UNDERSTANDING COGNITIVE IMPAIRMENT AND THE RISK FOR ELDER ABUSE

GREG JICHA, MD, PHD

PROFESSOR OF NEUROLOGY & VICE CHAIR FOR ACADEMIC AFFAIRS

MEDICAL DIRECTOR KY TELECARE

UNIVERSITY OF KENTUCKY COLLEGE OF MEDICINE

DISCLOSURES

- NONE RELATED TO THE CONTENT OF THIS PRESENTATION
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OBJECTIVES

- DESCRIBE RISKS FOR ELDER ABUSE AND THEIR RELATIONSHIP TO COGNITIVE DECLINE AND DEMENTIA
- UNDERSTAND HOW DIFFERENT TYPES OF DEMENTIA, COGNITIVE IMPAIRMENT AND BEHAVIORAL AND PSYCHIATRIC SYMPTOMS CAN AFFECT RISK FOR ELDER ABUSE
- DESCRIBE THE ROLE OF THE MEDICAL PROFESSIONAL IN PROTECTING OUR SENIORS FROM RISKS OF ABUSE

FACTS & FIGURES

NATIONAL CENTER FOR ELDER ABUSE

ELDER ABUSE IN PERSPECTIVE

Population (millions)

■ < 65 years
■ ≥ 65 years unabused
■ victims of elder abuse

Kaplan & Pillemer 2015

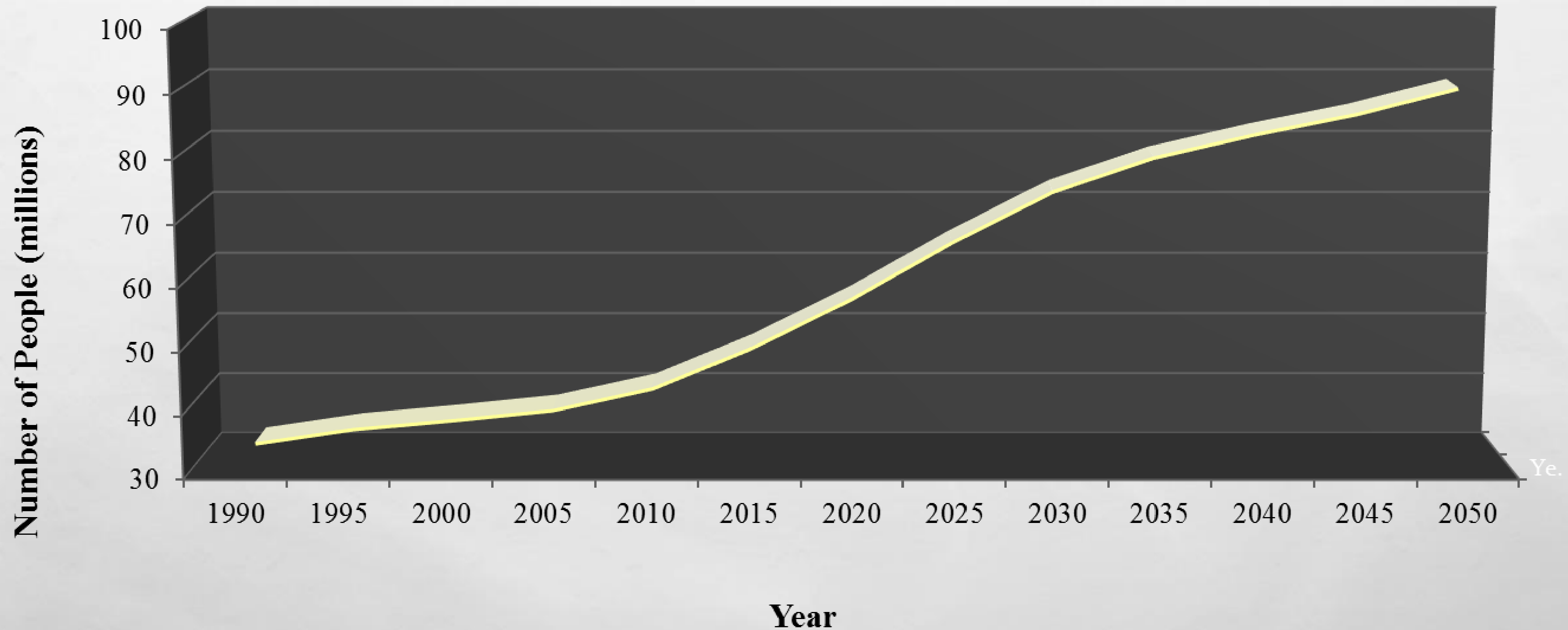
12.9% of the US population is over 65 years of age

10% of the US population over 65 years have been victims of abuse

=4.3 Million!

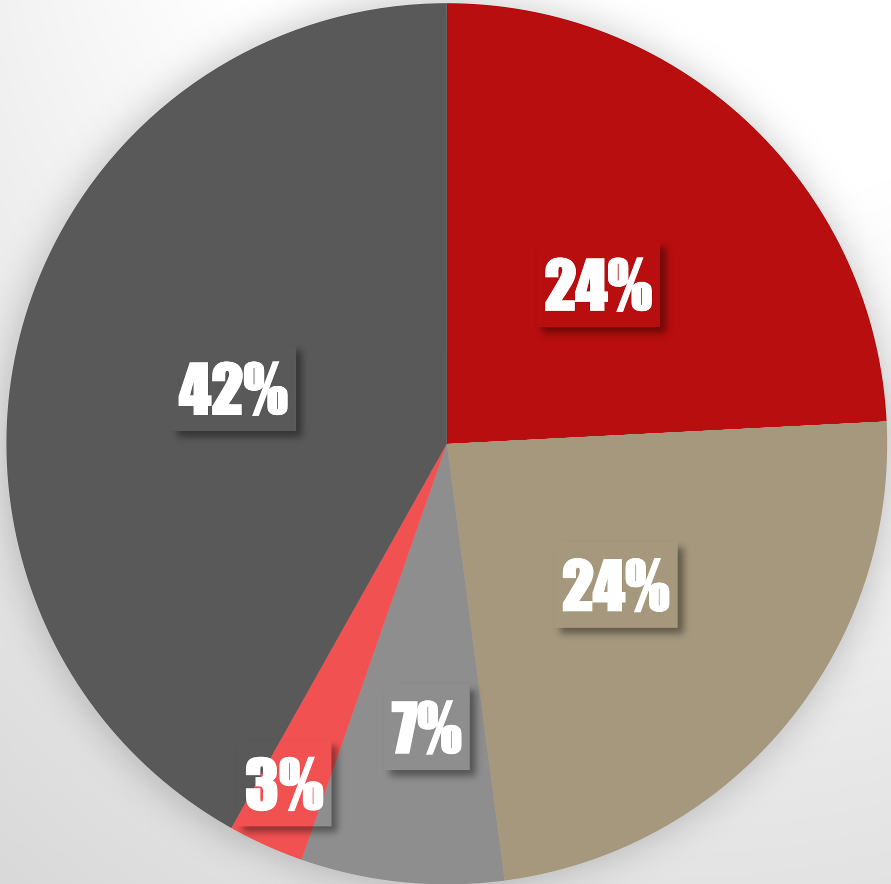
http://www.aoa.gov/Aging_Statistics/ ; https://www.alz.org/downloads/facts_figures_2012.pdf

THE SIZE OF THE PROBLEM IS GOING TO NEARLY DOUBLE IN THE NEXT DECADES



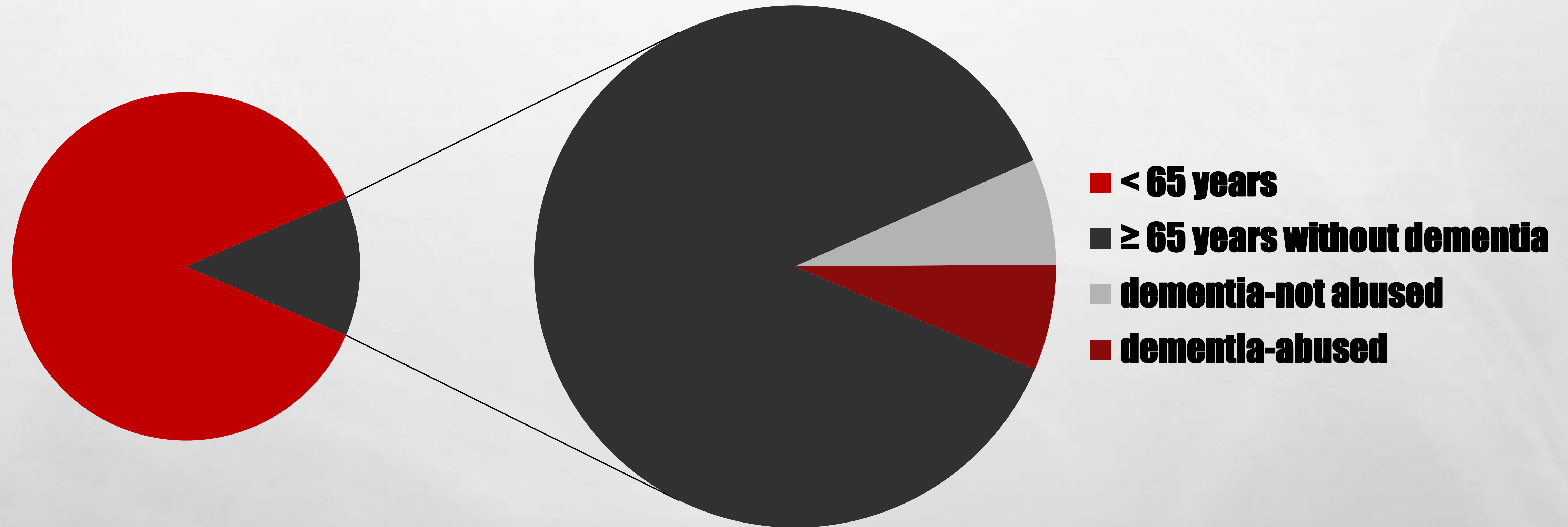
http://www.ncea.aoa.gov/Library/Data/index.aspx

RELATIVE % OF EACH TYPE OF ABUSE



Roberto 2016, American Psychologist 71 (4):302-311

SIZE OF THE DEMENTIA PROBLEM AND ELDER ABUSE IN THOSE OVER 65 YEARS OF AGE



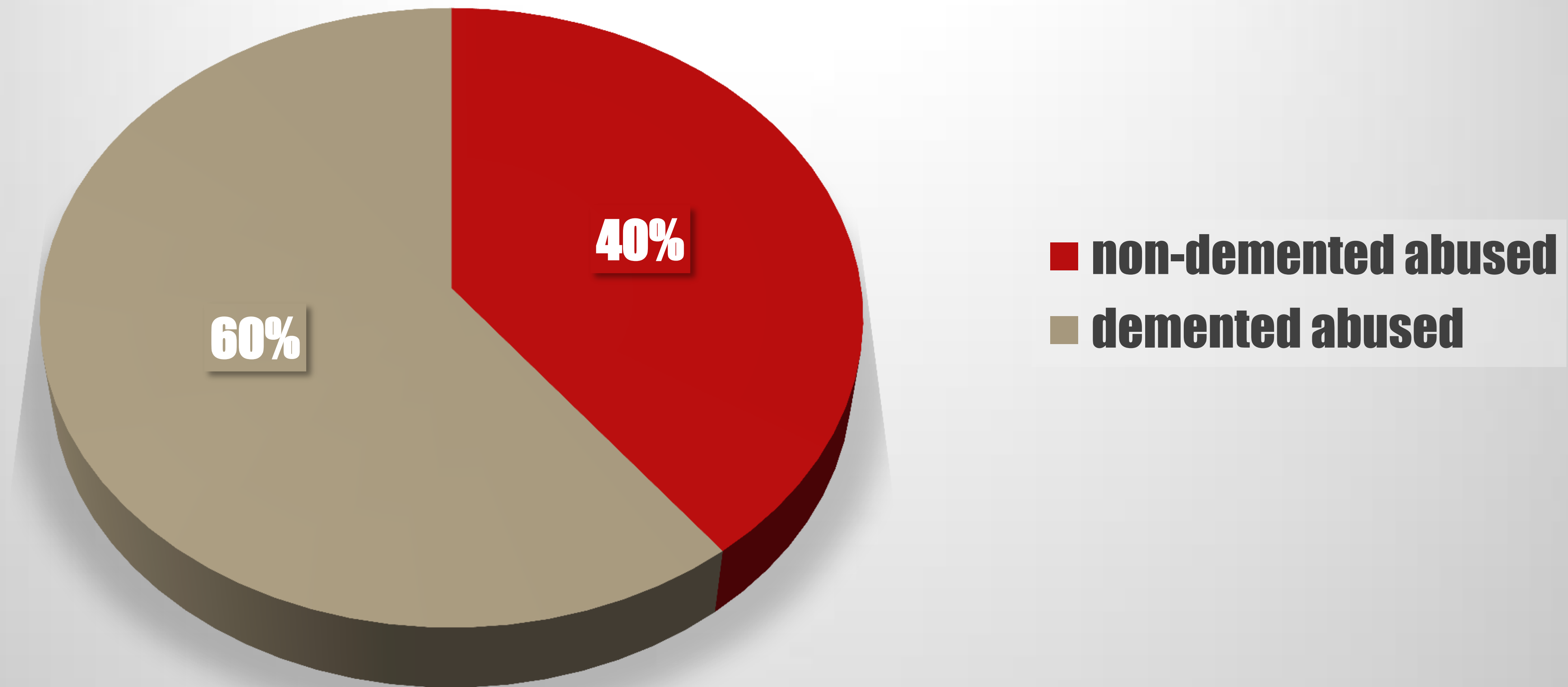
12.9% of the US population is over 65 years of age

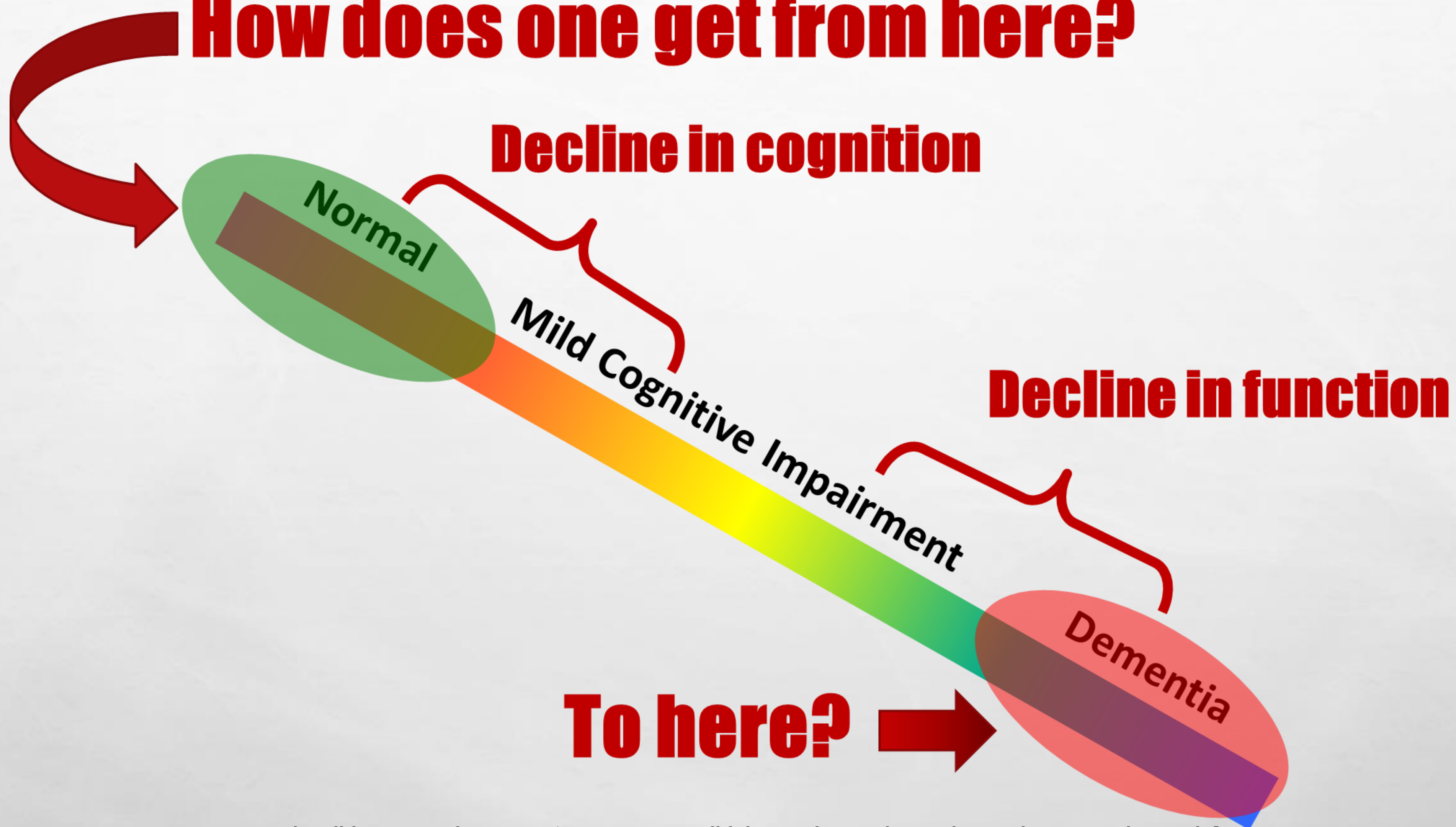
13.1% of the US population over 65 years is demented

=5.2 Million!

http://www.aoa.gov/Aging_Statistics/ ; https://www.alz.org/downloads/facts_figures_2012.pdf

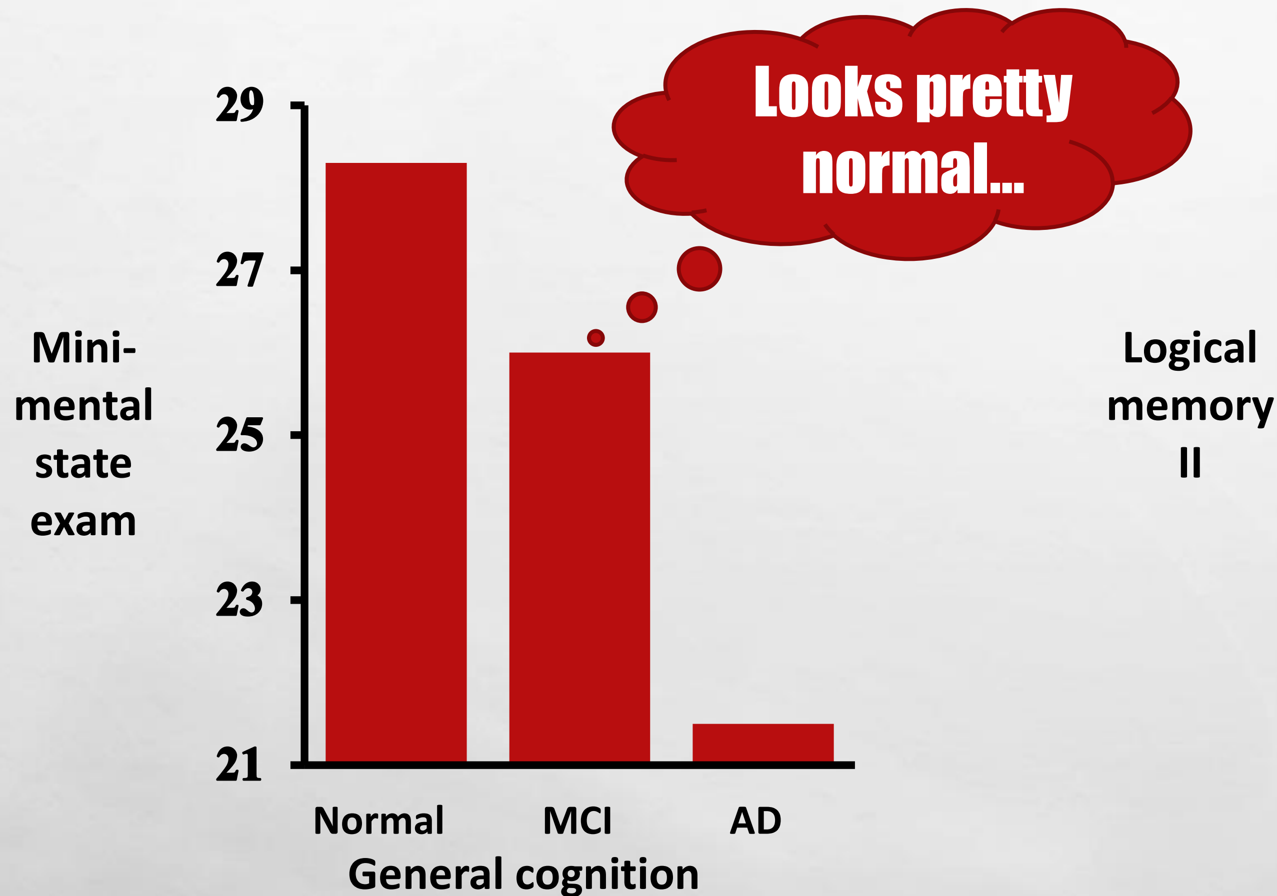
2 OUT OF 3 CASES OF ELDER ABUSE INVOLVE A PERSON WITH DEMENTIA

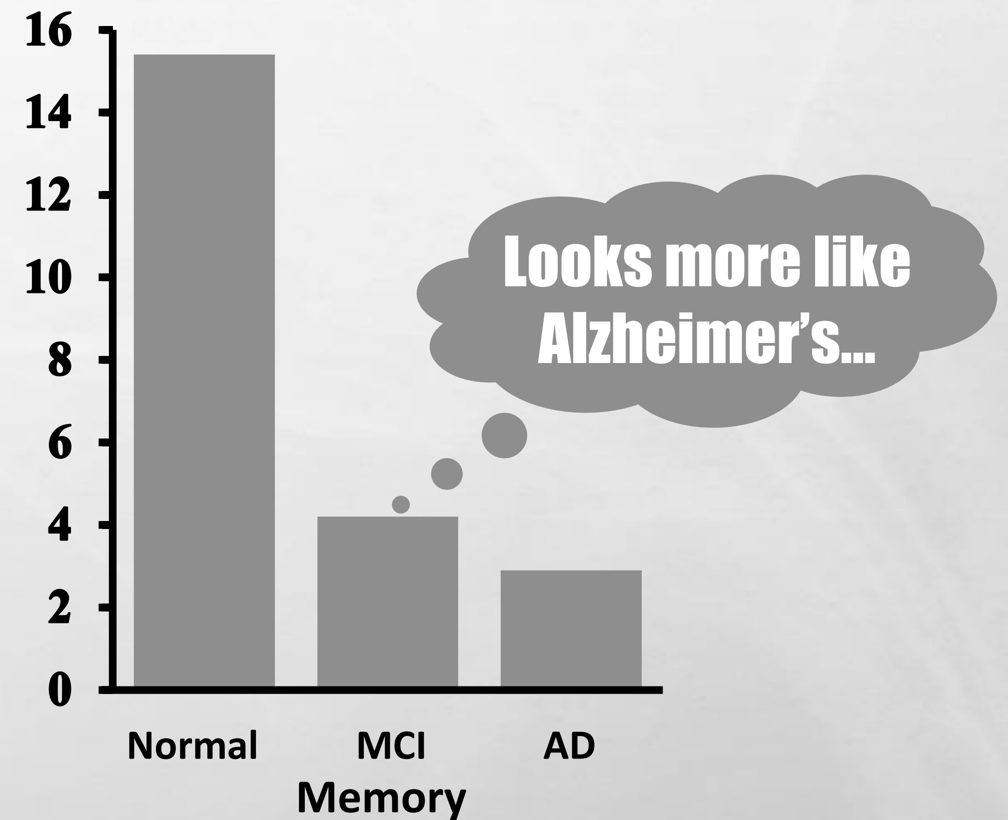




Normal→mild MCI→moderate MCI→severe MCI→mild dementia→moderate dementia→severe dementia?

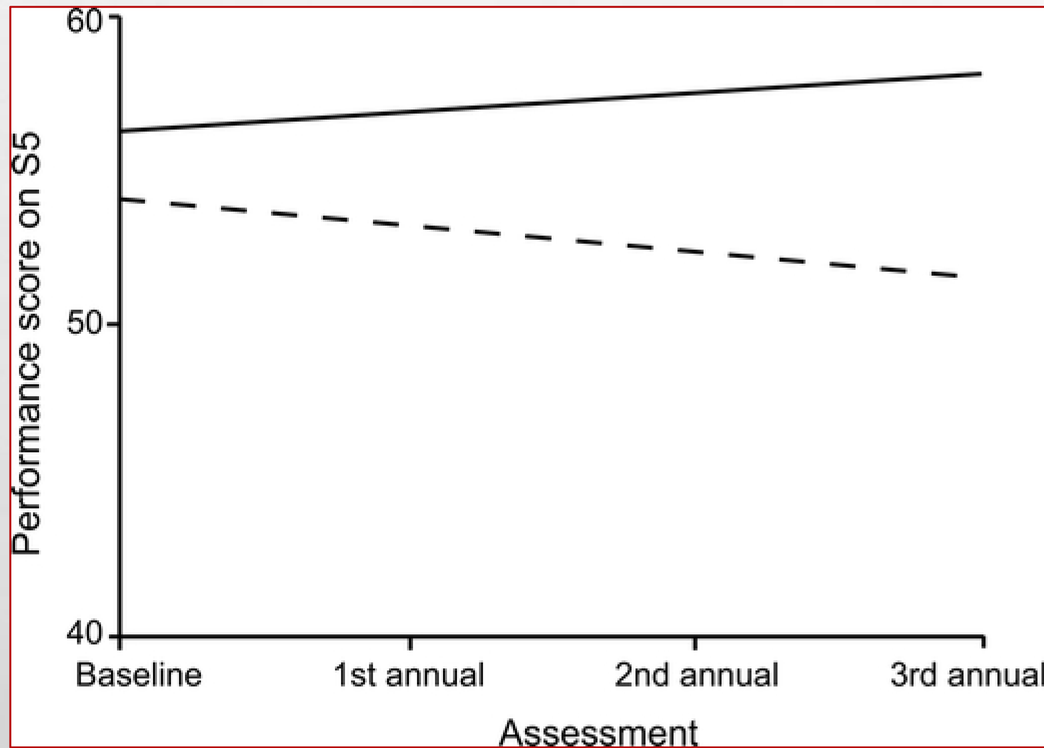
CLINICAL PROFILE OF MCI AND AD





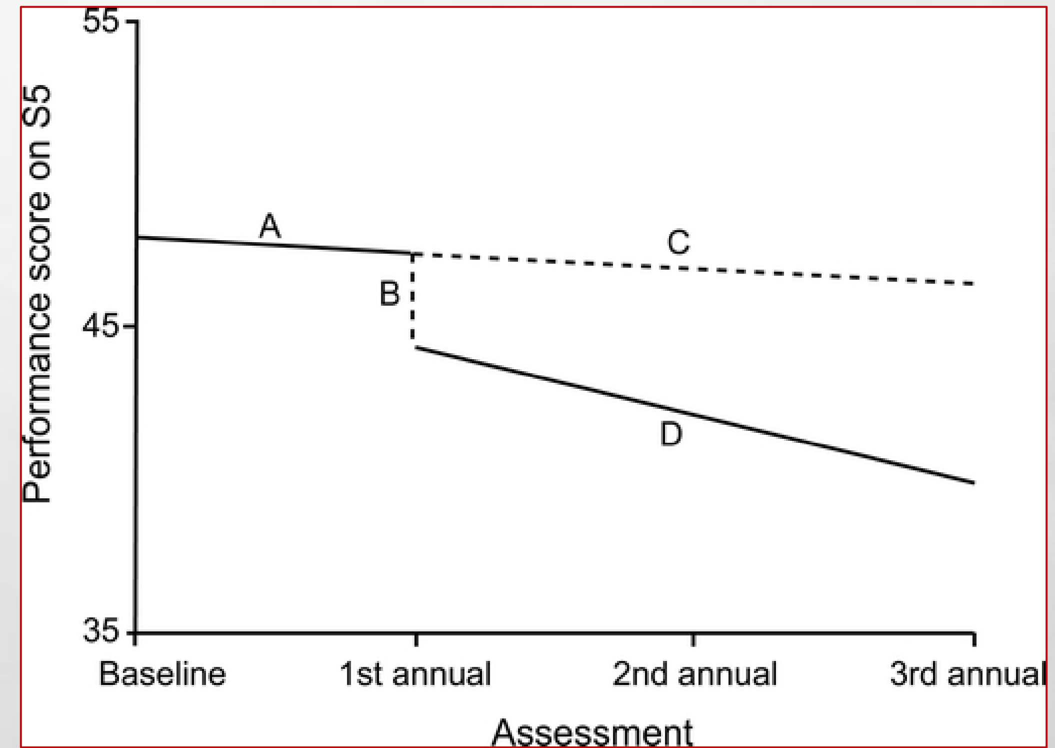
Petersen RC et al: Arch Neurol 56:303-308, 1999

MEDICAL DECISION MAKING CAPACITY DECLINES EARLY IN MCI, FASTER IN DEMENTIA



Normals (solid line) vs. MCI (dashed line)

Okunkwo et al., Neurology. 2008 Nov 4;71(19):1474-80



A) MCI; B) transition to dementia; C) continued MCI; D) faster decline in state of dementia

FINANCIAL DECISION MAKING CAPACITY DECLINES EARLY IN MCI: ABUSE OPPORTUNITY?

A

FCI total score (Domains 1-7)

230
220
210
200
190
180
170

Baseline
Year 1

B

FCI Domain 4 (Checkbook Management)

50
48
46
44
42
40

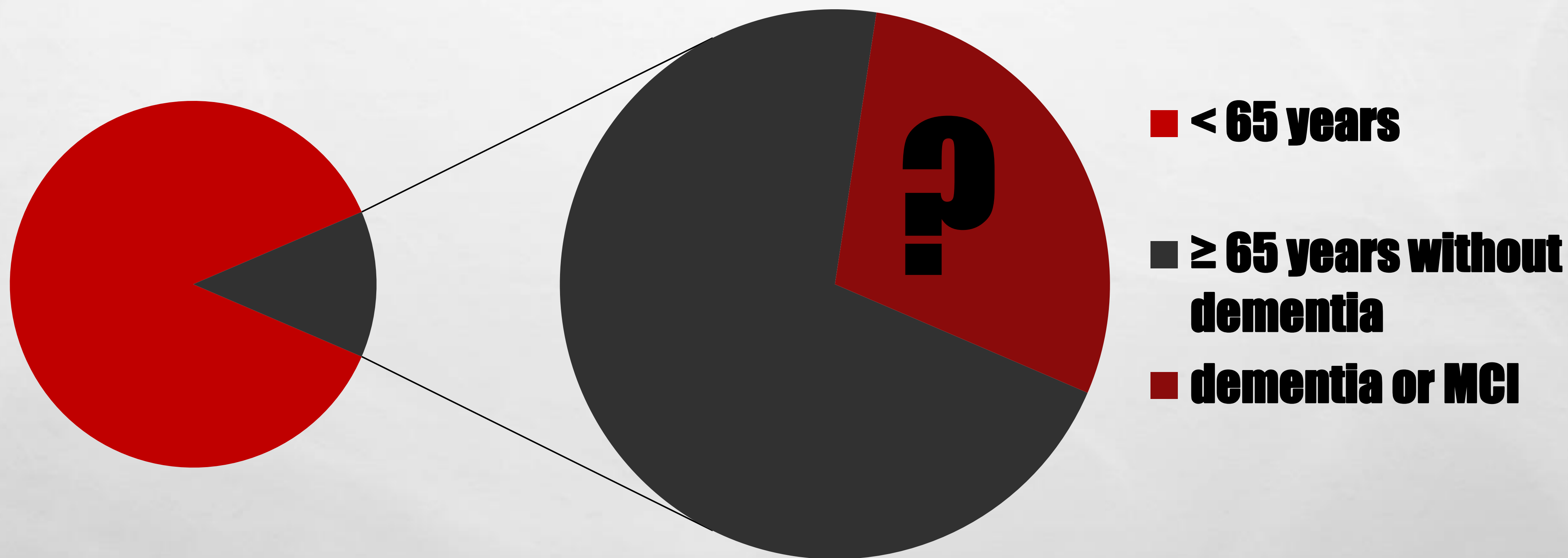
Baseline
Year 1

Controls
MCI nonconverters
MCI converters

Triebel et al., Neurology. 2009 Sep 22;73(12):928-34

IT'S UNCLEAR HOW LARGE THE PROBLEM IS IF WE WERE TO CONSIDER THOSE WITH MCI (MILD MEMORY PROBLEMS)

Population (millions)

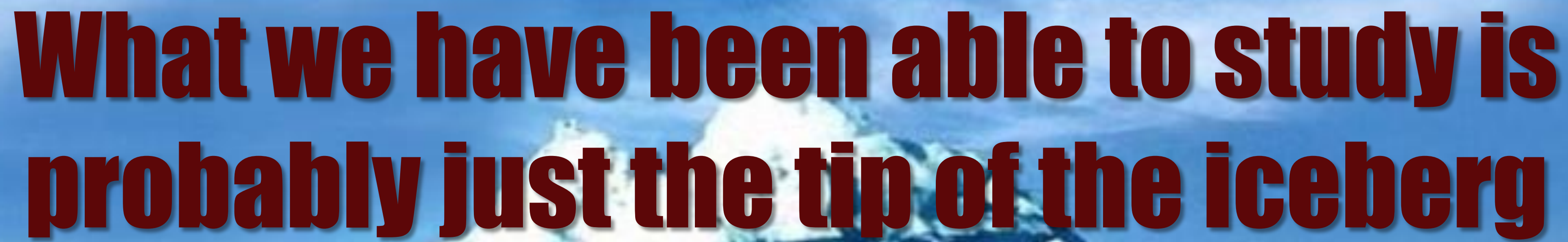


12.9% of the US population is over 65 years of age

29% of the US population ≥65 years has MCI or dementia

=11.5 Million!

Petersen et al, Neurology. 2010 Sep 7;75(10):889-97



For every 1 case reported,
another 23 are never seen

Source: NYS Elder Abuse Prevalence Study; Weill Cornell Medical College, NYC Department for the Aging; Lifespan; (2011), Slide courtesy of Life Long Justice

DEFINITION OF ELDER ABUSE

"DECEPTION" MEANS, BUT IS NOT LIMITED TO:

- CREATING OR REINFORCING A FALSE IMPRESSION, INCLUDING A FALSE IMPRESSION AS TO LAW, VALUE, INTENTION, OR OTHER STATE OF MIND;
- PREVENTING ANOTHER FROM ACQUIRING INFORMATION THAT WOULD AFFECT HIS OR HER JUDGMENT OF A TRANSACTION; OR
- FAILING TO CORRECT A FALSE IMPRESSION THAT THE DECEIVER PREVIOUSLY CREATED OR REINFORCED, OR THAT THE DECEIVER KNOWS TO BE INFLUENCING ANOTHER TO WHOM THE PERSON STANDS IN A FIDUCIARY OR CONFIDENTIAL RELATIONSHIP;

"ABUSE" MEANS THE INFLICTION OF INJURY, SEXUAL ABUSE, UNREASONABLE CONFINEMENT, INTIMIDATION, OR PUNISHMENT THAT RESULTS IN PHYSICAL PAIN OR INJURY, INCLUDING MENTAL INJURY;

"EXPLOITATION" MEANS OBTAINING OR USING ANOTHER PERSON'S RESOURCES, INCLUDING BUT NOT LIMITED TO FUNDS, ASSETS, OR PROPERTY, BY DECEPTION, INTIMIDATION, OR SIMILAR MEANS, WITH THE INTENT TO DEPRIVE THE PERSON OF THOSE RESOURCES;

SUPERVISION NEGLECT:

IF THE REPORTING SOURCE HAS OBSERVED A PHYSICAL HEALTH AND SAFETY RISK TO AN ADULT RESULTING FROM A LACK OF NECESSARY AND APPROPRIATE SUPERVISION;

FOOD NEGLECT, IF AN ADULT SHOWS SYMPTOMS OF:

- MALNUTRITION
- DEHYDRATION
- FOOD POISONING
- LACK OF ADEQUATE FOOD FOR A PERIOD OF TIME THAT:
  - RESULTS IN PHYSICAL SYMPTOMS
  - REQUIRES TREATMENT

ENVIRONMENTAL NEGLECT: IF A SERIOUS HEALTH AND SAFETY HAZARD IS PRESENT, AND THE ADULT OR THE ADULT'S CARETAKER IS NOT TAKING APPROPRIATE ACTION TO ELIMINATE THE PROBLEM; OR

MEDICAL NEGLECT, IF THE ADULT IS NOT RECEIVING TREATMENT FOR AN INJURY, ILLNESS, OR DISABILITY THAT:

- RESULTS IN AN OBSERVABLE DECLINE IN THE ADULT'S HEALTH AND WELFARE;
- MAY BE LIFE THREATENING; OR
- MAY RESULT IN PERMANENT IMPAIRMENT;

EXPLOITATION OF AN ADULT, AS DEFINED IN KRS 209.020(9), IF THE REPORT ALLEGES:

- ISOLATION FROM FRIENDS, RELATIVES, OR IMPORTANT INFORMATION, SUCH AS: SCREENING TELEPHONE CALLS, DENYING VISITORS, OR INTERCEPTING MAIL;
- PHYSICAL OR EMOTIONAL DEPENDENCY
- MANIPULATION
- ACQUIESCENCE
- LOSS OF RESOURCES

ANY PERSON, INCLUDING BUT NOT LIMITED TO PHYSICIAN, LAW ENFORCEMENT OFFICER, NURSE, SOCIAL WORKER, CABINET PERSONNEL, CORONER, MEDICAL EXAMINER, ALTERNATE CARE FACILITY EMPLOYEE, OR CARETAKER

HAVING REASONABLE CAUSE TO SUSPECT THAT AN ADULT HAS SUFFERED ABUSE, NEGLECT, OR EXPLOITATION, SHALL REPORT OR CAUSE REPORTS TO BE MADE IN ACCORDANCE WITH THE PROVISIONS OF THIS CHAPTER

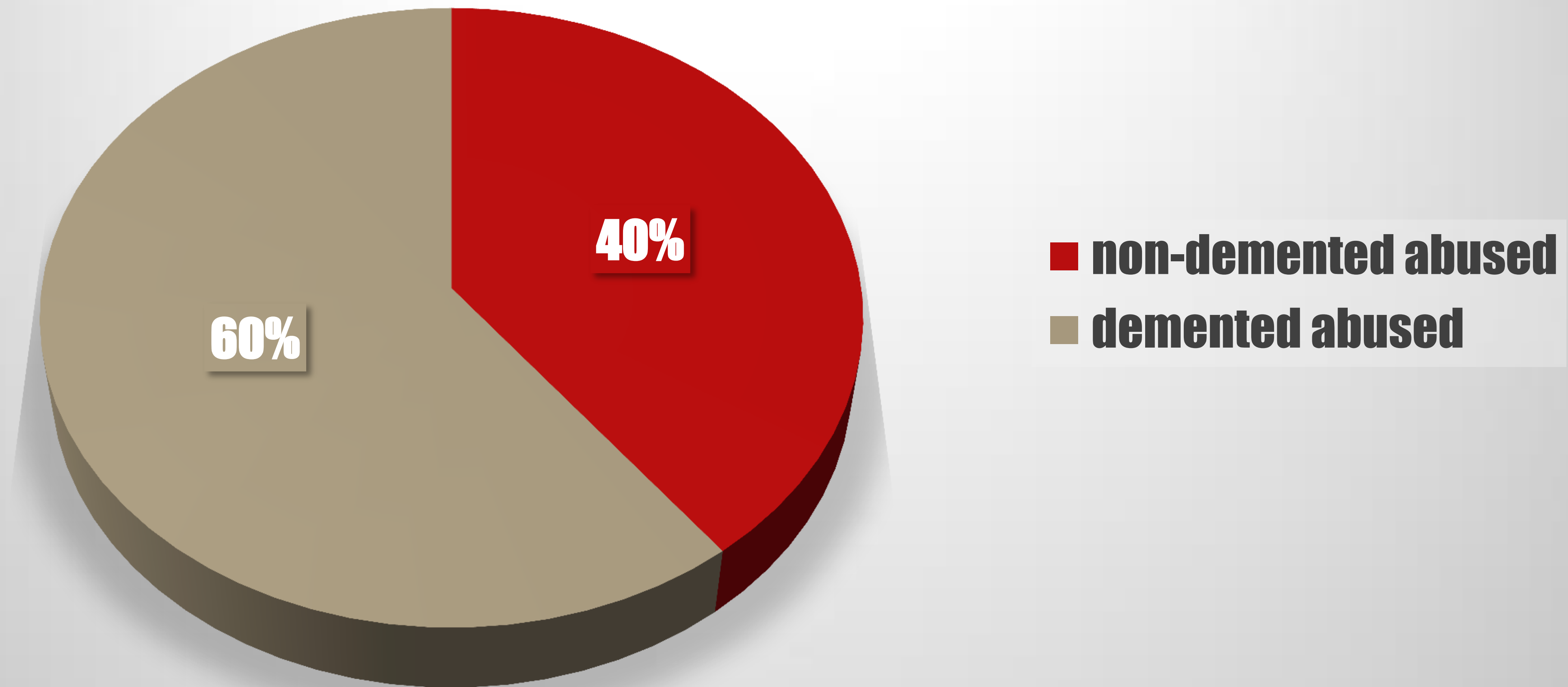
ANY PERSON MAKING SUCH A REPORT SHALL PROVIDE THE FOLLOWING INFORMATION, IF KNOWN:

- THE NAME, ADDRESS & AGE OF THE ADULT, OR OF ANY OTHER PERSON RESPONSIBLE FOR HIS CARE
- THE NATURE AND EXTENT OF THE ABUSE, NEGLECT, OR EXPLOITATION, INCLUDING ANY EVIDENCE OF PREVIOUS ABUSE, NEGLECT, OR EXPLOITATION
- THE IDENTITY OF THE PERPETRATOR, IF KNOWN
- THE IDENTITY OF THE COMPLAINANT, IF POSSIBLE
- ANY OTHER INFORMATION THAT THE PERSON BELIEVES MIGHT BE HELPFUL IN ESTABLISHING THE CAUSE OF ABUSE, NEGLECT, OR EXPLOITATION.

IMMUNITY FROM CIVIL OR CRIMINAL LIABILITY

- ANYONE ACTING UPON REASONABLE CAUSE IN THE MAKING OF ANY REPORT OR INVESTIGATION OR PARTICIPATING IN THE FILING OF A PETITION TO OBTAIN INJUNCTIVE RELIEF OR EMERGENCY PROTECTIVE SERVICES FOR AN ADULT PURSUANT TO THIS CHAPTER, INCLUDING REPRESENTATIVES OF THE CABINET IN THE REASONABLE PERFORMANCE OF THEIR DUTIES IN GOOD FAITH, AND WITHIN THE SCOPE OF THEIR AUTHORITY, SHALL HAVE IMMUNITY FROM ANY CIVIL OR CRIMINAL LIABILITY THAT MIGHT OTHERWISE BE INCURRED OR IMPOSED. ANY SUCH PARTICIPANT SHALL HAVE THE SAME IMMUNITY WITH RESPECT TO PARTICIPATION IN ANY JUDICIAL PROCEEDING RESULTING FROM SUCH REPORT OR INVESTIGATION AND SUCH IMMUNITY SHALL APPLY TO THOSE WHO RENDER PROTECTIVE SERVICES IN GOOD FAITH PURSUANT EITHER TO THE CONSENT OF THE ADULT OR TO COURT ORDER.

2 OUT OF 3 CASES OF ELDER ABUSE INVOLVE A PERSON WITH DEMENTIA



WHY THOSE WITH DEMENTIA?

DEMENTED PERSON

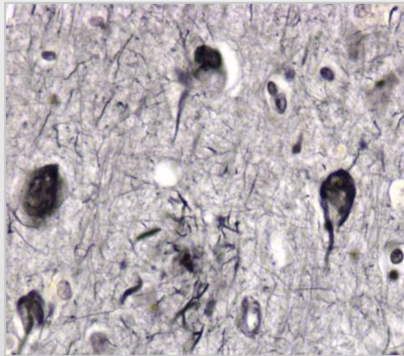
- MEMORY LOSS
- INCREASED DEPENDENCE
- POOR JUDGEMENT
- BEHAVIORAL PROBLEMS

CAREGIVER

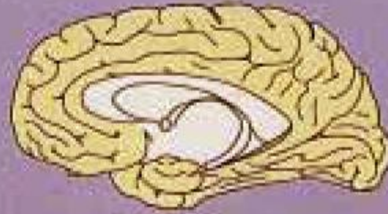
- HIGH STRESS
- UNEMPLOYMENT
- SENSE OF BEING OWED FOR THE CARE THEY PROVIDE
- LOW SOCIAL SUPPORT

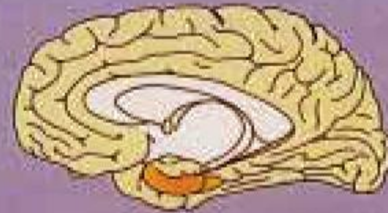
Roberto 2016, American Psychologist 71 (4):302-311

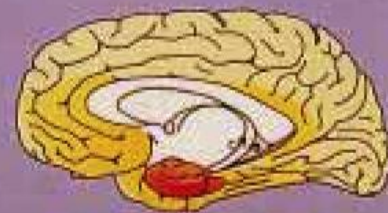
AS DEMENTIA SPREADS, NEW DEFICITS THAT MAY IMPACT FREQUENCY AND TYPE OF ABUSE OCCURS

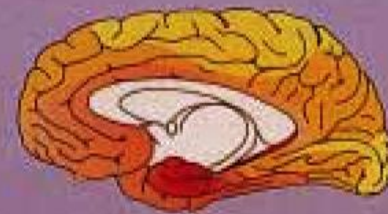


NFTs

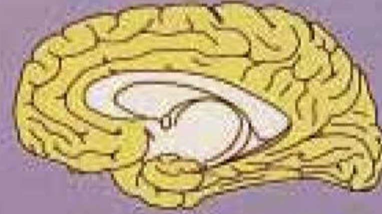


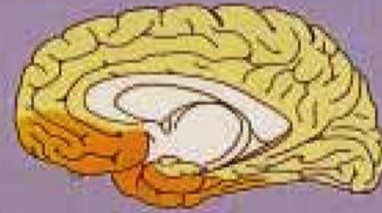


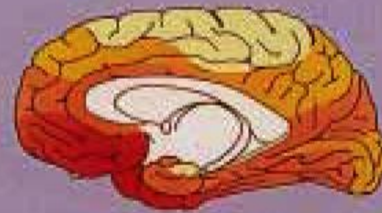


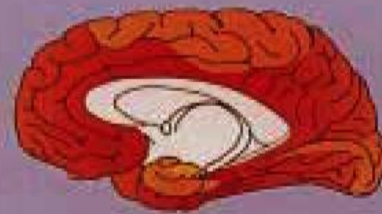


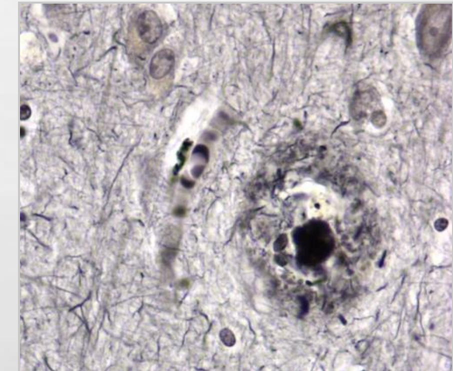
Increasing severity of disease





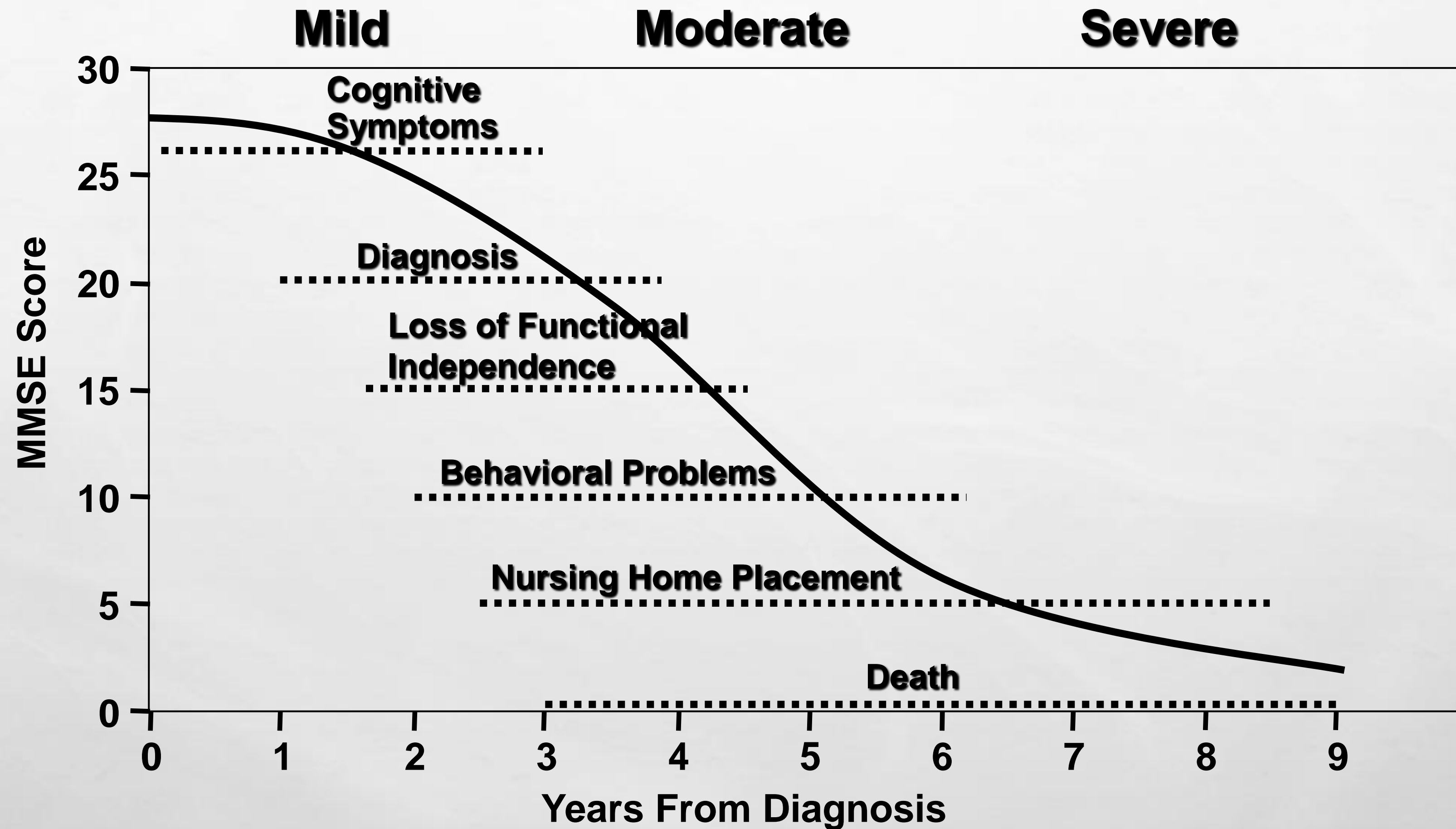






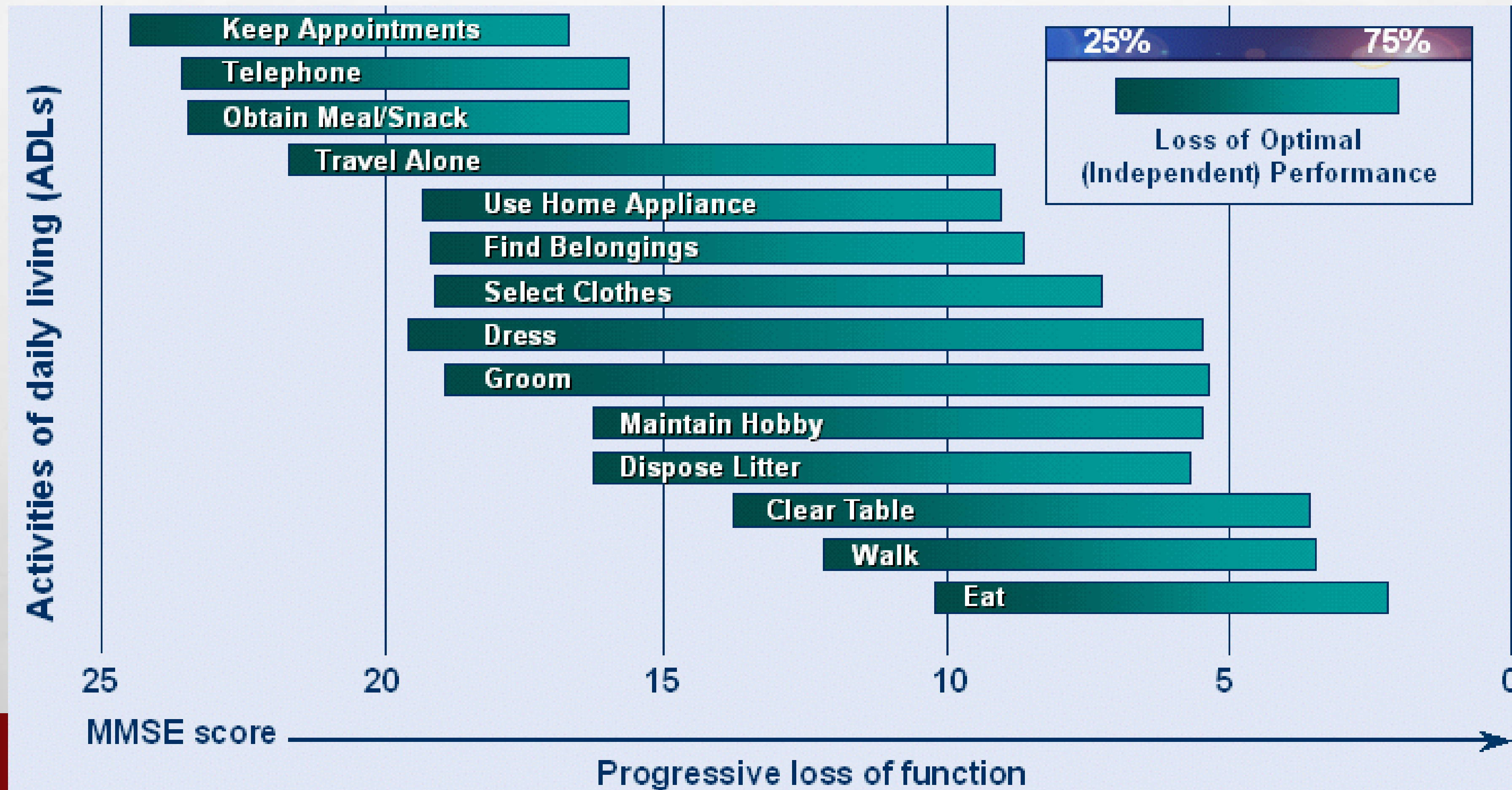
Amyloid plaques

CLINICAL DISEASE PROGRESSION



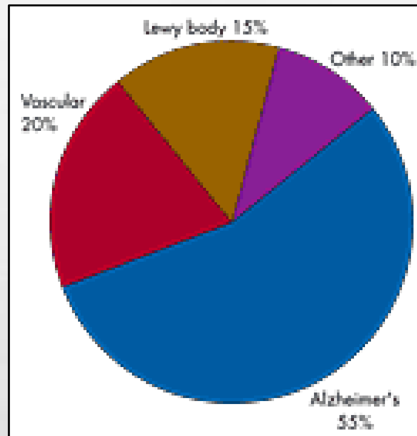
Reprinted from *Clinical Diagnosis and Management of Alzheimer's Disease*, H Feldman and S Gracon; Alzheimer's Disease: symptomatic drugs under development, pages 239-259, copyright 1996, with permission from Elsevier.

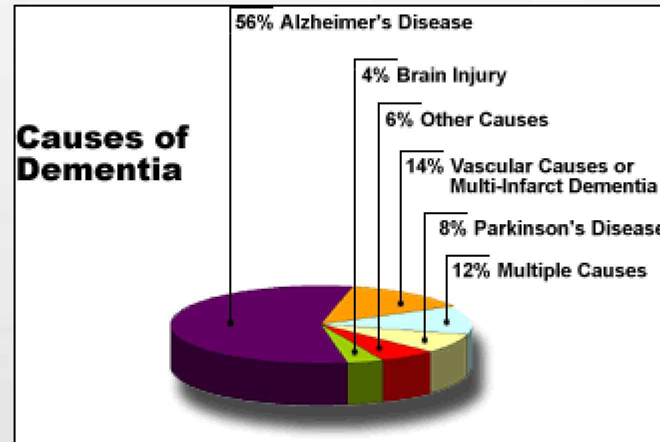
INCREASING FUNCTIONAL DEPENDENCE MAY AFFECT RISK AND TYPE OF ABUSE



Adapted with permission from Galasko et al. *Eur J Neurol.* 1998;5:S9-S17.

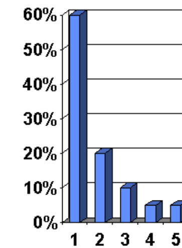
IT'S CLEAR THAT DEMENTIA IS A "MIXED BAG" OF DISORDERS, AND THAT RISKS FOR ABUSE AND TYPE OF ABUSE MAY DIFFER BETWEEN DISEASE STATES

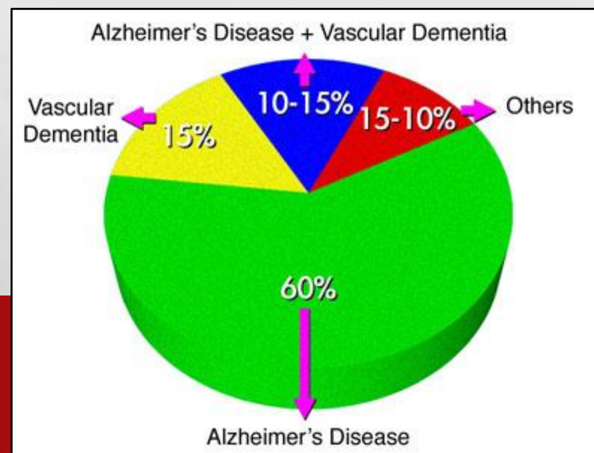


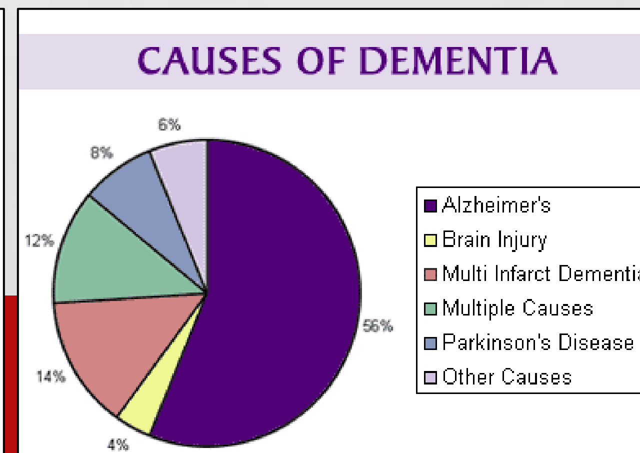


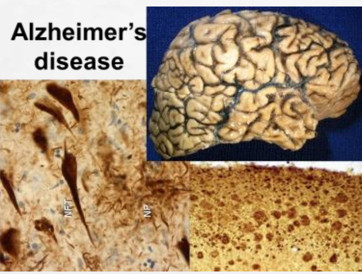
CAUSES OF DEMENTIA IN THE UNITED STATES

- #1-Dementia of Alzheimer's type.
- #2- Vascular/multi-infarct dementia.
- #3-Lewy Body dementia.
- #4-Mixed dementia (AD/VAS).
- #5-Other.





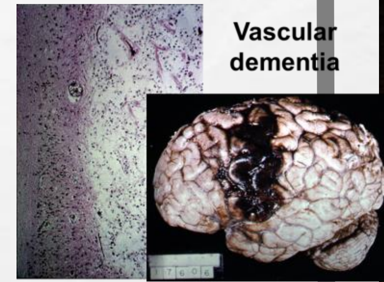




Alzheimer's disease (NINDS-ADRDA)

- Dementia by DSM criteria
- Deficits in two or more areas of cognition
- Progressive worsening of memory and cognitive dysfunction
- Onset age 40-90
- Absence of other systemic/brain disorders

Vascular dementia (NINDS-AIREN)



- Dementia by DSM criteria
- Cerebrovascular disease present:

a) focal neurologic signs (stroke)

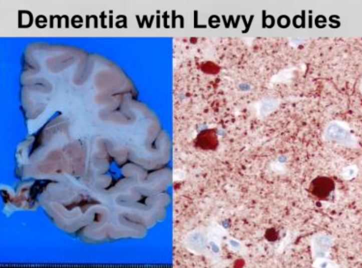
- history of stroke not necessary

b) CT or MRI evidence of stroke

- Onset of dementia within 3 months of stroke, or abrupt deterioration of cognitive function or stepwise course

Dementia with Lewy bodies (3rd Int. Workshop on DLB)

- Dementia by DSM criteria
- Deficits in cognition may not be memory (usually attention/spatial)
- Parkinsonism
- Early hallucinations
- Fluctuations
- Supportive:
  - Depression
  - REM sleep behavior disorder

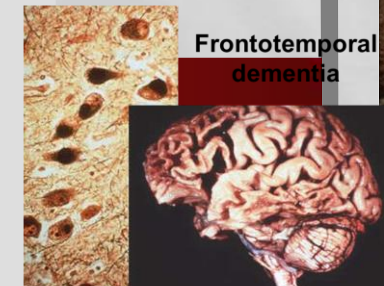


Frontotemporal dementia (NIH work group on FTD)

- Prominent behavioral disorder
  - Loss of interpersonal skills
  - Emotional blunting
  - Perseveration or impersistance

or

- Language involvement
  - Comprehension or fluency
- Cognition typically preserved
- Can be assoc with MND/ALS



LET'S LOOK AT COGNITIVE DOMAIN INVOLVEMENT AND HOW THIS MAY CREATE SPECIFIC VULNERABILITY TO ABUSE

- MEMORY- REPETITIVE ABUSE, NOT REPORTED
- EXECUTIVE FUNCTION- POOR JUDGEMENT & DECISIONS
- ATTENTION- OVERLOOKED ABUSES
- LANGUAGE- UNABLE TO EXPRESS NEEDS (NEGLECT) OR REPORT ABUSE
- VISUOSPATIAL- DEPENDENCE FOR TRAVEL, FINDING THE BATHROOM

BRIEF NOTE ON "FRONTAL SYMPTOMS"

Oh, that feels so good!

Yes, I think I want to do it!

Dorsolateral

parasagittal

dysexecutive

abulia

Orbitofrontal

disinhibited

Maybe I shouldn't?

Psychiatric symptoms in dementia

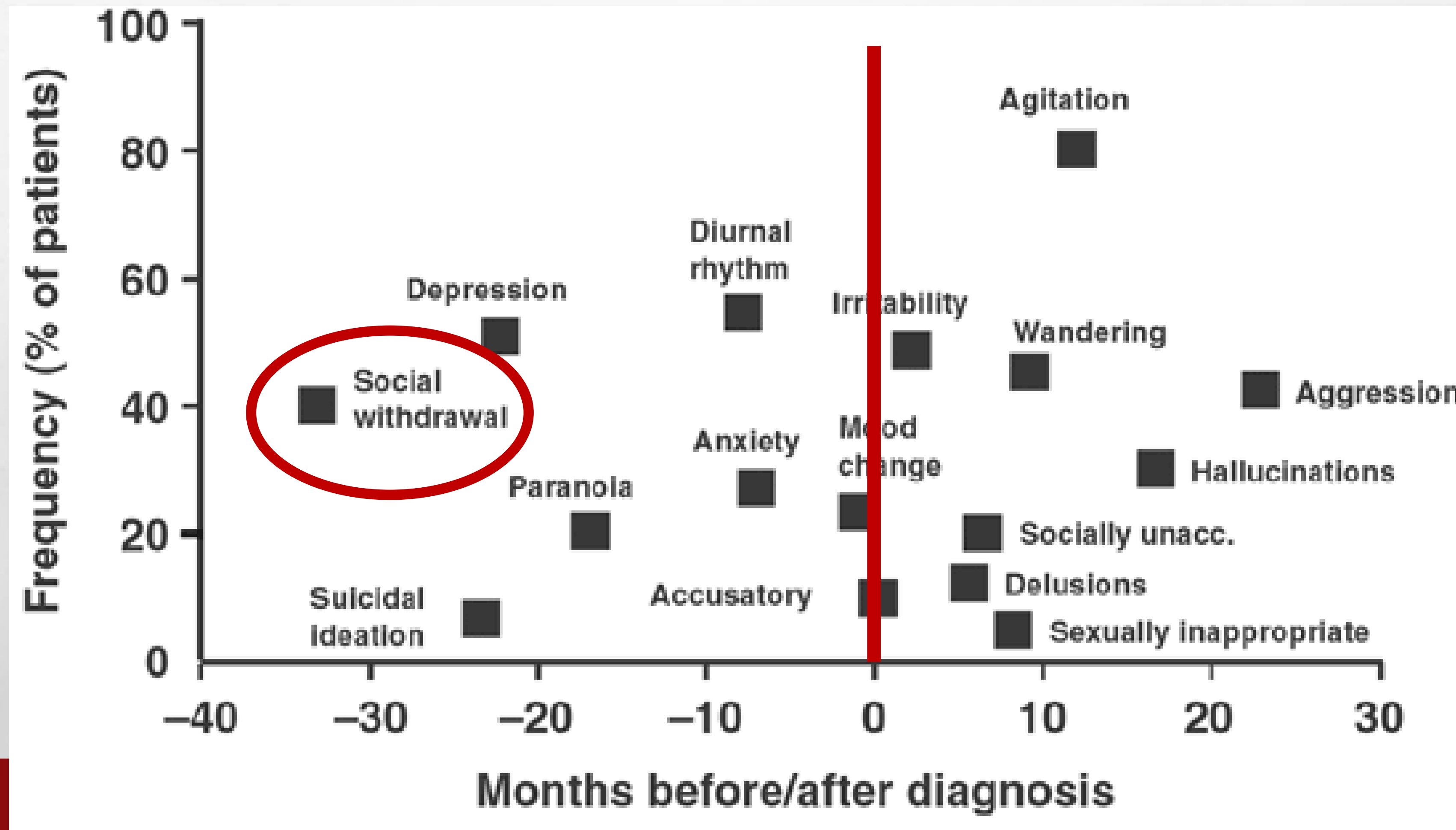


Figure from Medscape.com

IMPORTANCE OF BEHAVIORAL & PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD)

- BPSD ACCOUNT FOR 30% OF COST ASSOCIATED WITH AD
- STRONGLY ASSOCIATED WITH CAREGIVER DEPRESSION
- STRONGLY ASSOCIATED WITH INSTITUTIONALIZATION
- UNDERMINE CAREGIVERS ABILITY TO PROVIDE CARE

CAUSES OF BPSD CAN BE CENTRAL IN ABUSE

INTERNAL vs. EXTERNAL

Internal

- Behaviors may be an expression of unmet psychological needs
  - Thirst
  - Hunger
  - Pain
  - Distress
  - Feelings of abandonment
  - Fear

External

- Environmental factors
  - Excessive stimulation
  - Lack of daily structure/routine
  - Inadequate lighting
  - Confusing surroundings
  - Excessive demands
  - Distressing behavior of others
  - Loneliness/boredom

EFFECTS OF ELDER ABUSE ON VICTIMS

- **MORTALITY:** RATES THAN NON-ABUSED OLDER PEOPLE, UP TO 300% HIGHER (LACHS, ET AL, 1998; NATIONAL ACADEMIES, 2010)
- **DISTRESS:** SIGNIFICANTLY HIGHER LEVELS OF PSYCHOLOGICAL DISTRESS AND LOWER PERCEIVED SELF-EFFICACY THAN OTHER OLDER ADULTS (COMIJS, ET AL, 1999; DONG 2005)
- **HEALTH:** BONE OR JOINT PROBLEMS, DIGESTIVE PROBLEMS, DEPRESSION OR ANXIETY, CHRONIC PAIN, HIGH BLOOD PRESSURE, AND HEART PROBLEMS (DYER, ET AL, 2000; STEIN & BARRET-CONNOR, 2000)

COMPLEX DYNAMICS

- NO SINGLE DYNAMIC EXPLAINS ELDER ABUSE
  - MAY BE SITUATIONAL AND VARY FOR THE SAME ACT
- "DEPENDING ON THE VICTIM-OFFENDER RELATIONSHIP AND THE TYPE OF ELDER ABUSE, ELDER ABUSE MAY RESEMBLE DOMESTIC VIOLENCE, CHILD ABUSE, OR FRAUD OR THE PHENOMENON CAN STAND ON ITS OWN WITH THE COMPLEXITY OF THE RELATIONSHIPS, INDIVIDUAL VULNERABILITIES, AND CONTEXTS IN WHICH IT OCCURS." (AMENDOLA, ET AL, 2010)

CASE #1: FINANCIAL ABUSE?

- 84 YEAR OLD WITH EARLY ALZHEIMER'S
- FAMILY MEMBERS ARE ASKING FOR AND RECEIVING LARGE SUMS OF MONEY
- THE PATIENT IS VERY WELL OFF FINANCIALLY, AND CAN EASILY ABSORB THE FINANCIAL LOSS OF THESE "GIFTS"
- SEVERAL OF THE CHILDREN RAISE A CONCERN ABOUT ABUSE

CASE #1: FINANCIAL ABUSE?

- THE PATIENT HAS LIMITED RESOURCES THAT ARE NEEDED FOR THEIR CARE
- THE "GIFTS" ARE THINGS SHE WOULD HAVE NEVER DONE IN THE PAST
- THE "GIFTS" ARE PLACING HER IN FINANCIAL JEOPARDY

Is this elder abuse?

CASE #1: FINANCIAL ABUSE?

- THE PATIENT HAS A LIFELONG HISTORY OF GENEROSITY TO OTHER FAMILY MEMBERS
- THE CURRENT "GIFTS" ARE NO MORE OR LESS IN QUANTITY THAN PREVIOUSLY GIFTED
- THE RECIPIENTS OF THESE GIFTS HAVE NOT CHANGED

Is this elder abuse?

CASE #2: SAFETY, PATERNALISM AND DRIVING?

- 77 YEAR OLD WITH EARLY ALZHEIMER'S
- FAMILY MEMBERS HAVE ASKED ABOUT DRIVING RESTRICTIONS
- THE PATIENT IS STILL DRIVING WITHOUT INCIDENT AND BELIEVES HE IS FINE TO CONTINUE WITH THIS

CASE #2: SAFETY, PATERNALISM AND DRIVING?

- THE PATIENT HAS A MMSE OF 26 (ABOVE THE CUTOFF SET BY THE AAN PRACTICE PARAMETER FOR DRIVING SAFETY IN DEMENTIA)
- YOU DECIDE TO DISCONTINUE HIS DRIVING PRIVILEGES BY WRITING TO THE STATE DMV, CONCERNED THAT HE IS GOING TO DECLINE TO THE POINT WHERE HIS DRIVING WILL BECOME DANGEROUS

Is this elder abuse?

CASE #2: SAFETY, PATERNALISM AND DRIVING?

- THE PATIENT HAS A MMSE OF 26 (ABOVE THE CUTOFF SET BY THE AAN PRACTICE PARAMETER FOR DRIVING SAFETY IN DEMENTIA)
- THE PATIENT HAS LEWY BODY DISEASE WITH SEVERE VISUOSPATIAL DYSFUNCTION, AND PARKINSONISM THAT AFFECTS WALKING AND SPEED
- YOU DECIDE TO DISCONTINUE HIS DRIVING PRIVILEGES BY WRITING TO THE STATE DMV

Is this elder abuse?

CASE #2: SAFETY, PATERNALISM AND DRIVING?

- THE PATIENT HAS A MMSE OF 21 (BELOW THE CUTOFF SET BY THE AAN PRACTICE PARAMETER FOR DRIVING SAFETY IN DEMENTIA)
- YOU DECIDE THAT AS HE HAS DONE FINE WITH HIS DRIVING TO DATE, HE SHOULD BE ALLOWED TO CONTINUE DRIVING

Is this elder abuse?

CASE #3: THE DAIRY QUEEN INCIDENT?

- 58 YEAR OLD WITH FRONTOTEMPORAL DEMENTIA
- STOPS AT DAIRY QUEEN WITH CAREGIVER BEFORE THE APPOINTMENT
- WANTS A CHOCOLATE ICE CREAM, BUT THE CAREGIVER GETS THEM A VANILLA INSTEAD

CASE #3: THE DAIRY QUEEN INCIDENT?

- THE PATIENT HAS DEVELOPED AND INTOLERANCE/ALLERGY TO CHOCOLATE
- EATING CHOCOLATE CAUSES HIVES, AND SEVERAL DAYS OF SEVERE GI DISCOMFORT

Is this elder abuse?

CASE #3: THE DAIRY QUEEN INCIDENT?

- THE PATIENT HAS ALWAYS LOVED CHOCOLATE ICE CREAM
- THE CAREGIVER DOESN'T FEEL THEY DESERVE THIS AS THEY HAVE BEEN BEHAVING POORLY ALL MORNING TRYING TO GET TO THE APPOINTMENT

Is this elder abuse?

CASE #4: I DON'T WANT MY MEDICINES?

- 81 YEAR OLD WITH MODERATE ALZHEIMER'S
- REGULARLY REFUSING TO TAKE THEIR MEDICINES FOR A-FIB, HTN, AND DIABETES
- THE PATIENT DOESN'T UNDERSTAND THE IMPORTANCE OF THE MEDICINES

CASE #4: I DON'T WANT MY MEDICINES?

- THE CARE GIVER ALLOWS THE PATIENT TO TAKE THE MEDICINES ONLY WHEN THEY WANT THEM AS IT IS TOO MUCH TO FIGHT WITH THEM CONSTANTLY

Is this elder abuse?

CASE #4: I DON'T WANT MY MEDICINES?

- AS A RESULT OF NOT TAKING THEIR MEDICINES PROPERLY, THE PATIENT SUFFERS A MINOR STROKE, COMPLICATED BY A HYPERTENSIVE CRISIS AND DIABETIC KETOACIDOSIS THAT IS LIFE THREATENING

Is this elder abuse?

CASE #4: I DON'T WANT MY MEDICINES?

- THE CAREGIVER INSISTS ON THE PATIENT TAKING THEIR MEDICINES AND RESORTS TO CRUSHING AND HIDING THE MEDICINE IN THEIR FOOD TO MAKE SURE THEY TAKE IT REGULARLY AGAINST THE PATIENTS WILL

Is this elder abuse?

CASE #5: THIS MEDICINE WILL HELP YOU?

- 88 YEAR OLD WITH MODERATE ALZHEIMER'S COMPLICATED BY PSYCHIATRIC AND BEHAVIORAL PROBLEMS
- THESE ISSUES ARE CREATING SIGNIFICANT SAFETY CONCERNS DUE TO HALLUCINATIONS, DELUSIONS, AND PHYSICAL AGGRESSION

CASE #5: THIS MEDICINE WILL HELP YOU?

- THE DOCTOR PRESCRIBES AN ANTIPSYCHOTIC, DESPITE THE FDA BLACK-BOX WARNING REGARDING INCREASED RISK OF HEART ATTACK, STROKE, AND PNEUMONIA

Is this elder abuse?

CASE #5: THIS MEDICINE WILL HELP YOU?

- THE CAREGIVER SEES THAT THE PATIENT IS MUCH BETTER ON THE MEDICINE AND THAT THEY SLEEP MORE AFTER BEING GIVEN THE MEDICINE
- THE DANGEROUS BEHAVIORS HAVE RESOLVED
- THEY DECIDE TO DOUBLE THE DOSE TO KEEP THE PATIENT SEDATED THROUGH MOST OF THE DAY TO MAKE THEIR TASK OF CAREGIVING EASIER

Is this elder abuse?

CASE #6: WHO'S THE PATIENT?

- 76 YEAR OLD WITH LEWY BODY DISEASE LIVES WITH HIS WIFE IN A SENIOR COMMUNITY WITH A DINING HALL
- REGULARLY PERCEIVES THE PORTRAITS ON THE DINING ROOM WALLS AS REAL PEOPLE, AND HALLUCINATES OTHERS AT DINNER
- HE OFFERS FOOD TO HIS IMAGINARY "GUESTS" WHO HE IS QUITE PLEASED HAVE COME TO DINE WITH HIM

CASE #6: WHO'S THE PATIENT?

- THE DOCTOR PRESCRIBES AN ANTIPSYCHOTIC, DESPITE THE FDA BLACK-BOX WARNING REGARDING INCREASED RISK OF HEART ATTACK, STROKE, AND PNEUMONIA

Is this elder abuse?

CASE #6: WHO'S THE PATIENT?

- THE DOCTOR PRESCRIBES AN ANTIDEPRESSANT/ANTI-ANXIETY MEDICINE FOR THE CAREGIVER AND ALLOWS THE PATIENT TO CONTINUE TO EXPERIENCE THESE BENIGN HALLUCINATIONS

Is this elder abuse?

CASE #7: ALZHEIMER MEDICINES DON'T WORK?

- 74 YEAR OLD WITH MODERATE AD
- ON NO ALZHEIMER MEDICINES

CASE #7: ALZHEIMER MEDICINES DON'T WORK?

- THE DOCTOR DOES NOT PRESCRIBE APPROVED ALZHEIMER MEDICINES AS THEY DON'T FEEL THE DATA SUPPORTS THEIR USE

Is this elder abuse?

CASE #7: ALZHEIMER MEDICINES DON'T WORK?

- THE INSURANCE COMPANY APPROVES DONEPEZIL, BUT REFUSES MEMANTINE DESPITE THE FACT THAT IT IS FDA APPROVED FOR COMBINATION USE FOR SYMPTOMATIC MANAGEMENT OF ALZHEIMER'S

Is this elder abuse?

CASE #8: SMELLS LIKE PEE?

- 89 YEAR OLD WITH MODERATE-SEVERE AD
- SUFFERS FROM REGULAR BLADDER INCONTINENCE

CASE #8: SMELLS LIKE PEE?

- THE CAREGIVER GOES TO A MEDICAL SUPPLY STORE AND BUYS CATHETER SUPPLIES AS THEY CANNOT HANDLE THE FREQUENT CHANGING OF CLOTHES, AND LINENS
- THE COST OF DIAPERS IS ALSO A MAJOR ISSUE FOR THE CAREGIVER

Is this elder abuse?

CASE #8: SMELLS LIKE PEE?

- THE PATIENT IS BEDBOUND AT THIS POINT, AND IS BEGINNING TO EXPERIENCE SKIN BREAKDOWN AND DECUBITI THAT IS WORSENED BY THE CONSTANT URINE
- A CATHETER IS PLACED TO ALLOW THE DECUBITI TO HEAL, AFTER WHICH THE CATHETER IS REMOVED

Is this elder abuse?

CASE #9: I CAN WALK?

- 68 YEAR OLD WITH LEWY BODY DISEASE IN A SKILLED NURSING FACILITY
- HAS SEVERE PARKINSONISM THAT PREVENTS HIM FROM WALKING OR STANDING WITHOUT FALLS
- THINKS THAT HE CAN STAND AND WALK JUST FINE DESPITE RECURRENT FALLS

CASE #9: I CAN WALK?

- THE PATIENT HAS FALLEN SEVERAL TIMES AND HAS BROKEN BOTH HIPS ON SEPARATE OCCASIONS
- THE SKILLED FACILITY HAS TRIED TO PROVIDE ONE-ONE OBSERVATION TO PREVENT THESE FALLS, BUT DOES NOT HAVE THE STAFF TO MAINTAIN THIS
- THE USE A POSEY VEST TO PREVENT THE PATIENT FROM FURTHER HARMING THEMSELVES

Is this elder abuse?

CASE #9: I CAN WALK?

- AS POSEY VESTS ARE CONSIDERED RESTRAINTS AND A FORM OF ABUSE, THEY USE AN ATTACHED CHAIR TRAY TO KEEP HIM SITTING

Is this elder abuse?

CASE #10: HOME ALONE?

- 71 YEAR OLD WITH VASCULAR DEMENTIA THAT REQUIRES OVERSIGHT OR THEY DON'T EAT OR DRINK
- ALSO RECENTLY BURNT DOWN THE HOUSE TRYING TO COOK
- CAREGIVER HAS TO WORK
- PATIENT REFUSES TO "ALLOW" ANYONE BUT THE CAREGIVER TO BE PRESENT IN THE HOME AND ALSO REFUSES DAY PROGRAMS

CASE #10: HOME ALONE?

- THE CAREGIVER BUYS A HOME ALARM SYSTEM FOR FIRE, BREAK-IN,...ETC
- THEY FEEL THIS IS SUFFICIENT TO RETURN TO WORK AND LEAVE THE PATIENT ALONE DURING A 9 HOUR DAY

Is this elder abuse?

CASE #10: HOME ALONE?

- THE CAREGIVER INSISTS THAT THE PATIENT GO TO DAYCARE AGAINST THEIR WILL

Is this elder abuse?