Guidelines on Alcohol usage and older people	
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Context.

Alcohol in care homes is a complex issue that involves many stakeholders. The actual use of alcohol is relatively low among the residents. Residents experience alcohol in terms of life quality but also in terms of what it means for their health, physical sensations, and social relations inside and outside the care home. Residents have the right to use alcohol but only seem to exercise this right if there is an occasion that calls for it.Relatives and Staff often view use of alcohol as a quality of life issue.

Drinking is much more common among older men than older women – (5-20% difference between them, depending on age segment of senior population)

 % of older drinkers decreases with age, but the number and percentage of drinkers, occasional or regular, remains significant in later life.

Older adults and drinking can raise a variety of legal and ethical dilemmas among people who work with, or provide services to seniors. Often people ask themselves

- To what extent can we legitimately intrude into their lives?
- To what extent can we become involved with older people "living at risk" from alcohol? and
- "What is considered an acceptable risk for an older person to take?".

We justify becoming involved and limiting personal choice in the lives of people. For youth, we may place limits on their access to alcohol out of concern to their physical vulnerability to alcohol and their lack of experience with the drug (responsible drinking). For pregnant mothers, we may try to persuade women to not drink or limit their drinking during pregnancy out of our concern of harm to the foetus. For workers, we may offer help to them through employee assistance programs if the alcohol consumption is affecting their work and productivity (e.g. absenteeism).

But what about older adults?

There are at least two distinct views of alcohol use, misuse, or abuse.

One view sees it as a lifestyle choice. As a personal choice, the decision whether or not to drink (and whether or not to cease drinking) is left to the individual. If the individual is encountering a problem, the individual is responsible for extricating him or herself from the situation.

This view gives precedence to the ethical principle of autonomy over other competing ethical principles such as beneficence ("do good" and "promote well-being") or non-maleficence ("do no harm"). This approach focuses on autonomy in the sense of non-interference.

An alternate perspective also starts from a respect of autonomy, but in the sense of ensuring that the older person has relevant information on which to make choices, that the senior is capable of making choices and that the choice is voluntary. This approach asks: "In some circumstances, does alcohol use remove choice and if so, what is our responsibility at that point?" It is also important to consider, how heavy-handed do we become in "helping" a person or protecting the person from himself or herself? How do we avoid "health promotion" from becoming "health tyranny"?

Alcohol is a legal substance. There is a presumption that once a person reaches 19 or the age of majority, decisions about alcohol consumption rest with the individual. At the same time, our society restricts access to alcohol by placing controls on when it can be purchased or consumed; where; and by whom.

Drink licensing in Ireland treats care facilities in the same way as a private residence. A national accreditation organization for care facilities notes the importance of resident choice around alcohol.

At the same time, a significant percentage of residents in care facilities are experiencing some degree of cognitive impairment. It may range from mild to severe. Depending on the type of facility, the prevalence of cognitive impairment among residents ranges from 10 to 40%. The ability

to choose whether or not to drink may be substantially impaired. The challenge to care staff, is how to protect those who cannot care for themselves while respecting the choices of those who can, as well as determining the most effective and respectful ways of accomplishing that.

It is important to have stated protocols when the facility's policy is restrictive so that residents and family know what will be expected before admission. Developing protocols can also help staff and administration consider what are their personal attitudes about

- drinking,
- seniors drinking,
- alcohol problems and how these develop.

The protocol also needs to be considered within and consistent with the broader mission statement of the facility, as well as what we mean by "health" of residents in the facility and how that is achieved, for the individual and the collective. It needs to be considered in the context of both resident autonomy and the safety of staff and other residents, looking at ways in which it able to meet both goals in the least intrusive manner.

Significant rates of alcohol misuse have been recorded in nursing home settings (Johnson, 2000), and interactions between prescribed (as well as over-the-counter) medication and alcohol pose significant risks for older people drinking unregulated amounts of alcohol. Alcohol interacts with many of the commonly prescribed medications, especially anti- depressants and sedatives.
Alcohol consumption is accepted on a social basis within this service. However there is a duty to care for older people as alcohol can have many different faces.

Medical: Virtually every organ system can be acutely affected by alcohol--hepatic, gastrointestinal, neurological, hematologic, cardiac, cutaneous, sexual, and if included the effects of smoking that

usually accompanies alcohol) respiratory. Alcoholism is associated with nutritional disorders, trauma, and immunocompromise. Alcohol may also significantly contribute to chronic diseases--e.g., dementia, congestive heart failure, hypertension, cirrhosis, cerebellar degeneration, seizure disorders, and neuropathies.

Psychiatric Alcoholism can masquerade as almost any psychiatric diagnosis. For this reason, it is recommended that withdrawing alcohol first before making a primary psychiatric diagnosis. Alcohol can cause insomnia. Abrupt alcohol withdrawal may precipitate anxiety, hallucinations, and delirium.

Behavioural Even in the absence of dementia or delirium, alcoholic patients frequently have behavioural problems. They may elope while seeking a drink, or display lifelong patterns of emotionally lability, manipulation, or self-neglect. They may be impulsive and accident prone. They may also show more pervasive antisocial personality features or a frank character disorder, or cajole friends, family or even staff to supply alcohol to them in the nursing home, a skill they have perfected over many years!

Functional Alcoholics' neurologic impairments increase their risk of falls. Their motor deficits may impair other activities of daily living. They may have functional incontinence, neurogenic incontinence, or both. Alcoholic diarrhoea can cause faecal incontinence. They are susceptible to deconditioning and malnutrition.

Social Alcoholics frequently have a tumultuous social, legal, and occupational history. They may also have a variety of family dysfunctions. Some have estranged their families altogether. Their children may display characteristics of adult children of alcoholics--passivity, unassertiveness, anxiety, codependency. Alcoholics may also have been victims or perpetrators (or both) of physical and emotional abuse over multiple generations.

The greatest challenge comes from high-functioning alcoholics. They enter nursing homes either for short stays after acute hospitalizations or for longer stays because of inadequate home or community support. These patients typically have antisocial personalities, addiction, and active

substance-seeking behaviours. They will test the resolve of each facility to interdict alcohol supplies, as well as the cohesion of the multi-disciplinary team and the stamina and therapeutic focus of each caregiver.

To meet the challenge of active abusers, facilities and physicians need clear processes for managing alcoholism.

Nursing Responsibility within a multidisciplinary perspective.

The Policy of this service is that social alcohol is permitted within the context of rights, dignity and privacy of each resident. The policy of this service must also stay within permissible limits on personal possessions that can be set by the facility for reasons of health and safety of the resident and others. Therefore in the interests of health and safety of a resident, staff have the right to remove alcohol from a residents room and keep it in safe storage.

Assessment & Planning The care-planning procedure should explicitly assign responsibility for assessing alcohol abuse and for devising an appropriate care plan. This is the responsibility of the admitting nurse in conjunction with each new individual resident and their families. The nurse must make it explicitly clear that residents are allowed to have a social drink in `privacy if they so wish but that staff have a responsibility to ensure that such alcohol does not impact on the residents medical condition and that alcohol intake does not interact with prescribed or other medications that have an adverse effect on the resident. This requirement makes ignoring or denying alcoholism by staff members a violation of policy. It prods the team to stay vigilant for drinking problems.

Physician Notification This policy requires that notification is given to the Medical Officer about signs or symptoms of intoxication or observations of prohibited alcohol ingestion or resultant associated adverse behaviours associated with alcohol ingestion. The Medical Officer needs this information to make adjustments to drug therapy if necessary, to manage acute intoxication, and to address chronic chemical-abuse disorders. This policy helps frame alcohol abuse as a health problem, not just harmless misbehaviour.

Diagnosis Physicians and Nurses should keep a high index of suspicion for alcoholism, and make the diagnosis when warranted by the evidence. They should remember that defensive denial is a hallmark of alcoholism. If the diagnosis is in doubt, physicians should seek consultation. They should document the diagnosis in the record.

Supply of Alcohol.

Relatives and friends are not encouraged to bring alcohol on to the premises unless this has been sanctioned for use by the Clinical Nurse Manager and the Medical Officer. The purchase of alcohol may be considered both a contractual matter and a social responsibility. At a minimum contractually when this service is buying alcohol, the person must know and understand what he or she is buying and the cost.

Are There Special Considerations for Private Delivery to Older Adults by families and Friends?

Yes and no.

No, in the sense that most older adults are responsible drinkers, and do not have a problem with drinking. They should not be treated any differently than other adults, when it comes to making use of conveniences such as private alcohol delivery. It is very important to guard against paternalism and age discrimination.

Yes, there may be a need for special consideration of special sub-populations of seniors -- specifically, those who have mental impairments that affect their ability to make decisions related to purchasing alcohol, and about who is “trustworthy” in providing services. All care staff need to be vigilant of both of these areas.

If Nurses are administering alcohol to residents, they must be very aware of the interactions of alcohol on the individual and must take responsibility for any side effects of alcohol ingestion.

Prescribed Drugs and Alcohol.

Seniors constitute 111.5% of population

 Receive 25 to 30% of the prescription drugs

 10% of hospitalizations are due to improper use of medication.

 Older adults often unaware of the potential adverse interactions with alcohol,

Medications Commonly Taken by Older People.

Codeine 7-8%

 Tranquillizers 11-12%

 Sleeping pills 17-20%

 High blood pressure pills (27-49% (w))

 Antibiotics (2%)

 ASA (66- 78%)

 Stomach 7%

 Laxatives 9-12%

 Cold remedies (4-6%)

 Vitamins (18-24%)

 Antidepressants (3-6%).

Drug	Possible effects when combined with alcohol
Analgesics (pain killers)	Increases depression of central nervous system
ASA (e.g. Aspirin®)	Increases irritation of stomach lining
Anti-coagulants (e.g. Coumadin®)	Increased anti-clotting effect; easy bruising
Antidepressants	Increases depression of central nervous system
Antihypertensive medications (blood pressure pills)	Increases sedation; varies depending on type of drug
Barbiturates (e.g. seconal, phenobarbitol)	Increases depression of central nervous system; potentially lethal in high doses
Insulin	Increases chance of hypoglycemia
Tranquillizers (e.g. Valium®, Ativan®, Xanax®, Tranxene®, Halcion®)	Considerable increase in depression of central nervous system; potentially lethal in high doses

Planning for Prevention

Understand common behaviours among older adults

- **Recognize who may be most at risk**
- **Recognize the potential risks**
- **Integrate into prevention work**
- **Keep it relevant, positive & respectful – language, images, suggestions**