Comorbidities Matter
A Call to Improve Care for Hospitalized Patients with Alzheimer’s and Parkinson’s Disease

As gerontological practitioners, we are aware of the rapidly aging society, with Baby Boomers turning 65 years old at a rate of 10,000 per day for the foreseeable future (AARP, 2015). Many older adults will experience a hospitalization for an acute health event or elective surgery, and will bring with them a variety of chronic illnesses and comorbidities, which can greatly complicate the picture. Although the primary focus during the hospital stay is on the “admission diagnosis,” far too often significant comorbidities are dismissed simply as pre-existing conditions that older adults live with as a function of their advancing age. Progressive neurological conditions, such as Alzheimer’s or Parkinson’s disease, are prevalent in this population, and although rarely primary admitting diagnoses, both are equally problematic in adversely affecting length of stay and outcomes.

As both a long-time dementia educator and recent participant in the Edmond J. Safra Visiting Nurse Parkinson’s Disease Faculty Scholar program, several similarities in these two illnesses seem particularly relevant. Both can involve cognitive impairment as a symptom. However, in Alzheimer’s disease, memory loss is the hallmark symptom both early and throughout the disease trajectory, whereas cognitive changes are a less common, non-motor symptom affecting patients with Parkinson’s disease to a lesser degree and later in the illness (Ahlskog, 2015). Both diseases have no cure or disease-modifying treatment. However, medications are available to address symptoms to some degree. In Parkinson’s disease, the motor symptoms can be fairly well-managed with medications (carbidopa/levodopa being the gold standard); in Alzheimer’s disease, there are only a handful of U.S. Food and Drug Administration–approved medications that, at best, have a modest and temporary effect on cognitive function (Steinberg & Lyketsos, 2012).

Perhaps the greatest, and often overlooked, similarity in these conditions is the variety of serious consequences that can occur when patients with these conditions are hospitalized. In a study by Chou et al. (2011), the complication rate for patients with Parkinson’s disease was estimated to be 61%, with complications including confusion, pneumonia, urinary tract infection, deconditioning, and falls. Furthermore, an alarming 75% of patients with Parkinson’s disease reported not getting their medications on time. Similarly, individuals with Alzheimer’s disease can experience untoward consequences, so much so that astute practitioners go to great lengths to avoid hospitalization. Complications in this patient population also include pneumonia, falls, infections, and the inevitable deconditioning that results from bedrest, as well as the inappropriate or overuse of sedating medications to address the agitation that...
commonly occurs when placed in an unfamiliar and overstimulating environment.

The very notion of potential hospitalization for individuals with Parkinson’s disease is a source of considerable anxiety. Fears range from not receiving their specific formulation of carbidopa/levodopa on time to prevent “off” periods, to problems with timing of doses around meals (as protein can interfere with absorption and effectiveness), as well as the danger of receiving other commonly prescribed medications that are contraindicated. For patients with Alzheimer’s disease, who are usually confused and/or unable to advocate for themselves even under the best of circumstances, families often bear the burden. Individuals with Alzheimer’s disease are often medicated with antipsychotic agents at the first sign of agitation or resisting care, as opposed to the preferred alternative of trying nonpharmacological measures (e.g., modifying environment and communication strategies, encouraging family presence). Furthermore, delirium should be promptly explored as a cause for an acute onset of confusion or change in mental status with treatment aimed at the cause.

Parkinson’s and Alzheimer’s disease must be considered individually as key comorbidities that can greatly impact patient outcomes and satisfaction when hospitalized. The scenario can become even more complex as these conditions can co-occur (Perl, Olanow, & Calne, 1998). A change in both attitude and knowledge of hospital staff is necessary. Although physicians are certainly a fundamental piece of the puzzle, it is often the nurse who is in the best position at the bedside to ensure disease-specific, person-centered care. This change in mindset must begin in nursing school with a renewed emphasis on these common “secondary” diagnoses in older adults that must be included in the plan of care, as opposed to focusing predominantly on the reason for admission. Educational programs for health care professionals at all levels working in the hospital setting should address the intricacies of these illnesses with an emphasis on updated, evidence-based care strategies. Key priorities of care include a heightened sensitivity to the proper timing/dosing of Parkinson’s medications to prevent “off” periods, and in Alzheimer’s disease, implementing nonpharmacological measures first to address and/or prevent behavioral expressions before resorting to the ill-advised antipsychotic medications. Keen observation and assessment skills are a must, as well as a healthy dose of patience when communicating and assisting with activities of daily living—both of which can be slowed and/or impaired due to movement and cognitive issues. Lastly, because both conditions can involve mobility, balance, memory, and judgment problems, vigilant safety measures to prevent injury/falls are also of paramount importance.

With the aging of the U.S. population, it is imperative that health care providers be extremely mindful as to the prevalence of Alzheimer’s and Parkinson’s disease and modify care accordingly when older adults with either of these conditions require hospitalization. It is incumbent upon gerontological nurses to look beyond the admission diagnosis so that appropriate evidence-based care strategies are implemented, including monitoring for and, optimally, preventing related complications. Furthermore, input from families (i.e., what works, what does not work) should be actively solicited when patients are no longer able to act as their own advocates. Nurses can also take the lead in educating other health care professionals where appropriate.

Resources, such as the Alzheimer’s Association and National Parkinson Foundation, have a plethora of educational materials available for both professional and lay caregivers. The National Institute on Aging (2015) provides a booklet for professionals outlining specialized care approaches for hospitalized individuals with Alzheimer’s disease, whereas the National Parkinson Foundation (2015) provides patients and families a free “Aware in Care” kit with tools and information to share with hospital staff during a planned or emergency hospital stay. Education, advocacy, and, most importantly, care plans that are nurse-coordinated, multidisciplinary, and person-centered are essential strategies to ensure positive outcomes when individuals with these conditions are hospitalized.

REFERENCES

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