GAPNA Section

Reminiscence: Improving the quality of life for older adults

Cynthia Stinson, PhD, APRN, CNS, RN-BC, Elizabeth M. Long, DNP, APRN, GNP-BC

Recently a Clinical Nurse Specialist (CNS) on a busy oncology unit was encouraging a 90 year-old gentleman to drink his prescribed supplement when he started talking about the days he had spent on a ship during World War II as a navy officer. He talked about the fact that he had been young and that he had visited many places. During this time he had met his wife of over 60 years who was now dead. While he drank his supplement, his face sparkled with excitement as he talked about how they met, how they danced, and how she laughed at his jokes. The nurse left him to care for other patients but noticed that he had drank all his supplement in a much shorter time and now he was sleeping peacefully with a look of contentment on his face. Reminiscence, once thought to be detrimental to older adults, is now an evidence-based therapeutic intervention for older adults.

Structured reminiscence is a planned process of interaction between individuals in which past events are recalled and individuals talk about their life. Reminiscing is an independent nursing intervention used in a variety of settings including long-term care, assisted living, and independent living.1 Administered in both group and individual settings, reminiscence recall is intended to prompt forgotten memories, increase emotional awareness, and cultivate social interaction in older adults.2

In 2006 and 2007, the protocol was implemented in research studies to determine whether there was a decrease in depression after structured reminiscence sessions. The sessions were implemented twice weekly for 6 weeks with women older than 60 years in assisted living facilities with a positive decrease in depression and increase in self-transcendence with use of objective screening tools, The Geriatric Depression Scale and the Self-transcendence Scale. In 2010 Stinson’s Protocol for Structured Reminiscence was implemented with over 5000 senior adults (males and females) by Ulla Peterson (Linnaeus University, Department of Health and Caring Sciences, Kalmar, Sweden) at the Karolinska Institutet in Stockholm, Sweden showing a significant decrease in depression.

If the protocol is used, there should be an evaluation phase. The facilitator should document benefits obtained from the reminiscence sessions. Objective screening should be conducted before and after the conclusion of reminiscence sessions to evaluate the benefits of intervention. Participants in the reminiscence sessions should be given an opportunity to reflect on sessions and offer input about refinement of the protocol. Only through evaluation can nurses document and refine protocols to improve the quality of life for older adults.3–7

The advanced practice nurse is in an excellent position to inform and educate other health care workers about the benefits of Reminiscence. In long-term care facilities or assisted living facilities, activity directors, social workers, nurses, and certified nursing assistants can incorporate Reminiscence into their daily activities or do as a structured group activity. Hospice nurses and workers can also be trained to utilize these skills in the care of their patients. Use of the protocol and reporting of the results can help to promote this researched activity that can improve the quality of life for older adults.
Table 1

Stinson’s protocol for structured reminiscence.

<table>
<thead>
<tr>
<th>Week</th>
<th>Sessions</th>
<th>Themes/Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Session 1</td>
<td><strong>Introduction of leaders and members</strong>&lt;br&gt;Concentrate on personal background. Encourage members to bring a picture of an animal or stuffed animal that represents them. Have them introduce themselves and tell why the animal reminds them of themselves. Have extra stuffed animals available.</td>
</tr>
<tr>
<td></td>
<td>Session 2</td>
<td><strong>Remembering the past through songs from the 1920’s to 1960’s</strong>&lt;br&gt;Play different songs in chronological order. See if members recognize songs and discuss any special memories associated with songs. Have members talk about a song that might have special meaning to them and why it has special meaning to them. Encourage clapping and singing.</td>
</tr>
<tr>
<td>Week 2</td>
<td>Session 3</td>
<td><strong>Sharing photographs</strong>&lt;br&gt;Have a show-and-tell of personal memorabilia. Give time to explain attachment associated with pictures. Discuss families. Discuss friends. Talk about fun times.</td>
</tr>
<tr>
<td></td>
<td>Session 4</td>
<td><strong>Discussing work/home life or volunteer activities/first job</strong>&lt;br&gt;Pass around picture cards with specific occupations/children/volunteer activities from 1920’s to 1960’s. Specifically ask questions to get people to talk about “paths not taken.” Encourage participants to bring any memorabilia from career or occupation (badges, pictures, etc.).</td>
</tr>
<tr>
<td>Week 3</td>
<td>Session 5</td>
<td><strong>Remembering favorite holiday</strong>&lt;br&gt;Discuss holidays. Bring scents and cues associated with past. Sing songs of holidays. Talk about foods of holidays. Talk about clothes of holidays. Talk about traditions of holidays.</td>
</tr>
<tr>
<td></td>
<td>Session 6</td>
<td><strong>Remembering school days/first day</strong>&lt;br&gt;Discuss first day of school. Have participants talk about school days. Show pictures of schools 1920s–1960s. Discuss what was worn and teachers.</td>
</tr>
<tr>
<td>Week 4</td>
<td>Session 7</td>
<td><strong>Remembering first toy/toys of childhood</strong>&lt;br&gt;Bring toys from the past. Discuss first toys. Discuss most unusual toys. Discuss favorite toys. Discuss toys made at home. Show pictures of toys.</td>
</tr>
<tr>
<td></td>
<td>Session 8</td>
<td><strong>Remembering first date/spouse/weddings/marriage</strong>&lt;br&gt;Discuss first dates. Discuss proposals. Discuss weddings. Discuss marriages. Play songs from the past. Show short clip of old movie with “courting.” Bring wedding pictures.</td>
</tr>
<tr>
<td>Week 5</td>
<td>Session 9</td>
<td><strong>Remembering family/pets</strong>&lt;br&gt;Discuss children, pets, and family. Encourage pictures to remind of memories.</td>
</tr>
<tr>
<td></td>
<td>Session 10</td>
<td><strong>Remembering foods</strong>&lt;br&gt;Discuss favorite foods of childhood, favorite foods at holidays, and favorite smells. Discuss recipes. Have participants bring recipes and discuss memories associated with recipes.</td>
</tr>
<tr>
<td>Week 6</td>
<td>Session 11</td>
<td><strong>Remembering first friend/old friends</strong>&lt;br&gt;Talk about friends. Bring pictures. Explain who the friends are in pictures. Discuss fun times. Discuss fun memories. Discuss friends in assisted living facility.</td>
</tr>
<tr>
<td></td>
<td>Session 12</td>
<td><strong>Closure</strong>&lt;br&gt;Have participants talk about experiences of being in group. Share any last thoughts about topics discussed previously. Serve refreshments. Give certificates.</td>
</tr>
</tbody>
</table>

References


Case study II: Moving beyond the Beers list to translating the evidence into practice

Teresa Kireuk, DNP, ANP/GNP
Assistant Professor and Program Director, Adult Gerontology Primary Care, Nurse Practitioner Program

George Byron Peraza-Smith, DNP, GNP-BC, CNE
Associate Professor and Program Director, Post-Masters DNP

Advancing age is a critical risk factor toward developing multiple chronic illnesses and conditions. Over 50 percent of older adults have three or more chronic disease.\(^1\) Studies on the treatment of multi-morbid diseases in older adults are limited and there is a dearth of evidence on the interactions of diseases and treatments with older adults.\(^2\) Clinical practice guidelines primarily address one disease condition and do not generally provide evidence for managing disease interaction with other diseases and treatments. Case studies are invaluable tools for generating a dialog from real world examples of the many challenges in working with older adults. This case study will examine our experience with managing disease interaction with other diseases and treatments. Case studies are invaluable tools for generating a dialog from real world examples of the many challenges in working with older adults.2 Clinical practice guidelines primarily address one disease condition and do not generally provide evidence for managing disease interaction with other diseases and treatments. Case studies are invaluable tools for generating a dialog from real world examples of the many challenges in working with older adults. This case study will examine our experience with managing one established older adult patient with our clinic. The case will also examine the application of the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.\(^3\)

Case presentation

Maribeth is a 72 year-old female

CC: 6 month routine follow up for multiple medical problems

HPI: No new problems per patient report, generally feeling well

CHF: reports sleeping on 1 pillow, dyspnea with exertion of walking 1 block – at baseline
No chest pain or palpitations, slightly puffy ankle edema for which she wears her tan compression stockings daily, no PND, cough, wheezing or increased fatigue
Depression with anxiety: reports mood has been good, she has no concerns regarding her mood. Denies feeling down, weeping, or suicidal ideation

Medications
- Cardiazem CD 240 mg daily
- Simvastatin 40 mg daily
- Fluoxetine 30 mg daily
- Cyanocobalamin 1000 mcg daily
- Acetaminophen 1000 mg 4 times daily prn
- Oxycodone 5 mg four times daily prn
- Ibuprofen 400 mg four times daily prn
- initiated on own

ROS: nagging low back pain, rates 3–4/10 most days, worse with activity and relieved some by rest, occasional Tylenol brings pain level down to a 1– taking almost daily now, also taking Vicodin on occasion- this medication was left over from knee surgery several years ago though she is almost out of pills nocturia x 1–3, no dysuria, incontinence or urgency.

Independent in self care ADLs, no falls, no imbalance, no changes in gait, denies memory impairment, Remainder of full ROS is negative.

Physical exam
- General: well dressed/groomed, appears stated age
- Vital Signs: BP 138/76, P 70, R 18, T 97.5, O2 Sat 98% on room air, Wt 132 lbs
- HEENT, Skin, Neck, Abdomen, GU, & Neurologic systems WNL
- Respiratory: lungs clear though diminished in bases
- Cardiovascular: PMI laterally displaced, 2/6 systolic murmur, no gallops
- Musculoskeletal: moderate kyphoscoliosis, no pain with palpation of lumbar spine, moderate tenderness at right SI joint with muscle spasm noted
- Extremities: puffy non-pitting edema to feet/ankles bilateral, feet warm, no redness or cyanosis, + pedal pulses
- Psychiatric: PHQ-9 of 1

Labs and diagnostics
- BMP, Fasting Lipids, and Liver Function Tests WNL — except
- Calcium 11.0 (8.4–10.2)
- Alkaline phosphatase 146 (39–117)
- X-ray: Lumbosacral spine: osteopenia, old vertebral fractures at L4, and 5
- CBC WNL except WBC 11.0 (4.6–10.2)
- B12: 743 (200–500)

Assessment:
1. **HTN**-elevated BP increases risk for CVA, CAD > with elevated SBP than DBP- goal <150 SBP, <90 DBP\(^4\) — Maribeth is at goal for SBP
   a. Principles of HTN management in elderly:
      i. Elderly have slowed baroreceptor, slowed sympathetic neural responses, impairment in blood pressure cerebral autoregulation.
      1. Blood pressure lowering should occur gradual over weeks to months instead of the approach of hours to days seen in younger adults.\(^5\) Dose requirements start at 1/2 the dose used for younger adult patients.
      ii. **Orthostatic hypotension** — seen in 20% of elderly raising risk for falls and is associated with increased incidence of hip fracture.\(^5\)
      ii. **Pharmacologic therapy choice**: based on ACCOMPLISH Trial (combination therapy),\(^6\) ALLHAT Trial (monotherapy)\(^7\) & JNC8.\(^8\)
         1. It is the amount of BP lowering not the choice of drug that impacts CV risk when monotherapy is used. Combination therapy found that ace inhibitor and long-acting calcium, channel blockers were more effective than ace inhibitor and thiazide diuretic
         2. Beta blockers are no longer considered primary monotherapy due to decreased efficacy for stroke prevention
b. Maribeth is on long-acting CCB which meets JNC8 guidelines. Her BP goal is stable, given her h/o CHF, as well as presentation of lower extremity edema consider changing to ACEI or ARB

2. CHF-NYHA classes of heart failure

Maribeth fits NYHA class II- symptoms with ordinary exertion, stage C structural heart disease with current or prior symptoms, current medications (CCB) put Maribeth at risk for CHF worsening due to decreased peripheral vascular resistance and subsequent fluid retention.

3. Hyperlipidemia — Age changes have an impact on lipoprotein metabolism. Lipid levels plateau around age 70 then begin to fall (subtle changes). Women remain with cholesterol levels that are higher than men in older age groups. Elevated lipid levels correlate with increased cardiac death risk. Multiple studies show that reduction of elevated lipid level reduces the risk of cardiac death.9

Pharmacologic therapy: decision based on cardiovascular risk. Requires risk calculator as well as individualized decision based on chronologic and physiologic age. Relative risk versus attributed risk: relative risk is similar to younger age group absolute benefit is greater for elderly. Benefits of lipid reduction are equal or greater than that of younger adults. Reduction takes 6–10 weeks and benefit can usually be seen in the patient’s life expectancy. CHD is the most common cause of death in older patient.

Maribeth 10-years risk of general cardiovascular disease. Using normal cholesterol and HDL numbers along with age, systolic blood pressure, non-smoker, negative for diabetes is 15.35%.10

Based in this risk level, ongoing therapy would be beneficial.9 Pharmacologic Options: Non-statin therapies, Statins: Beers Based in this risk level, ongoing therapy would be beneficial.9

Pharmacologic Options: Non-statin therapies, Statins: Beers Based in this risk level, ongoing therapy would be beneficial.9

Back pain — no known trauma, multiple self medication strategies including opioid use that was not prescribed, and ibuprofen use. Both opioids and NSAIDs medications are on the Beers list for potentially inappropriate medications in the elderly. Opioids contribute to confusion, constipation, sedation and increased risk of falls. NSAIDs contribute to renal impairment and gastrointestinal bleeding disorders. Both medications should be limited when used in the elderly.14


7. Depression: The Patient Health Questionnaire (PHQ-9) — 9 of 1 and is unchanged from PHQ-9 done 1 year ago, recommendations is for trial reduction in medications.

Plan
• HTN: monitor with change of medications
• CHF: obtain cardiac Trans Thoracic Echo
• Discontinue cardiazem, initiate lisinopril 5 mg bid which will treat HTN and CHF, consider low dose diuretic
• CAD, Hyperlipidemia: decrease simvastatin, recheck lipids and liver function tests in 3 months
• Osteoporosis: Obtain DXA for baseline, Obtain Vit D level
• Initiate Vit D supplementation — dose dependent on level
• Initiate Calcium — dose dependent on dietary intake — RDA of 1200 mg/day
• Back Pain: discontinue ibuprofen, continue Tylenol 650 mg tid, prn oxycodone limit the number used, start physical therapy
• B12 deficiency: continue current B12 therapy
• Depression: decrease fluoxetine to 20 mg daily and monitor mood with a 1 month follow up appointment or phone check in

References

<table>
<thead>
<tr>
<th>Functional capacity</th>
<th>Objective assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I:</td>
<td></td>
</tr>
<tr>
<td>• Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or angina pain.</td>
<td>A. No objective evidence of cardiovascular disease</td>
</tr>
<tr>
<td>Class II:</td>
<td></td>
</tr>
<tr>
<td>• Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or angina pain.</td>
<td>B. Objective evidence of minimal cardiovascular disease</td>
</tr>
<tr>
<td>Class III:</td>
<td></td>
</tr>
<tr>
<td>• Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or angina pain.</td>
<td>C. Objective evidence of moderately severe cardiovascular disease</td>
</tr>
<tr>
<td>Class IV:</td>
<td></td>
</tr>
<tr>
<td>• Patient with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.</td>
<td>D. Objective evidence of severe cardiovascular disease</td>
</tr>
</tbody>
</table>

Classification of Functional Capacity and Objective Assessment. NYHA Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels.8
Baclofen induced delirium in an older adult an unusual cause of delirium

Nina M. Flanagan, PhD, GNP-BC, PMHCNS-BC
Assistant Professor of Nursing, Binghamton University, USA

Delirium represents a common, serious and potentially life-threatening problem for older adults. The American Psychiatric Association defines delirium as 1) disturbance of consciousness with reduced ability to focus, sustain or shift attention, 2) changes in cognition or development of a perceptual disturbance that is not better accounted for by a pre-existing, established or evolving dementia, 3) disturbance that develops over a short period of time and tends to fluctuate during the course of a day, and 4) evidence that the disturbance is directly caused by the effects of a medical condition. Delirium is characterized as an acute decline of attention and cognition and can be a severe complication for older adults with occurrence rates from 14% to 56%, hospital mortality rates from 25% to 33% and poor long term outcomes. Delirium is a multi-factorial syndrome, like many other geriatric syndromes such as falls or incontinence. Delirium may be caused by a single drug or underlying illness including infection.

The following case study will illustrate an acute delirium episode of an elderly woman admitted to post acute care following a laparoscopic cholecystectomy.

Case presentation

R.P. is a sixty five year-old woman admitted to our skilled nursing center for post acute rehabilitation following a laparoscopic cholecystectomy. Past Medical History included: hypertension, diabetes mellitus, peripheral neuropathy, osteoarthritis, and obesity. Current medications: Metformin 500 mg po BID, Neurontin 300 mg po bid, Simvastatin 20 mg po daily, Norvasc 10 mg po daily, Lisinopril 5 mg po daily, Tylel 650 mg po tid and q 12 h prn pain. She arrived at the center on her third post operative day after an uneventful hospital stay. Upon admission, she was pleasant and cooperative. Vital signs: 98.8 Heart rate 76 Respirations 18 BP 138/78. Blood sugars were well-controlled (120–140 range). The laparoscopy sites were clean and dry. Abdomen was soft and non-tender, positive bowel sounds, minimal tenderness. No lower extremity edema. She had full range of motion of all four extremities. Brief Mental Status exam revealed her to be cognitively intact. Incision pain was minimal and well controlled with the Tylel.

She participated in therapy the first two days without any difficulty. On her third day at the center, she complained of right shoulder discomfort. The licensed nurse examined the right shoulder and found limited range of motion and some “tightness.”

The resident at the time was oriented, able to recall events prior to hospital admission and did eventually calm down and went to sleep. The physician was called and ordered a medical work-up which consisted of a complete metabolic pro file, complete blood count, chest X-ray, thyroid function tests, urine culture and chest X-ray for the morning. The next day, R.P. was agitated, refusing her medications and any care. The same day, her physician came to the center to evaluate her. The medication list was reviewed with the physician and her home medication list reconciled. She was not on baclofen at home. At this time, she had low grade fever of 99.6, BP and HR were stable. Her CBC was normal. Liver function tests were mildly elevated but lower when compared to previous hospital lab work. Chest X-ray was normal. Urinalysis showed occasional bacteria, negative nitrates, 3–5 WBC otherwise unremarkable. The physician felt this may be a urinary tract infection and started Levauquin 500 mg po daily until the culture and sensitivity was completed. No other medications were changed. For the next 2 days, R.P. continued to be very paranoid, refusing to come out of her room and telling her family that “she was not talking about anything.”

She did continue to take her medications. She refused any therapy. The physician was updated daily on her status. She remained afebrile for 24 h. The urine culture was negative for infection, so levauquin was discontinued. Interestingly, she never complained...
about the arm pain again. She remained cooperative with her care but the delusion of the hands remained fixed.

It was now four days since the baclofen was started. On the fourth day, the clinical team convened and reviewed the case with the physician including medications. The baclofen was discontinued. Within 24 h, R.P. was back to her baseline mental status, had recalled that “she was not thinking straight,” but had no further paranoia or hallucinations. Baclofen was added to her allergy list. She continued to do well and was discharged to home after a twelve day stay.

*Baclofen and delirium*

Baclofen is a y-aminobutyric acid (GABA) receptor agonist frequently used for management of spasticity in persons with spinal cord injuries or multiple sclerosis. There have been studies of baclofen withdrawal inducing delirium,\(^4\) however no documentation of baclofen inducing delirium was found in the literature.

*Discussion*

This was the first experience for the clinical team with baclofen and delirium. This resident has a positive outcome. The clinical team examined this case and discussed the interventions which worked and examined what the team may have done better.

The clinical team and physician responding quickly to initiate the medical work-up to rule out an infection or other medical cause for the delirium. There was consistent staff assigned to the resident to maintain continuity. A care plan outlining specific behavioral interventions to calm R.P. and maintains her safety was immediately instituted. The behavioral interventions were successful and no other medications to control the agitation were added. Daily communication and education about delirium were provided to the residents’ responsible party and they understood how to approach her and interact with her during the times when she was paranoid.

The clinical team and the nursing staff discussed how at the onset of the residents’ complaint of arm pain, interventions could have been handled differently. The nurse did offer the modality of heat and the resident refused and was insistent on the physician being called. The nurse may have suggested to the physician to use a topical treatment or other modality to decrease the pain and eliminated the use of another medication. The nurse also could have alerted the physical therapist to the residents’ concern and devised a plan to treat prior to calling the physician.

The team used this case as a learning tool for direct care staff for both identifying and managing delirium as well as the use of modalities for treatment of musculoskeletal disorders in collaboration with the rehabilitation team.

*References*