzy and scrambling at the last moment. Yet, there should be no shock, and the lack of preparedness should be solely planted on the shoulders of the person who is alone and manic in the shops as we all knew it was coming.

Here is where the comparison of being 'unprepared for something we all knew was coming' ends. Being unprepared for a holiday or yearly event will only result in the minor annoyance of having to endure a few hours of uncomfortable manic preparation. Whereas failure to prepare for the population change that we are experiencing is a completely different matter leaving contemporary health- and social-care services in a position that cannot be quickly or smoothly rectified and results in older adults receiving substandard care which could negatively affect the rest of their lives.

If you were a policy-maker what would you do? If you were an older person what would you do? If you belonged to a group advocating for older people what would you do?

Defining older age and older people's needs

Many people, when asked, can identify a point in time when they decide for themselves that they have reached older age—it could be retirement age, stopping work, having grandchildren, or simply feeling less (or more!) energetic. In addition to our personal definitions of old age there are societal definitions that tend to focus on laws and conventions and may change from time to time. For instance, as we write this book the retirement age in many high-income countries is 65 years but set to rise to 67 years in future; however, having a set age for retirement is a much rarer thing in some middle- to low-income countries. Some services such as health- and social-care services distinguish age into further classifications; for instance, health- and social-care services often divide older age into three discrete categories: old age (75–84), old-old age (85–94), and oldest-old age (95+). Doing this might seem slightly strange when other definitions start around the late 60s but this is one way to ensure that services and skilled teams are targeted to meet the increasingly more complex physiological, cognitive, and social needs of older people.

Whilst many older people need minimal care from health- and social-care services, others will have "high support needs" and as such require more intensive or prolonged care—some of which will rely either solely or partly on nurses. The Joseph Rowntree Foundation (JRF) defines older people who have high support needs as:

> Older people of any age who need a lot of support due to physical frailty, chronic conditions and/or multiple impairments (including dementia). Most will be over 85 years old, though some will be younger. Many will be affected by other factors including poverty,

> disadvantage, nationality, ethnicity, lifestyle etc. Some of the very oldest people may never come into this category.
>
> (Blood et al. 2010, p. 3)

All nurses whether they are qualified or students, specialists in elderly care or general adult, or mental health nurses will care for or provide advice to or about older people at some time in their careers. This inevitability means that all nurses must understand the effect of having high support needs on an older person and their family if they are to provide sound care.

Health and the ageing population

As we have seen living longer does not necessarily equate with living longer in good health, quantity of years does not directly correlate with quality of life. Recent evidence indicates there is a significant difference between a person's life expectancy and their healthy life expectancy—roughly seven/eight years (WHO 2011, Dewar and Nolan 2013). For those specifically concerned with health and human services this translates to hundreds of thousands of older people needing care and support towards the end of their lives. And these numbers will increase over the next 30 years or so. Experts predict, by the year 2050, one out of every five people will be 60 years of age or older. Additionally, those who live to the age of 85 can further expect to live around another seven years. Although those living the longest are unlikely to experience good health for all seven of those extra years: this group is projected to double in size to nearly 2 billion people—making it the fastest growing demographic group in the world (WHO 2015a).

It is clear then that there is a pressing need for change if we are to meet the health- and social-care needs and demands of the ageing population. Some of this modification needs to come from finding out the best ways to address the issues and challenges faced by older people, and this requires age-sensitive/relevant research that is multidisciplinary, multinational, and representative of the diversity that exists within present and future cohorts of older people (Conference Board of Canada 2013, WHO 2013a, b, 2015c, Bähler et al. 2015, Gould et al. 2015). The findings from this body of research need to underpin clinical practice, public health interventions, and health and social policies. Whilst age-appropriate, person-centred care is built on having the best evidence for care it is also about having adequate resources (including people with non-ageist views) to maintain the dignity and respect of those involved.

As the population ages and grows so too will the number of people living with chronic disease (Boyd et al. 2005, Rockwood et al. 2005, WHO 2009b, Bähler et al. 2015). Internationally, chronic long-term diseases now surpass infectious diseases as the leading cause of death and disability. Non-communicable diseases account for 46% of the worldwide burden of illness and 59% of the world's annual deaths (averaging 57 million) (WHO 2013a, 2015c)

Although older people experience acute illness and infections many older people have chronic, multiple, interacting health- and social-care needs that require sophisticated management by health- and social-care providers (Hoffman et al. 1996, Paez et al. 2009, Rechel et al. 2009, Elbourne et al. 2013, Oostrom et al. 2014). For most older people these long-term conditions are well-controlled and require little more than regular monitoring meetings with primary-care nurses and doctors, but for some people their conditions require more intensive care in hospitals or ongoing care at home or in residential

or specialist nursing homes. Any older person, even after a short hospital stay for treatment of an acute condition, may lack the necessary financial/personal support needed to return home and have to remain longer in institutional care than needed. Older people require systems that can deal with their complex needs in an integrated way that promotes continuity and completeness of care (Wolff et al. 2002, Rechel et al. 2009, Steis et al. 2012, Fillmore Elbourne and le May 2015, Canadian Institute for Health Information 2016, Prentice et al. 2017).

Whilst older patients' needs and circumstances have changed significantly over the last few decades the systems developed to care for them have often not kept pace and require significant adjustment if they are to provide effective care. Older people with an acute, long-term, or palliative condition often require a multidisciplinary approach which can cut across the boundaries of health and social care (Elbourne et al. 2013, Fillmore Elbourne and le May 2015). But current demands frequently see those providing care struggling to deliver it because of staff shortages, bed shortages, seasonal pressures, and ineffective communications across departments or sectors, or simply because care is provided at a distance from supporting family and friends. However, not all change requires money or change to infrastructures. An example of this is the practical guide to care that resulted from the JRF's 5-year programme, A Better Life. The programme posed the question, "What needs to happen to make life better for older people who need a lot of support – now and in the future?" Many qualitative and quantitative research reports came from this programme and of specific note here is the practical guide for people working with older adults (Blood 2013). In this guide Blood and her colleagues set out seven challenges for care providers as well as numerous practical ideas as to how one could convert these into reality (Box 2.2). The seven challenges are central to the principles underpinning this book (see Chapter 1).

Box 2.2 The seven challenges set out in A Better Life (Blood, 2013, p. 13)

"We all need positive images and balanced narratives to challenge ageist assumptions. Old age is not about 'them', it is about all of us.

We all need to make the effort to see and hear the individual behind the label or diagnosis, taking into account the increasing diversity of older people as a demographic group.

We must ensure that all support is founded in, and reflects, meaningful and rewarding relationships. Connecting with others is a fundamental human need, whatever our age or support needs.

We need to use the many assets, strengths, and resources of older people with high support needs through recognising and creating opportunities for them to both give and receive support.

We must all be treated as citizens: equal stakeholders with both rights and responsibilities, not only as passive recipients of care. We must also have clarity on what we

can reasonably expect from publicly funded services and what we will need to take responsibility for ourselves.

The individual and collective voices of older people with high support needs should be heard and given power. We must use a much wider range of approaches to enable this.

We need to be open to radical and innovative approaches; but we also need to consider how, often simple, changes can improve lives within existing models".

All too often the emphasis remains on the physical aspects of illness and recovery and fails to consider the impact that psychological health can have on an older person's wellness and independence. There is considerable evidence which shows that for older adults, psychological wellness decreases their need for health care and increases their quality of life (Prohaska et al. 2006, Worsfold 2013). Psychological *and* physical care are essential components of skilled nursing care, and we will come back to talk about this in subsequent chapters.

Regardless of age, patients are best served when they receive age-specific support and care (Mezey et al. 2004, Dewar and Nolan 2013, Dewar and Kennedy 2016, Hirst and Lane 2016, Melillo 2017) which reflects appropriate age-related policies and care practices. These should always show respect for the older person's human rights and freedoms; empower and enable older people and their families to be assertive and actively involved in their care; and ensure that health and social support focuses on maintaining and maximising independence whilst sensitively assessing risk. All care, from the policies set in the boardroom to care provided at the bedside, must be non-discriminatory.

Whilst we can each imagine the impact of increasing frailty and/or multimorbidity it is better to understand what older people themselves experience and so we have laid out short stories and examples throughout this book to help with this. In addition to reading these, consider asking older people and their families themselves about their experiences. JRF asked a team of researchers (Katz et al, 2011) to ask older people with high support needs what they valued in their lives and devised a wheel-shaped model to help portray these findings—you might consider using the areas covered in it to guide conversations with older people and their families. The model has at its centre the older person, they are surrounded by two circles—an outer circle and an inner circle. The outer circle focuses on what the person values—these are categorised as social, physical, and psychological factors. The social factors comprise cultural activities, making a contribution, social interaction, good relationships with carers, and personal relationships; the physical factors are getting out and about, physical health, physical activities, good environment, safety, and security; and the psychological factors are associated with mental health, sense of self, self-determination, continuity and adjusting to change, and humour and pleasure. The inner circle details factors that help the person to achieve or prevents them from achieving what they want from life (transport, equipment, technology, finances, information, support, and other people's time).

Using this sort of model in daily care can enable nurses to understand the person they are caring for better, to help build connections between everyone involved in care, and to

tailor dignified care more appropriately to suit the older person and their family's needs. When you read the subsequent chapters of this book remember to think about Katz et al.'s model and compare your experiences in practice with these ideas. You will probably find that you need to expand the factors to suit the context of care that you are working in and each older person's individual wishes.

Several researchers have highlighted the importance of nurses building respectful relationships with older people and their carers/families to help to include them in decision-making, give them more control over their environments and care, and enable them to feel dignified and be heard (e.g. Bridges and Nugus 2010, Calnan et al. 2013, Andrews et al. 2015). Building such relationships is a cornerstone of good practice.

Think about this ...

Think back over your last year of work and build a picture of a person you've care for who has had high support needs and needed care either in hospital, a nursing or residential home or their own home. What were their needs and what did you and the other members of the multidisciplinary care team do to ensure that their care was person-centred and your relationships respectful? As you read through this book keep this person (and their family and carers) in your mind – how do they compare to the people in the stories used in later chapters?

Ageism

Many of you reading this chapter will have heard people talk about the "Silver Tsunami" metaphor. It is one of the most commonly used analogies associated with population ageing and is overtly ageist. The metaphor (with occasional variations e.g. "Gray/Grey Tsunami", the "Senior Tsunami", "Senior Wave") initially made its debut in the late 1980s (Barusch 2013), suggesting that population ageing could be as devastating to our world as a seismic sea wave is to a seaside community. Rather than water the "silver tsunami" has been described by some as bringing a 'wave' of dependent, chronically ill older adults that will flood health- and social-care systems, destroy our economies, and wash away the quality of life as we know it (Charise 2012). Such talk is obviously offensive and ageist.

Just like other "isms" (such as racism and sexism) the uses of the Silver Tsunami metaphor push forward an ageist agenda based on partial truths and designed to generate fear (Charise 2012). These partial truths include the fact that population ageing will result in the largest group of seniors our world has ever had and so could be used to justify the very large wave notion by some people: but that is where the comparison ends. Historic data indicates this demographic ratio has been in the making for the last four to five decades so ironically, the mere fact that the Silver Tsunami metaphor has been in circulation since the late 1980s shows that its arrival cannot be, as a tsunami, unexpected. The continued use of this metaphor and similar ones, such as military metaphors that focus on "fighting/ battling against old age', extends the fatalistic and negative perceptions of what it truly means to be an older person (Officer et al. 2016).

Box 2.3 An example of ageist talk

Such was the case when, a highly respected, trailblazing gerontology nurse in a position of authority joined in on an informal discussion I was having with a nursing student. The area in which we sat was an open concept nursing station, in the centre of a busy medical/surgical unit. At the time of the discussion, the unit's beds were predominantly filled by older people. The hallway adjacent to the nursing station was a flurry of family members, patients, and hospital staff. Busy professionals and students filled the seats close to us. The nursing student and I were discussing population ageing and the potential challenges that lay ahead for acute-care settings. Using a tone and volume that made the following comment easily heard, the gerontology nurse said, "All we hear about is how the grey tsunami is coming. The tsunami is not developing – it is here, and we are swimming in it as we speak!".

It is important that nurses fight ageism and set a positive example to others (Butler 1969, Haight et al. 1994, Herdman 2002, Ferrario et al. 2007, Martin et al. 2009). This starts with holding non-ageist attitudes and beliefs and ensuring that these are translated into everyday actions and conversations. Many people believe that they do not use ageist language, and only, when probed further with examples of ageist jargon, do they become aware of the extent of their habitual use of ageist language (see Box 2.3 for an example from HFE's personal experience).

Think about this ...

If this happened to you, what would your response be? Would your answers differ if you were:

- One of the patients on this unit?
- A family member of a person who is 79 years old and critically ill next to the nursing station?
- The senior medical doctor at the station beside the nurse?
- An administrator who just happened to walk in and hear this comment?

Take another minute to think some more:

Did the way you responded change depending on which person you were thinking of? If so, why? If not, why not?

A movement is now underway calling for the elimination of the 'Silver Tsunami' metaphor (and its variations). Critics of this metaphor are urging professionals to remove it in favour of 'neutral' language to describe population ageing (Martin et al. 2009, Charise 2012). Arguing that the unconscious use of ageist expressions, mainly by those genuinely interested in the quality of care and life for older adults (such as providers, professionals, policymakers, and practitioners), is one more telling sign of how far-reaching and ingrained ageism is (Butler 1969, 2002, Herdman 2002, de la Rue 2003, Gould et al. 2012).