Myths and Stereotypes about Care

Stereotyping and myths affect the medical treatment older individuals receive and the way caregivers treat them. Clinical expertise is beginning to challenge many commonly held perceptions about inevitable age-related declines and appropriate interventions.

As an Ombudsman, you need to know which conditions indicate a need for more assessment and/or consideration of different treatment interventions, instead of assuming that the conditions are simply manifestations of the aging process.

Since your job will be working with individuals in long term care facilities, this section will focus on applications in that environment. The same principles are applicable to individuals in home settings or other residences.

The Imperative for Good Care

In addition to challenging some of the long-held perceptions about the causes of decline and appropriate treatment, there is a solid legal basis for rethinking stereotypical responses. The Nursing Home Reform Law (OBRA ’87) challenges the mindset that “this is the way we’ve always done it,” or “we don’t have the staff to do it.”

OBRA challenges everyone to re-examine assumptions, such as “old people are hopelessly depressed,” or “bedsores and incontinence are unavoidable.” There are practitioners who have blazed the trail and found that time spent on thorough assessment and care planning saves time in the long run; that accommodating individual needs is possible and is more efficient; and that eliminating restraints results in better care. Their experience shows the law’s potential.

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2 The Pioneer Network serves as a national focal point for this type of activity, promoting “culture change,” cultivating and sharing best practices. P.O. Box 18648, Rochester, NY 14618. (515)271-7570. www.pioneernetwork.net
One of the principle provisions of OBRA—Quality of Care—says, “A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.”

**The requirements for long term care facilities explain what Quality of Care means:**

“Based on a comprehensive assessment of a resident, the facility must ensure that a resident’s abilities in activities of daily living do not diminish unless circumstances of the individual’s clinical condition demonstrate that diminution [decline] was unavoidable. This includes the resident’s ability to bathe, dress, and groom; transfer and ambulate; use the toilet; eat; and use speech language or other functional communication systems.”

The regulation applies to vision and hearing, pressure sores, urinary incontinence, range of motion, mental and psychosocial functioning, and other areas of care.

In short, this provision means that people should not get worse because of what the nursing home does to them. In fact, they should reach the highest level of functioning and well-being that they are capable of achieving. If a resident was able to walk, transfer, bathe himself/herself, move his/her arms, or maintain his/her skin condition when he/she entered the facility, he/she should still be able to do so after six months or a year. In fact, this should continue for the rest of his/her stay in the facility, unless circumstances of his/her clinical condition demonstrate that a decline was unavoidable.

There are only three instances in which a decline would be unavoidable:

- A new disease or condition is experienced by a resident (e.g. heart disease added to the existing Parkinson’s disease).
- A resident’s disease progresses (e.g. the Parkinson’s medicine no longer works and the individual becomes so rigid he is rendered immobile).
- A resident refuses care.

The following is a description of some common myths and stereotypes that are being proved false.
MYTH OR STEREOTYPE

Given the frail condition of residents, movement is not as important for them as it is for other adults. They will experience a decline in mobility as an inevitable part of growing older.

REALITY

“Movement, like other basic human needs, is lifelong and doesn’t end with [old age and] institutionalization. The ability to meet these needs may fluctuate with physical and mental ability, but the drive that initiates the pursuit is forever. Frail, elderly persons who enter nursing facilities retain the drive to meet their need for movement, just as they do for the other basic needs. Institutions often fail to assist residents in meeting movement needs because they fail to recognize movement as a basic human need.”

But it’s true: all individuals need to move. In fact, well-documented research shows that “impaired mobility can lead to a number of harmful physical and mental complications which, taken to their extreme, can be fatal.”

In a limited study of nursing home residents, those who walked outdoors reported less fatigue than residents who did not. Residents in the walking group slept better and reported better appetites than others in the study.

The reality is…Mobility is essential to life, regardless of your age or condition.

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3 Tempkin, T., Mobility: A Basic Human Need, Quality Care Advocate Special Section, National Citizens’ Coalition for Nursing Home Reform, Washington DC, 1993, p.i.
4 Ibid.
**PRESSURE ULCERS**

**MYTH OR STEREOTYPE**

Because of the age-related changes in the skin and the frailty of nursing facility residents, pressure ulcers/sores are inevitable for individuals who are not independently mobile. Pressure sores are an unfortunate part of normal aging for frail, elderly persons.

**REALITY**

A pressure ulcer is an injury caused primarily by unrelieved pressure that damages the skin and underlying tissue. An ulcer of this type is a serious problem that can lead to pain; longer hospital or nursing home stays; slower recovery from health problems; and even death. Over 7% of residents in nursing facilities have pressure ulcers. Sixty percent (60%) or more of residents will typically be at risk of pressure ulcer development. Individuals who are at risk of developing pressure sores are those with limited mobility, incontinence, diabetes, decreased mental states, confusion, or apathy. Almost all pressure ulcers can be prevented.

The assessment of risk factors is critical to prevention and/or early detection and intervention. The primary risk factors are:

- immobility or unrelieved pressure, including pressure from use of a restraint
- laying in urine or feces
- poor nutrition and hydration

The reality is... All of the major causes of pressure sores can be addressed by facility staff and are relate to basic, daily care routines.

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10 Ombudsman Guide to the Nursing Home Reform Law, op.cit.
MYTH OR STEREOTYPE

Urinary incontinence – the involuntary loss of urine – is to be expected, especially among residents in nursing facilities. It is another signal of advanced age and physical decline. Once it occurs, there is nothing that can be done except to keep individuals clean and dry.

Reality

“Contrary to myth, incontinence is not a normal part of aging. It is actually easier to treat in the elderly than in the young. It is not inevitable, even in those with dementia (25% of the bedridden with dementia are continent), and it is manageable in a third of those with dementia.”

It is estimated that more than one-half of all nursing home residents experience urinary incontinence. Urinary incontinence is a symptom rather than a disease. In some cases, the disorder is temporary, the result of an easily reversed cause such as a medication or acute illness (e.g., urinary tract infection). The most probable cause of urinary incontinence is immobility caused by chemical or physical restraints, or lack of a toileting program. Many cases are chronic and last indefinitely unless properly diagnosed and treated.

“Despite the high prevalence of urinary incontinence and the fact that it is associated with social and physical problems that impair general well-being, nursing home staff often overlook urinary incontinence as a potentially curable phenomenon. Care plans that address incontinence are often custodial rather than rehabilitative. In an attempt to keep residents dry, staff may diaper them, change their clothing and linens frequently, toilet regularly, limit fluid intake, or use a catheter. Such approaches have their place under certain circumstances, but not until the resident has been evaluated properly to uncover the underlying cause of incontinence.”

12 Harrington, C., op. cit.
“Continence depends on many factors. Urinary tract factors include a bladder that can store and expel urine and a urethra that can close and open appropriately. Other factors include the resident’s ability (with or without staff assistance) to reach the toilet on time (locomotion); his/her ability to adjust clothing so as to toilet (dexterity); recognizing the need to void in time and in an appropriate place (cognitive function and social awareness); and the resident's motivation. Fluid balance and the integrity of the spinal cord and peripheral nerves will also have an effect on continence. Change in any one of these factors can result in incontinence, although alterations in several factors are common before incontinence develops.”

In summary, incontinence not only affects skin conditions and care routines, but also has a profound effect on an individual’s dignity, self-esteem, and social relationships. Minimizing risk factors, performing thorough assessments, and providing appropriate interventions are essential to helping individuals maintain, or regain, urinary continence. Restorative care is also important.

The reality is...Urinary incontinence is not an inevitable part of aging, and many things can be done to help prevent, and even cure it.

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**MYTH OR STEREOTYPE**

*Older individuals tend to withdraw, slow down, and become depressed. Sadness is a natural response to the loss of physical abilities and other life stage changes. Therefore, depression is a normal part of living to an advanced age.*

**Reality**

“The ability to think, feel, interact with others, share a sense of purpose, work, love, experience gratification, care for others, and maintain self-responsibility are precious human attributes that elderly people strive to maintain. In only a few circumstances are these elements of our experience and capacity so broadly and deeply challenged, as with depressive disease.” 17

Currently, depression in the elderly is usually effectively diagnosed and treated.18 Symptoms such as loss of appetite, sleeplessness, lack of energy, and loss of interest in and enjoyment of life, are more common among the elderly than a depressed mood. The risk of depression among women is over two times higher than that of elderly men,19 but white men over 80 are at the greatest risk for suicide out of all the groups of older people.20

**The reality is**... Treatment for depression in the elderly is usually quite effective. With proper assessment, detection, and intervention, the symptoms of depression among residents can often be alleviated.

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17 Diagnosis and Treatment of Depression in Late Life, Consensus Statement, Vol. 9, No. 3, National Institutes of Health, Bethesda, MD, November 4-6, 1991.
18 Levenson, S., Psychoactive Medications, Politics, The Unconventional “Wisdom” of LTC, Caring for the Ages, February 2002.. In fact, Dr. Levenson says antidepressants are being overused without regard to the adverse effects that may accrue.
**M Y T H  O R  S T E R E O T Y P E**

As individuals become older and more physically frail, they need to be protected. Safety becomes very important; thus, minimizing risk is desirable. Using restraints is sometimes necessary to keep individuals from harming themselves or others.

**R e a l i t y**

All of life has risks. It is impossible to create a totally risk-free, 100% safe environment. However, some of the care practices that have been justified on the basis of safety may need to be questioned. “Physical restraints do not make people safer. In fact, restraints are often harmful. Caregiver experience and medical research now show:

When a person stops using a body part, that part no longer works very well. The old saying, ‘use it or you’ll lose it’ is true—people who are able to get up to try to walk and are restrained become weaker. In addition, restrained residents often try to get out of restraints, sometimes resulting in serious injuries, such as broken bones, cuts requiring stitches, and concussions.

In addition, some people fall if they are not restrained. However, research shows that these residents, when they do fall, have less serious injuries than those who are restrained.”

In talking with residents, families, and home staff, remember that individuals have the right to take risks and need enough information to allow them to make an informed decision. Advanced age does not remove an individual’s ability to accept risks. More information on restraints can be found in *Nursing Homes: Getting Good Care There* or in the fact sheets on the web site of the National Citizens’ Coalition for Nursing Home Reform:

[www.nursinghomeaction.org](http://www.nursinghomeaction.org)

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