Original Article

Interview with a Nurse: An interdisciplinary approach to caring for the frail elderly

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Abstract

Palliative care is defined by the National Hospice and Palliative Care Organization (NHPCO) as treatment that enhances comfort to improve quality of life (https://www.nhpco.org/about-nhpco/). No specific therapy is excluded from consideration. Palliative care focuses on the needs of the whole person throughout the illness trajectory, rather than focusing only on the disease. Palliative care aims to provide the best possible quality of life for patients and their families. As a leading organization representing hospice and palliative care providers, NHPCO works to expand access to a proven person-centered model for healthcare. Providing quality care for older patients is one of our biggest challenges in the post-COVID-19 era (Lapid et al., 2020). The World Health Assembly (WHA) recognizes that palliative care, when indicated, is fundamental to improving quality of life, overall well-being, and human dignity for individuals (WHA, 2020). In this paper, we review the literature on caring for the frail elderly and present a case study of an 80-year-old military widow. Then, we address conclusions and implications for best practices in palliative care from an interdisciplinary approach.

Key Words: *Palliative care, frailty, elderly, biopsychosocial emotional support, spiritual care, interdisciplinary approach*

Introduction

Palliative care is defined by the National Hospice and Palliative Care Organization as treatment that enhances comfort to improve quality of life (https://www.nhpco.org/about-nhpco/). Palliative care focuses on the needs of the whole person throughout the illness trajectory, rather than focusing only on the disease. Providing quality care for older people is one of our biggest challenges in the post-COVID-19 era (Lapid et al., 2020). The World Health Assembly (WHA) recognizes that palliative care, when indicated, is

fundamental to improving quality of life, overall well-being, and human dignity for individuals (WHA, 2020).

Be it physical, psychological, social, or spiritual, alleviating suffering is essential to palliative care. In this paper an 80-year-old military widow is interviewed for the purpose of understanding her individualized needs during the 2020 pandemic. Recommendations for best practices are then provided from an interdisciplinary perspective; specifically, perspectives of a pharmacist, an advanced practice nurse specializing in mental health, and a social worker. The authors offer expertise and advice to readers from their respective disciplines and to other colleagues in the healthcare community. Their perspectives follow and demonstrate an interdisciplinary approach with the shared goal of promoting the overall well-being.

Ethical Considerations

The university Office of Research Compliance (ORC) reviewed the protocol for this interview. The ORC determined that it was not required to submit a full protocol application as it is a case study of a single individual. The authors took additional ethical and confidentiality measures such as obtaining informed consent from the participant and assuring anonymity with identifying information. Therefore, patient initials, place of residency, date of birth, etc. have been changed to protect the client's identity.

Case Study: Interview with a Nurse

A community nurse conducted a phone interview with I.K. The telephone interview was conducted with the safety and welfare of the individual in mind. I.K. is a frail 80-year-old military widow living alone. I.K. was born and raised in Bavaria, Germany in the early 1930's. I.K. also speaks English as a second language (ESL). Her husband of over 50 years passed away in 2012. I.K. has one adult child who lives nearby and visits on occasion. During the 2020 COVID-19 pandemic, I.K. was faced with many daunting challenges, including access to care, social isolation, chronic back pain, anxiety, difficulty understanding automated phone messages, no internet access, filling prescription medications, transportation needs, insomnia, etc. Significant health concerns include but are not limited to cardiovascular disease with a history of three previous heart attacks, chronic back and neck pain, osteoporosis, hypertension, hyperthyroidism, Bipolar depression, generalized anxiety, and insomnia.

Self-reported Medical History

- Hypertension
- Cardiovascular disease (significant cardiac events 2000, 2010, 2013)
- High cholesterol (diagnosed in 2000)
- General Anxiety Disorder
- Bipolar depression (diagnosed in 2003)
- Chronic back pain (lumbar fusion 2003, Cervical blocks C-3 – C-6 2021, Cervical Block C-2-3 2021)
- Osteoporosis
- Abdominal aneurysm (<5cm since 2015)
- Septic kidney (2010)

Telephone Interview

During the telephone interview, I.K. reported extreme pain, significant weight loss (10 pounds in one week), muscle wasting, and depression. The community nurse made arrangements to speak with I.K.'s primary care provider (PCP) to explore the possibility of home health care (i.e., nurse, physical therapist, etc.). The PCP and community nurse discussed I.K.'s immediate needs and developed a care plan.

I.K.'s PCP requested authorization for home health nurse and physical therapist visits. I.K. has standing monthly appointments with her psychiatrist to address her depression, anxiety, loneliness and insomnia. I.K.'s PCP reviewed her medication profile to include prescriptions to treat her hypertension and osteoporosis. Weekly home health nurse visits were approved for three months, then extended for another three months. The home health nurse proved to be instrumental in assisting I.K. with scheduling appointments, refilling prescriptions, and identifying local support systems for transportation needs, as well as providing ongoing physical assessments and social support.

To address her extreme pain, I.K.'s PCP referred her to a neurologist and pain management specialist. I.K. opted for cervical spinal blocks instead of surgery at this time. Cervical block interventions provided short term relief, and there is ongoing evaluation to determine next steps. In addition, lab values revealed

hyperactive thyroidism, which is attributed to her weight loss and increased heart rate. I.K.s PCP encouraged her to follow up with her endocrinologist to assess thyroid function. I.K. 's endocrinologist prescribed Methimazole and Propranolol. To address muscle wasting and weakness, physical therapist home visits were approved for three months, and subsequently extended for another three months as were home health nurse visits. The physical therapist was instrumental with assisting I.K. with strength building exercise so she could resume activities of daily living. To address I.K.'s reports of depression, monthly psychiatric care helped with maintaining healthy coping mechanisms, and also provided a sense of social support as reported by I.K. I.K. was prescribed Cymbalta, Ativan and Ambien.

Review of the Literature. Current literature suggests the following biopsychosocial recommendations when caring for a frail elderly patient such as I.K. Pain management is a priority, followed by nutrition, mobility, and sleep, then psychological, emotional, social and spiritual support.

The prevalence and cost of chronic pain in the United States continues to have a major impact on physical and mental health (Gatchel et al., 2007). Cheatle (2016) reported that in spite of diagnostic and therapeutic advances in the field of medicine, the prevalence of chronic pain continues to rise; it now affects approximately 30% of the United States population. One method demonstrated to be effective is a biopsychosocial spiritual approach to care.

Recent evidence presented at the 2016 Nutrition Society Winter Meeting (Owen & Corfe, 2017) shows compelling support for nutrition as a modifiable risk factor to promote overall well-being of mind and body. Proper nutrition and dietary recommendations for I.K. will be useful for reaching a healthy weight and preventing muscle degeneration.

I.K. reports feeling "lonely" on a continuum. Social support has the potential of buffering stress and anxiety, along with alleviating feelings of loneliness (Ozbay et al., 2007). Social support systems are currently limited to I.K.'s healthcare team. Her son visits on occasion or as needed for limited periods of time. Spiritual, psychological and emotional care is ongoing to manage I.K.'s depression, anxiety, and feelings of loneliness.

English is also not I.K.'s first language, a significant consideration when educating I.K. about healthcare treatments and interventions. I.K. recommends healthcare providers treating ESL patients should speak slowly, seek feedback from patients to confirm they understand medical recommendations, and consider not using automated phone messages for appointment reminders and confirmations, as these messages can be difficult for ESL patients to understand. Lack of effective communication from a healthcare provider can be quite frustrating for the elderly. Perspectives and recommendations from a pharmacist, psychiatric mental health nurse practitioner, and social worker are now presented.

Medication Reconciliation

Medication Reconciliation is defined as the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route. This medication list was obtained from the patient via telephone interview with the nurse.

- Metoprolol (Lopressor) 25 mg: 1 tablet by mouth twice daily to treat hypertension
- Propranolol (Inderal) 20 mg: 1 tablet by mouth daily to regulate heart rate
- Isosorbide Monohydrate (Imdur) 30 mg: 1 tablet by mouth as needed for chest pain/angina (history of 3 heart attacks 2000, 2010 and 2013)
- Aspirin 81 mg: 1 tablet by mouth daily
- Clopidogrel (Plavix) 75 mg: 1 tablet by mouth daily in the morning
- Rosuvastatin (Crestor) 20 mg: 1 tablet by mouth daily
- Fenofibrate (Tricor) 48 mg: 1 tablet by mouth daily
- Duloxetine (Cymbalta) 60 mg: 1 capsule by mouth daily in the evening
- Lorazepam (Ativan) 1 mg: 1 tablet by mouth nightly at bedtime and as needed for anxiety up to 3 times daily
- Zolpidem (Ambien) 10 mg: 1 tablet by mouth nightly at bedtime for insomnia

- Pantoprazole (Protonix) 40 mg: 1 tablet by mouth daily in the morning
- Solifenacin (Vesicare) 10 mg: 1 tablet by mouth daily
- Methimazole (Tapazole) 5 mg: 1 tablet by mouth twice daily (overactive thyroid with history of significant weight loss in 2020)
- Denosumab (Prolia) 60mg: inject subcutaneously every six months
- Fluticasone (Flonase) 50 mcg: 2 sprays daily
- Docusate (Colace) 100mg: 1 capsule by mouth twice daily or as needed
- Calcium Carbonate/Vit D3 (Caltrate Gummies with D-3) 500 mg/800 IU: 1 gummy by mouth twice daily
- Vitamin D-3 1,000 IU: 2 capsules by mouth twice daily (2021 labs D-3 extremely low)
- Vitamin B-12 1000 mcg: 1 tablet by mouth daily
- Preservision capsule: 1 capsule by mouth daily (history of macular degeneration)
- Biotin 5,000 mcg: 1 capsule by mouth daily

Pharmacotherapy Discussion

Review of I.K's medication list presents several opportunities for improvement. I.K. reports concurrent use of two different beta blockers for different purposes. This most likely represents the involvement of two different prescribers that are not aware of the duplicate prescriptions. The involved prescribers as well as the patient's PCP (if not one of the prescribers) should be made aware of the duplicate prescription. I.K. should be evaluated for greater than intended therapeutic response (hypotension, orthostasis, bradycardia, fatigue, hypoglycemia, altered mental status (Khalid et al., 2020). Beta blockers, like most blood pressure-lowering medications, pose a fall and corresponding fracture risk primarily from the potential for orthostasis. A change to a single prescription, in addition to reducing the pill burden, would likely reduce the risks from accidental overdose (if the patient inadvertently takes morning medications twice in a day, for instance).

Aspirin plus Clopidogrel is dual antiplatelet therapy (DAPT), which is typically recommended only for up to 12 months after an intervention following a cardiac event to limit bleeding risk (Lee et al., 2013). I.K. reports her last cardiac event was over seven years ago in 2013. The bleeding risk from DAPT is further increased by the concurrent use of Duloxetine. The intended duration of DAPT and current indication should be verified with I.K.'s cardiologist and PCP.

In 2013, the FDA required labeling for Zolpidem products to recommend a maximum of 5mg daily for women (Norman, et. al, 2017). At a minimum, I.K.'s initiating dose of Zolpidem should be reduced to 5mg. The use of Lorazepam and Zolpidem in patients over 65 years old, while not uncommon, is controversial. In a 2016 publication, Markota et al note, "Several major medical and psychiatric organizations, including the American Geriatrics Society, advise against using benzodiazepines or nonbenzodiazepine hypnotics in older adults." The main risk posed by these medications in I.K. is an increased likelihood of falls.

The patient's osteoporosis compounds the risks posed by a fall by increasing the likelihood and possible severity of a fracture. The patient's DAPT also increases the risk posed by a fall because of increased bleeding risk. Furthermore, I.K. is currently taking five other medications that also increase fall risk (Metoprolol, Propranolol, Duloxetine, Isosorbide Mononitrate, and Solifenacin). The duration of the fall risk posed by Lorazepam should also be considered. If chronic benzodiazepine (Lorazepam) therapy is established, discontinuation can be difficult with tapering off taking months to years. Therefore, even if I.K.'s fall risk is deemed acceptable currently, if her condition

changes and fall risk increases beyond the point where the benefit of Lorazepam outweighs the risks, it will likely be a lengthy and difficult process to discontinue Lorazepam while minimizing withdrawal effects. I.K.'s PCP is likely to have the most robust clinical picture with which to assess the risk posed by the initiation of these medications. A discussion between the patient, her PCP, her psychiatrist, and her pharmacist is recommended to discuss the potential benefits and risks prior to taking any action.

Calcium carbonate is poorly absorbed in patients taking proton pump inhibitors (PPIs), such as Pantoprazole, as PPIs inhibit gastric acid secretion and calcium carbonate requires a highly acidic environment for full dissolution. Calcium citrate is the preferred salt form for calcium supplementation in patients taking PPIs because it is soluble in less acidic environments. I.K. should be advised to switch from calcium carbonate with vitamin D to calcium citrate with vitamin D for more effective calcium supplementation.

Denosumab (Prolia) can cause or worsen hypocalcemia. Calcium levels should be closely monitored. If Calcium levels remain or become low after the change to Calcium Citrate, the involvement of Denosumab should be investigated.

While the most likely source of the patient's anxiety, depression, and insomnia are a confluence of many factors unrelated to medication, Isosorbide mononitrate can cause anxiety, insomnia, and depression. Since the patient is currently experiencing these symptoms, it may be prudent to verify that the patient's frequency of use of isosorbide mononitrate has been assessed. In addition, I.K. 's psychiatrist and PCP should discuss the potential that she is experiencing side effects which could be mitigated by changing therapy without the need for additional medications to treat these conditions. A maximum frequency should be specified for isosorbide mononitrate to reduce the potential for overdose.

Methimazole is typically administered three times a day instead of twice daily. The prescriber should be contacted and the intended dosing frequency verified.

Biotin is dubiously marketed as improving the strength of hair, skin, and nails. Biotin deficiency severe enough to affect hair, skin, or nail strength is very rare outside of patients with chronic alcoholism, pregnant/breastfeeding women, or a rare biotinidase deficiency (typically identified at birth). The National Institutes of Health Office of Dietary Supplements reports that "severe biotin deficiency in healthy individuals eating a normal mixed diet has never been reported" (Mock, 2010). While biotin supplementation is unlikely to be harmful, I.K. is unlikely to receive any clinical benefit from this moderately-priced supplement.

The biggest risk that I.K. faces from side effects of pharmacotherapy, given her age and osteoporosis, is falling. Falls are responsible for significant morbidity and mortality in frail elderly patients. As discussed above, some of those risks can be mitigated by changes in medications. Several of the medications required to mitigate her cardiovascular risk may not have alternative therapy with reduced orthostasis/fall risk. Physical therapy is likely to have a positive impact on reducing I.K. 's fall risk. In addition to weekly physical therapy, exercise should be encouraged to total at least three hours per week to reduce fall risk (Sherrington et al., 2017). Exercise can also have significant benefits in anxiety, depression, and insomnia. The multidisciplinary team can play an important role in monitoring I.K. for the occurrence of side effects and monitoring her fall risk.

Psychiatric Mental Health Nurse Practitioner Discussion

Clinical assessment is essential with older adults with psychiatric disorders. Common screening tools for anxiety and depression include the Patient Health Questionnaire (PHQ) and the Geriatric Depression Scale

(GDS). These tools are tedious to administer and language-specific, and even more so for ESL patients or patients who are deaf or hard of hearing. Therefore, emoticons have been used widely for rating pain and psychometric analysis in cognitively intact elderly patients, and have possible use in screening for depression in the elderly (Tan et al., 2018).

Screening tools can assist in distinguishing bipolar disorders from other mood disorders and provide evidence leading to proper diagnosis. The Mood Disorder Questionnaire (MDQ), the Bipolar Spectrum Diagnostic Scale, and the Hypomanic Checklist (HCL-32) are the most commonly used tools, as they are easy to score and self-report. Bipolar disorders have a significant morbidity and mortality risk due to suicidal behavior; thus, in I.K. 's case it is essential that the healthcare provider assess and monitor suicidal risk and attempts on an ongoing regular basis (Stiles et al., 2018).

According to Wheeler (2014), there are three common psychotherapies that have been reported as successful in older adults with bipolar disorders. These are Cognitive Behavioral Therapy (CBT), Relaxation therapy, Interpersonal Psychotherapy (IPT), and Reminiscence and Life Review. Based on our patient case, the following therapies are recommended to support her life situation and health care needs: psychotherapy, behavioral therapy, relaxation training, biofeedback, CBT, IPT, and psychoeducation.

Evidence-based psychotherapy modalities involving treatment options for common psychiatric disorders in older adults may include psychotherapy, behavioral therapy, relaxation training, biofeedback, Cognitive Behavioral Therapy (CBT), Interpersonal Psychotherapy (IPT), and psychoeducation. The goal of therapy to treat anxiety includes symptom reduction to remission, adherence to a health care regimen, reduction in inappropriate use of primary care, and relapse prevention. The theme of therapy focuses on specific worries of the older adult such as self-reports about health status and feelings of loneliness. These specific therapies have evidence-based Complementary and Alternative Medicine (CAM) modalities which include Kava, yoga, mindfulness-based stress reduction (MBSR), guided imagery, biofeedback, rosemary and lavender essential oils, and music therapy (Wheeler, 2014).

Treatment options for bipolar disorders have specific goals of therapy which include healthcare management, enhancing quality of life, optimizing adherence to medications, and achieving remission. The focuses of therapy include skills of daily living, maintaining meaningful relationships, health status, substance use management, and coping skills. Evidence-based psychotherapy modalities include psychoeducation, psychosocial skills training, CBT, and family therapy (Wheeler, 2014). As a resource to the patient, it is suggested that the Depression and Bipolar Support Alliance (dbsalliance.org) can serve as a successful community support group for patients and their family members who are dealing with bipolar disorders. Additionally, in Stiles et al.’s integrative review, it was discussed that more women than men diagnosed with a bipolar disorder were more likely to experience insomnia and hypomania. Therefore, it is highly critical to integrate interventions to help reduce suicidal ideation and suicide attempts with cognitive behavioral therapy which has been shown to decrease self-injurious behaviors.

Due to the patient's age and comorbid condition of septic kidney disease, polypharmacy can present a challenge and a solution for the psychiatric mental health nurse practitioner. Although polypharmacy is often used in management of psychiatric disorders, there is very poor evidence of its efficacy (Shrivastava et al., 2019). If medications are being considered for this patient, it is essential that there are clear indications, well-defined therapeutic goals, and evidence-based reasoning. The provider needs to evaluate whether polypharmacy enhances clinical outcomes or whether it

promotes adverse effects when considering prescribing medications for this client. Regular reassessments are important when adding, continuing, or stopping medications.

Social Worker Discussion

Little has been published on the social support needs of elderly populations since the early 2000's, and most of those publications are meta-analyses. From a social psychology perspective, future research is indicated to assess the unique social support needs of the elderly during a pandemic or other global crisis. In the case of I.K., she craved social support, and oftentimes battled moments of loneliness, despair, and hopelessness. To minimize psychosocial distress and maximize care, healthcare providers are encouraged to assess individual social support needs. Social isolation is reported as being the most contributing factor to all-cause mortality in older adults (Finset et al., 2020, p. 875).

A systematic overview of the literature by Leigh-Hunt et al. (2017), highlights that there is consistent evidence linking social isolation and loneliness to worsened cardiovascular and mental health outcomes. Social isolation and loneliness should be considered as important upstream factors impacting morbidity and mortality due to their effects on cardiovascular and mental health (Leigh-Hunt et al., 2017). I.K. reported suicidal ideation during the pandemic. I.K. was immediately referred to her psychiatrist by the nursing staff. According to Raffaelle et al., (2019), social isolation is strongly associated with suicidal outcomes, and that objective and subjective social isolation should be added in suicide risk assessment. The main social constructs associated with suicidal outcomes were reported by Raffaele et al. as marital status (being single, separated, divorced, or widowed) and living alone.

Spiritual Care Discussion

In 2016, the Spiritual Care Association released the first of a series of foundational documents describing the evidence for spiritual care in health care and why it is important (https://spiritualcareassociation.org). The Spiritual Care Association is an international leader in promoting evidence-based knowledge for spiritual care. Awareness assists in meeting the unique spiritual needs of others (Sweat, 2017). I.K. found comfort in watching church services on television, attending service face-to-face when possible, reading scriptures, and talking with others about faith beliefs.

Conclusion

Recommendations for future studies in the care of elderly clients living alone is indicated. Biopsychosocial needs should be adequately assessed as it relates to culture sensitivity, ethnic backgrounds and English as a second language. As healthcare providers, individually and collectively, we improve the quality of care (Diggins, 2017). As we communicate and collaborate in our various roles, there is opportunity to improve best practices from an interdisciplinary approach.

“Personal stories of illness give depth to otherwise clinical descriptions of diagnosis”, (Kiser-Larson, 2017, p. 88). I.K.s personal story explained physical, psychological, emotional, and social pain from her perspective. I.K.s story allowed the nurse interviewer to collaborate with her PCP and other members of the interdisciplinary team to intervene with a plan of care best suited for I.K. For example, referral for weekly in-home visits by a registered nurse, referral to neurologist, physical therapist and pain management clinic to address chronic neck and back pain, follow up appointment with endocrinologist, ongoing care and consultation with psychiatrist, new labs and diagnostic studies, ongoing pharmacologic management of chronic neuronopathic pain, etc.

I.K. reinforced the importance of clearly articulating healthcare instructions to patients, especially to those with English as second language. Reaching automated clinic

lines, or retrieving home phone messages from clinic personnel who speak too rapidly or unclearly, increases anxiety and frustration as reported by I.K.

References

Cheatle, M. D. (2016). Biopsychosocial approach to assessing and managing patients with chronic pain. *Med Clin N Am 100*(2016) 43–53. https://doi.org/10.1016/j.mcna.2015.08.007

Diggins, K. (2017). Advanced Practice Nursing (APRN): A Nurse first and foremost. *Journal of Christian Nursing 34*(2), 78.

Finset, A., Bosworth, H., Butow, P., Gulbrandsen, P., Hulsman, R. L., Pieterse, A. H., Street, R., Tschoetschel, R., & van Weert, J. (2020). Effective health communication: A key factor in fighting the COVID-19 pandemic. *Patient Education & Counseling, 103*(5), 873–876. https://doi-org.libproxy.boisestate.edu/10.1016/j.pec.2020.03.027

Gatchel, R. J., Peng, Y. B., Peters, M. L., Fuchs, P. N., & Turk, D. C. (2007). The biopsychosocial approach to chronic pain: Scientific advances and future directions. *Psychological Bulletin, 133*(4), 581–624. https://doi.org/10.1037/0033-2909.133.4.581

Healthy Nutrition for Older Adults: Professional Caregiver Webinar. Retrieved from *American Society on Aging*. January 2021. https://www.asaging.org/web-seminars/healthy-nutrition-older-patients.

Khalid M. M., Galuska M. A., & Hamilton R. J. (Updated 2020 Nov 21). Beta-Blocker Toxicity. In: StatPearls. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK448097/

Kiser-Larson, N. (2017). The experience of intense pain, nursing management and interventions. *Journal of Christian Nursing 34*(2), 88-96.

Lapid, M., Koopmans, R., Sampson, E., Van den Block, L., & Peisah, C. (2020). Providing quality end-of-life care to older people in the era of COVID-19: Perspectives from five countries. *International Psychogeriatrics, 32*(11), 1345-1352. doi:10.1017/S1041610220000836

Lee, M., Saver, J. L., Hong, K. S., Rao, N. M., Wu, Y. L., Ovbiagele, B. (2013). Risk-benefit profile of long-term dual- versus single-antiplatelet therapy among patients with ischemic stroke: a systematic review and meta-analysis. *Annals of Internal Medicine, 159*(7):463-70. doi: 10.7326/0003-4819-159-7-201310010-00006

Leigh-Hunt, N., Bagguley, D., Bash, K., Turner, V., Turnbull, S., Valtorta, N., & Caan, W. (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness. *Public Health, 152*, 157-171. https://doi.org/10.1016/j.puhe.2017.07.035.

Lloyd, N. (Director). (2016). *Malnutrition: A Hidden Epidemic in Older Adults* (Short film). Allegiance for Aging Research. https://www.agingresearch.org/press-release/malnutrition-a-hidden-epidemic-in-older-americans/

Markota, M., Rummans, T. A., Bostwick, J. M., & Lapid, M. I. (2016). Benzodiazepine use in older adults: Dangers, management, and alternative therapies. *Mayo Clinic Proceedings, 91*(11):1632-1639. doi:https://doi.org/10.1016/j.mayocp.2016.07.024

Mock, D. M. (2010). Biotin. In: Coates, P. M. et al. (Eds). *Encyclopedia of Dietary Supplements*. (2nd ed). London and New York: Informa Healthcare, pp. 43-51.

National Hospice and Palliative Care Organization. https://www.nhpco.org/about-nhpco/

Norman, J. L., Fixen, D. R., Saseen, J. J., Saba, L. M., & Linnebur, S. A. (2017). Zolpidem prescribing practices before and after Food and Drug Administration-required product labeling changes. *SAGE Open Medicine, 5*, 1-5. https://doi.org/10.1177/2050312117707687

Owen, L., & Corfe, B. (2017). The role of diet and nutrition on mental health and wellbeing. *Proceedings of the Nutrition Society, 76*(4), 425-426. doi:10.1017/S0029665117001057

Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan, C. A., Charney, D., & Southwick, S. (2007). Social support and resilience to stress: from neurobiology to clinical practice. *Psychiatry, 4*(5), 35–40. PMID: 208060328

Raffaella, C., Ferrari, C., Brittner, M., Oasi, O., Olié, E., Carvalho, A. F.,& Philippe, C. (2019). Suicidal thoughts and behaviors and social isolation: A narrative review of the literature. *Journal of Affective Disorders, 245*, 653-667. doi.org/10.1016/j.jad.2018.11.022.

Sherrington C, Michaleff, Z. A., Fairhall N., Paul, S. S., Tiedemann A., Whitney J., Cumming R. G., Herbert, R. D., Close, J. C. T., & Lord, S. R. (2017). Exercise to prevent falls in older adults: An updated systematic review and meta-analysis. *British Journal of Sports Medicine, 51*(24):1750-1758. doi: 10.1136/bjsports-2016-096547.

Shrivastava, A., De Sousa, A., & Lodha, P. (2019). Polypharmacy: A challenge for community psychiatrists. *Psychiatric Times, 36*(8), 25. Retrieved from https://www.psychiatrictimes.com/view/polypharmacy-challenge-community-psychiatrists

Stiles, B. M., Fish, A. F., Vandermause, R., & Malik, A. M. (2018). The compelling and persistent problem of Bipolar Disorder disguised as major depression disorder: An Integrative Review. *Journal of American Psychiatric Nurses Association, 24*(5), 415-425. doi: 10.1177/1078390318784360

Sweat, M. T. (2017). FAQs in spiritual care: How do nurses implement spiritual care for caregivers? *Journal of Christian Nursing*, *34*(2), 128.

Tan, L. Toh, H. J., Sim, L. K., & Low, J. A. (2018). Sensitivity and specificity analysis: Use of emoticon for screening for depression in elderly in Singapore. *Journal of American PsychiatricNurses Association*, *24*(5), 452-456. doi: 10.1177/1078390318766665

Wheeler, K. (2014). *Psychotherapy for the advanced practice psychiatric nurse: A how-to guidefor evidence-based practice.* 2nd Ed. New York, New York: Springer Publishing Company, LLC.

World Health Assembly. (2020). https://www.who.int/health-topics/palliative-care