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Facilitating Positive Outcomes in Older Adults with Wounds

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Older adults represent a significant portion of the wound care population. The number of individuals with wounds is anticipated to increase as the United States population ages. In 2002, 1 in every 12 Americans was at least 65 years of age, which totals approximately 35.6 million people. It is estimated that by 2030, this number will reach 71.5 million [1,2]. People who reach 65 years old have a life expectancy of an additional 18.1 years (19.4 for women and 16.4 for men). The population of oldest old, those 85 years of age or more, is increasing at the fastest rate and will increase to approximately 2.5% of the population by 2030 [2]. At that time, being more than 100 years old will be common, and we will have a large number of people in their 90s.

Older adults are different than younger people. More than 80% of seniors have at least one chronic condition, and 50% have at least two [3]. Additionally, they experience vision loss, hearing impairment, decreases in physical function, and alterations in cognition [4]. Although a small percentage of people live in long-term care facilities, most older adults live in the community. Their goal often is not to increase longevity but to have a good quality of life [5]. Women outlive men, and many women live alone. Between the ages of 65 and 74, approximately 13.8% of men and 30.6% of women live alone, whereas, beginning at age 75, 21.4% of men live alone, as do 49.4% of women [2]. The financial resources of many older people are constrained because they live longer than they had planned, and often, financial needs exceed their income. In fact, the income of more than half of

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America's older people is severely limited; 31.5% live on $830 or less per month, and 21.4% receive between $830 and $1250 per month [1]. It is hard to imagine how older persons can stretch such a budget to include wound care costs.

The size of the population of older adults with wounds is difficult to estimate. Of the 41 million surgical procedures performed in the United States, 36% of them are performed on person 65 and older [6]. All of these individuals experience healing needs. Diabetes is present in 8.6 million persons who are 60 years of age or older [7]. Approximately 15% to 20% of persons with diabetes will be hospitalized for a diabetes-related wound in their lifetime [8]. Venous disease is seen in approximately 2% of the population, and although venous disease often begins in younger persons, the prevalence peaks at age 60 to 80 [9]. New onset pressure ulcers are estimated to occur in up to 29% of long-term care patients [10], and the incidence in acute care is variable, occurring in 5% of blacks and 15% of whites, in a large multisite study [11]. Thus, there are significant wound care needs among older people.

When possible, health care professionals expect the older person with a wound to understand wound care issues, participate in decisions about wound care, as well as all aspects of their physical care, and, if the wound is located in an accessible area, to actually perform their wound care. Their participation is modulated by a number of factors, including their ability to understand instructions and make decisions, their physical capacity for self-care, and their personal goals and how important the wound care is in their overall life, and whether they are receiving care in the hospital, a long-term care facility, or the home. Consideration also must be given to whether the wound is able to heal, how to maximize quality of life, and to balancing aggressive wound care with palliation. When the patient is unable to make decisions, understand the plan, or perform the wound care, then the expectation is that the family or designated decision maker will participate in wound care-related planning and implementation.

The expectations that older people will understand wound care issues and choices of treatment available to them, and participate in wound care decisions and physical care as well as have personal goals for their life are not different than for younger individuals. Yet physiologic changes associated with aging require health professionals to consider additional parameters. Older persons heal at a slower rate and are at increased risk of infection and dehiscence. Their understanding of wound-related issues may be modulated by decreased sensory ability, for example, loss of hearing and decreased vision. Information processing may be impaired because of temporary or permanent cognitive changes. Alterations in functional status may limit wound self-care. Most care is driven by an individual clinician's experience, because research in this area is sparse. Application of existing knowledge about older persons specifically to the care of wounds is limited.