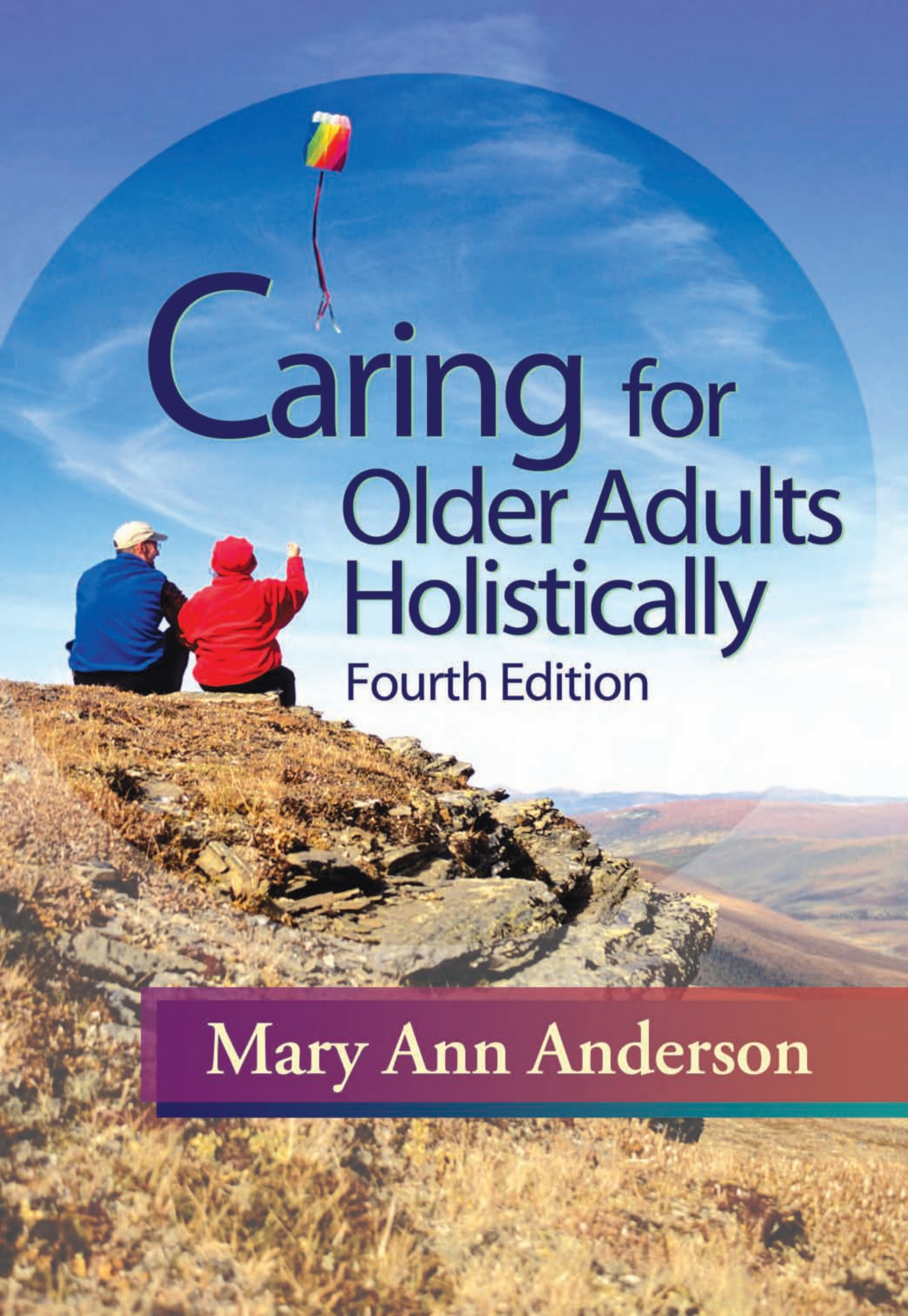
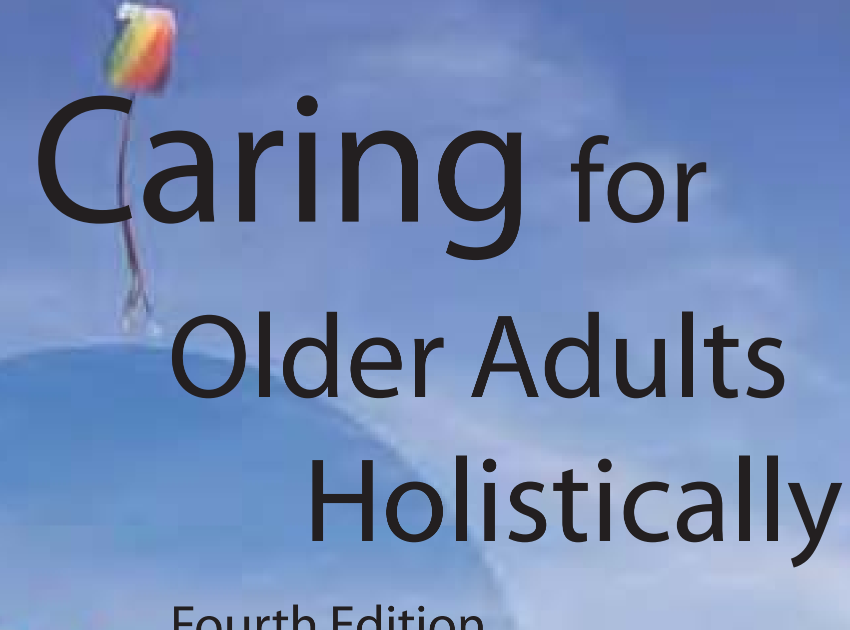

Caring for
Older Adults
Holistically
Fourth Edition
Mary Ann Anderson



Caring for Older Adults Holistically

Fourth Edition

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This book is dedicated to Joanne Carlson, MSN, APRN. Joanne had written the test section of several of my books, but was unable to finish the test bank for this edition. Joanne died tragically as the result of a violent crime just before this book's deadline. She was intelligent and kind and had an infectious laugh. She was a person who truly lived the concepts of caring shared in this text. My love to her children, Rachel and Trevor.

Preface to the Fourth Edition

What a wonderful time to be a gerontological nurse! There are more and more older adults who are better educated, healthier, and older than ever before in our history. The complexity of skills necessary to care for these exciting and interesting older people can be daunting. This fourth edition is my effort to assist licensed practical (LPN) and vocational nurses (LVN) in giving the care essential for this growing population of people—the wise and wonderful older persons who live in our society.

This edition of *Caring for Older Adults Holistically* has four new chapters that address additional skills and knowledge necessary to giving excellent gerontological nursing care:

Holistic Caring (Chapter 1) — This chapter is based on Dr. Jean Watson's nursing theory, *The Science of Human Caring*. Her theory is explained in an immediately applicable way and is used throughout the book. In addition, the concept of holistic care is defined, with multiple examples of its application. A major effort has been made to level this content to the needs of an LPN.

Nutrition for Older Adults (Chapter 6) — With people living to be older and older, new information is available regarding their nutritional needs. This chapter addresses the age-specific nutritional needs of people over age 65 years and supports it with current research presented in an easily understandable way. This chapter introduces the student to the U.S. Government's *MyPyramid* Web site about nutrition and asks for personal work to be done by the student through the Web site. The idea is that if students understand nutrition for themselves, then it is easier to apply this information to patients and residents.

Culturally Specific Care (Chapter 7) — Because minority cultures are growing at a rate unprecedented in our history, it is essential to be familiar with the ethnic and culturally specific care individuals need. This chapter introduces the student to five major cultures that are present in this country. There is a brief history and information pertinent to older persons from each culture. The purpose of this chapter is to assist the student with identifying the general differences among people based on culture and ethnicity. The chapter is filled with stories that are excellent examples of the complexity of culture and the caregiver's responsibility to respond to cultural needs.

Activity, Rest, and Sleep as Criteria for Health (Chapter 8) — These critical aspects of health are essential to understand in order to provide the specific care that older adults require. Older people are challenged in their quest for improved health because of physiological changes that occur naturally as they age. LPNs need to know about the specific changes, the demands they put on the aging body, and how to intervene to promote optimum health.

To the basic structure of each chapter I have added two more learning tools. Because of the necessity for LPNs to be able to set priorities, each chapter has a priority setting section. It points out the highest priority item addressed in the chapter and my rationale for selecting it as a priority. This is designed to introduce students to the concept of priority setting and to give them an example of the process. The second addition to the chapters is the Focused Learning Charts. They are visual representations of a concept in the chapter that is challenging to understand. These learning maps are bright and colorful and are designed for easier comprehension.

Each chapter has been reviewed and revised to keep the content current and applicable to daily nursing practice. One of my delights in the book is the new pictures. I had so much fun traveling from place to place with the photographer, taking pictures of wonderful older people. What I found were active, happy, and healthier older adults. The improved aging of people over age 65 is portrayed in the pictures in this book.

I have retained the critical thinking exercises in each chapter. These exercises are written to be used as homework to be submitted on the day of class (this requires the student to come to class prepared for the discussion) or to be completed after the class session. They also can be used as "think" pieces that will enrich class discussion. I also have retained the Points of Interest feature of the book. This is simply what it says: something interesting and unique to know about the chapter content. At the end of each chapter, the case studies and the multiple-choice study questions also have been retained and updated.

The instructor's guide has been updated with interesting teaching suggestions that promote critical thinking, diverse learning activities, and a diversified test bank. This edition has retained its personality of being easily readable and immediately useful to students.

Acknowledgments

I sincerely appreciate Alan Sorkowitz, of Alan Sorkowitz Editorial Services, the developmental editor for this book. Alan and I have done six books or editions of books together, and we seem to be a wining team. I could not have prepared this manuscript without his creativity, sense of organization, and patience. I also am touched by the professional and caring nurses who responded to the call to write, rewrite, and update the information in this book.

Gratitude also needs to be expressed to Travis Ravsten, the artist who developed the book's Focused Learning Charts. I was skeptical about using learning maps in the book until I saw the beautiful work he did. Thank you, Travis. Jeff Harris is the photographer who traveled with me to nursing homes, homeless shelters, homes, and churches to get the photographs. His charm brought out the best in those in front of the camera. I also appreciate the excellent ideas and support of Lisa Deitch, acquisitions editor at F. A. Davis.

I would also like to thank the following individuals for their contributions to previous editions: Sister Rose Therese Bahr, Colleen Brill, Kay Martin Grott, Pamela E. Hugie, Vivian J. Koroknay, Mary Lou Long, Jeanne Robertson Samter, Yvonne A. Sehy, Mary McCarthy Slater, Elaine Tagliareni, and Verle Waters.

My most important acknowledgment is to those people who have the courage to grow old and have done it so well. I have spent my life learning from those older than myself, and I am grateful for the lessons that have been patiently taught to me about life and living. I hope I have done justice to the lessons taught as I have written this book.

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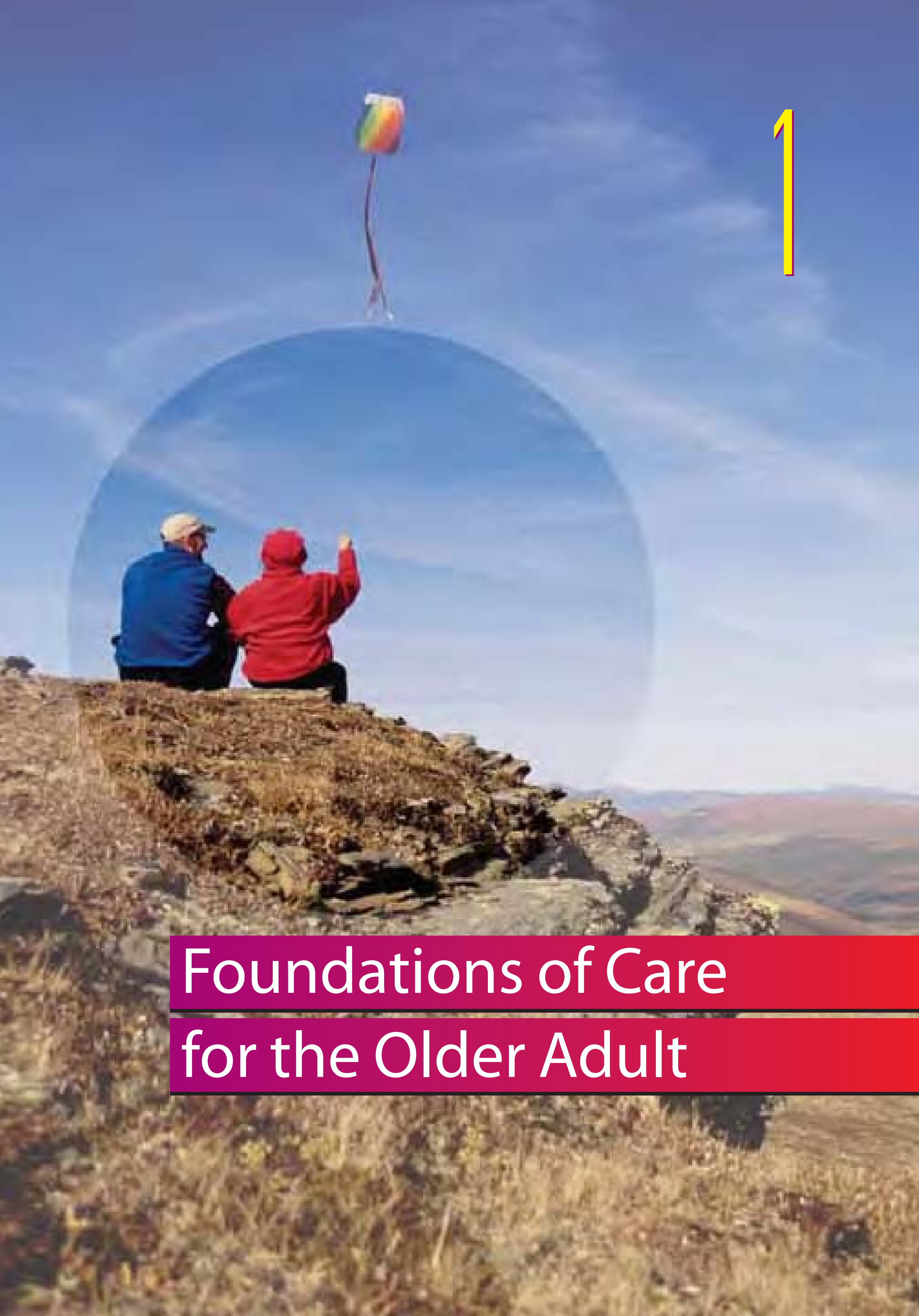


1

Foundations of Care for the Older Adult

1

Holistic Caring

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Define gerontological nursing.
2. Discuss the current demographics of people over age 65 years.
3. Write a one-sentence nursing philosophy.
4. Define the word *holism* as it relates to gerontological nursing.
5. Discuss the theory The Science of Human Caring by Dr. Jean Watson as it relates to clinical practice.
6. Describe five examples of how you, as a novice nurse, can use Watson's theory as you give nursing care to older adults.

Welcome to gerontology! This is where you will learn information and skills that will assist you in being successful in all areas of nursing. "How can one class touch all segments of health care?" you may ask. "How" is by the simple growing number of persons over age 65 who are living instead of dying. Caring for them is what gerontology is by definition. This country's growing number of older adults need, and will continue to need, health care because of the normal consequences of aging as well as the acute and chronic diseases that occur in all age groups.

GERONTOLOGICAL NURSING

If you are a gerontological nurse, you are guaranteed a future in nursing, because older adults are the fastest growing population in the United States. There are elderly people in home health settings, hospitals, homeless shelters, assisted living centers, and nursing homes. They also are more frequently present in pediatric and neonatal intensive care units as the grandparents of crack- or AIDS-infected babies whose parents are unable or unwilling to care for their ill children. You will be relating to and caring for older people throughout your career wherever you work.

Gerontology is a relatively new nursing specialty and has within it certified nurses, clinical specialists, and geriatric nurse practitioners who give care only to people over the age of 65 years. There are nurses who have a great deal of experience, as well as novice (or new) nurses just like you. Together, all of us, experienced and novice,

PRIORITY SETTING 1.1

As you enter your new profession of licensed practical/vocational nursing, you will be expected to determine priorities that relate to the person receiving care, the environment, and the health-care team, among other things. In each chapter of this book, there will be a box titled "Priority Setting." It will focus on your development as a professional and the management of the priorities of care for the elderly people to whom you are responsible as a nurse. Setting priorities is a challenge. Once you are licensed as a practical nurse, you will realize that others expect you to identify and meet the demands of patient-care priorities.

Thoughtfully read the Priority Setting boxes and work to incorporate the priorities identified into your nursing practice. Some may seem simple; others may seem a bit daunting. I want to assure you, though, that all of them are important in your role as an LPN.

Here is your first Priority Setting challenge.

The priority for this chapter is to incorporate within yourself holistic caring, as this puts you on the cutting edge of health-care delivery and transforms you into a professional nurse.

As a nurse in the 21st century, you are expected to practice the skills of this profession on the cutting edge. Holistic approaches to care that are guided by what the literature refers to as a caring ontology (caring philosophy) are on that edge. Historically, nurses have been very task oriented. Such nurses carried the notorious list I refer to later in the chapter. Once everything was checked off the list, that nurse considered his or her work completed. There is more expected in this era of nursing. Everything on the list has to be done, as "the list" contains the critical interventions that will improve the health of the person receiving care. Yet . . . it needs to be done within the framework of holistic caring.

You will need to reread this chapter if you finish it and aren't sure what the characteristics of holistic caring are. Why? Because you need to start now and work to incorporate them into your philosophy of nursing and daily practice.

- You must learn to really listen to people both verbally and nonverbally.
- You probably need to slow down. Don't rush people or even seem to be in a hurry when with a patient or the family. This is especially true of older adults, who may need to do things more slowly because of the process of aging.
- Consider the family and significant others as critical to the care you administer. They need to be involved with every stage of treatment and are a valuable source of information.
- Give your FULL attention to the individual to whom you are giving care at the moment. Consider that person's feelings, personal needs, and strong individuality while you are with him or her. Learn from the individual as you teach him or her, and respect the person for the life that he or she has lived.

These are some of the components of transpersonal caring. Learn to live this concept as you practice your art of nursing.

make a valuable team for the frail and vulnerable older adults who come to us for nursing care. In addition, many nurses have the opportunity to work with well elderly persons who are focused on health promotion. Gerontological nursing is exciting and varied, and I compliment you for being interested in this area of health care.

Early in my 40+ years of experience as a registered nurse, I chose to be a gerontological nurse. I did that at a time when gerontological nurses were thought to be lesser skilled nurses. "If they were any good, they would be working in the intensive care units (ICUs), wouldn't they?" was a common comment. Fortunately, things have changed.

Gerontological nurses have a specific body of knowledge that they must master (just like the ICU nurse) in order to be effective in their practice. For example, did you know that most elderly persons who have heart attacks do not have chest pain? Medication doses for the middle-aged person may overwhelm the systems of an elderly person with devastating results. Aging brings with it stages of life development that are different from any previous stage; gerontological nurses need to know and understand these stages. The knowledge required to give gerontological care needs to be learned, understood, and implemented in order for the elders in this society to have the best quality of life possible.

In the current health-care environment, people respect gerontological nurses for their multiple skills and abilities. If they don't, the person may be ageist, or prejudiced against older adults. This has long been a social construct of this country and is something every gerontological nurse should be willing to work toward eliminating. Who but a nursing-home nurse can pass medications to 42 residents twice in one shift without making a mistake? Who has the skill and knowledge to calm a pacing, agitated older person with dementia by using validation therapy, a communication technique specifically for demented elderly persons? I am proud to be a gerontological nurse and willingly talk to others about how wonderful my career has been because of that choice made long ago to work with older adults.

DEMOGRAPHICS OF AGING

Old age is new. I find that simple statement to be true because of my age. I actually feel the consequences of aging. I am sure many of you reading this book do not notice from week to week or month to month that you are aging. I am 59 years

This elegant woman represents the growing number of older women in this country who are living longer than older men.

old, have some chronic diseases, and feel it. Growing older is new for every person who experiences it, and it is new for our society as well. In the history of this country, there never have been so many people over the age of 65. The composition of the American population is different today from that of any previous generation.

Of course, there were old people before, but their numbers were small compared with the number of older adults who are age 65+ today. In the 2002 U.S. census, there were 35.6 million older adults, and they constituted 12.3% of the population. It may surprise you that one in eight Americans was over age 65 years in 2002. There were 20.8 million women over age 65 but only 14.8 million men. The U.S. Census Bureau (2002) also projects that the number of people who are 85+ years of age will increase from 4.6 to 9.6 million by 2030.

Compare the previous numbers with the fact that, in 1776, when the Declaration of Independence was signed, a child born in the United States had a life expectancy of 35 years. In 1930, it was 59.7 years; in 1965, it was 70.2 years. Today, the average life expectancy is 79 years for women and 72.9 years for men (U.S. Census Bureau, 2002). When an older adult reaches age 65, that person can expect another 18.1 years, or

POINT OF INTEREST

The increased numbers of elderly people in the United States has resulted in new definitions of aging. The term *young-old* is used for people 65 to 74 years old; *middle-old* is used for people 75 to 84 years old; *old-old* is used for people 85 to 100 years old; and *elite-old* is used for persons older than 100 years of age. It is necessary to define the differences for each age group because of the health needs, medication dosages, and frailty that relate specifically to each age category.

to reach 82.9 years of age. Because more women reach 65 years of age than men, there are more older women in the 85+ category. This also means there are more single older women than older men. The 65+ age group is projected to double within the next 25 years (U.S. Census Bureau, 2002). If you are a gerontological nurse, you will have a future in nursing!

NURSING PHILOSOPHY

I know the underlying reason that I love what I do, working with older adults, is because it allows me to practice within the framework of my nursing philosophy. I was educated at a Catholic school of nursing and was taught to "Serve the Sick as Though They Were Christ in Person." I embraced that philosophy and still practice it today. When I care for elderly persons in all settings, I am able to give them excellent physical and emotional care as well as to be caring. When I add holism to my caring approach, I have a successful format for delivering quality nursing care within the framework of my nursing philosophy. This book is based on the two concepts of holism and caring, and the purpose of this chapter is to share these critical concepts with you.

Have you considered what your nursing philosophy might be? As a beginning nurse, you probably have not known what a nursing philosophy is, let alone defined one for yourself. This is a personal concept that has to come from within you. At this point in your career, you may find a philosophical statement that you like, and as you obtain more education and clinical experience, it is something you may change. I have shared my philosophy with you. It is simple, specific, and has great meaning for me. These are three characteristics of a valuable nursing philosophy.

Holistic Nursing

The word *holism* or *wholism* is derived from the Anglo-Saxon root "hal," which means "whole" or "to heal" (Random House College Dictionary, 1984). Its very definition makes the word and its concepts important to the profession of nursing. When you examine the career of Florence Nightingale in your nursing history class, it will be apparent to you that she was able to integrate holistic concepts into her personal nursing practice. For example, she considered touch, light, empathetic listening, music, and quiet reflection essential components of good nursing care (Dossey, 2000). If she were not holistic, she would have considered just the soldier's wound and nothing else. You will learn that Nightingale is known as the Lady with the Lamp. This is because when the other nurses had gone to bed, she would walk through the wards at Scutari with her lamp to check on the wounded; she wrote letters for them; and she spent her own money to buy them fruit and vegetables to eat.

Holistic nursing is something Florence Nightingale practiced without a textbook or a

CRITICALLY EXAMINE THE FOLLOWING:

Ponder the idea of having a nursing philosophy to guide your clinical practice. Remember that it will change as you learn and grow in the profession. It could simply be:

1. Be kind and thorough in the care I give.
2. Always practice high-level physical and emotional care.

   I am hopeful that by the end of this book or even this chapter, you will be able to say something like the following:
3. Practice holistic nursing based on the philosophy of caring.

Write a one- or two-sentence personal nursing philosophy and put it somewhere where you will find it again. It will be interesting to read it at the end of this class or at the end of your licensed practical nurse (LPN) education. Your instructor may want to have you share your philosophy in class.

teacher to explain it to her. How did she, the Mother of Modern Nursing, capture the essence of holism with her patients in Scutari? More importantly, how do we, as modern nurses, accomplish that vision today?

The Basic Concepts of Holistic Care

According to modern writers (Savage & Money, 2003), understanding the concepts of holistic nursing is important for the practice of 21st-century nursing. It is a philosophy that weaves the demanding technical skills of nursing with the social science skills that enhance the humanity of both the nurse and the person receiving care.

The philosophy of holism, which was first formulated in the 1930s, emphasizes the importance of understanding a person's whole being rather than treating only specific parts. When someone is recovering from a total hip replacement, the person definitely wants the hip fixed and fixed properly! However, there may be other needs, such as loneliness, fear about being able to live alone again, or a misunderstanding about medications. The person needs more than treatment for the hip.

The philosophy of holistic care should put an end to comments like "the gallbladder down the hall," which ignores the person and focuses on the illness alone. A holistic identification of the "gallbladder down the hall" should be the person's name or something pleasantly descriptive such as "the grandmother who knits all of the time."

If you are a holistic nurse, you will take an active role in developing a healing relationship with the patient. This relationship focuses on the multiple needs of persons who are ill and how they can best be resolved. The critical activity to promote holistic care is listening. This approach encourages people who are sick to be more involved in their care. Listen to what has worked in the past for patients, and discuss their ideas as to what will be the best for them in the current situation. The nurse needs to provide an environment where the patient is able to make decisions that are honored by the healthcare team.

FOCUSED LEARNING CHART

Components of holistic nursing

Holistic nursing is based on the importance of understanding the whole person rather than treating parts of the person (IVs, wounds, oxygen).

Develop a Healing Relationship	Work with a Team	Excellent Clinical Skills
Unrushed time	Family, friends, and pets	Holistic communication
Truly listen	IDT	Medication administration
Determine what has worked in the past and discuss options	Other specialists	Assessment
		Bedside skills
		Management skills

Holistic nursing practice can be implemented in many ways. Here are four basic concepts:

Rule # 1: Always follow the physician's orders. If the patient refuses the treatment or medication ordered, call the doctor. That is an excellent way to validate that you are listening to the patient. Be sure to share the patient's concerns with the physician.

Rule # 2: You will develop clinical expertise; use it.

Rule # 3: Also draw on the personal intuition and creativity patients have to resolve their own health problems. You will need to consider the patients' values and life experiences when devising treatments. Remember, all of the older adults you will be giving care to are the survivors; the people who didn't die; they are strong and smart and have lived with their body long enough to know what it needs. Can you imagine telling a man who endured imprisonment and torture as a prisoner of war how to manage his postoperative pain? I wouldn't do it. Instead, I would listen to what he had to say about it.

Rule # 4: Take every opportunity to develop a closer relationship with family members and/or significant others. This is your true entry into getting support and assistance for the older person who is ill. You also will learn many things about the patient in your care.

Holistic Care Is Based on Teamwork

The holistic approach to nursing is effective when dealing with most populations, and it is an excellent way to deliver care to older adults. One of the principles of holistic care is that neither you nor the older person is alone. There always is a team of people working for the best outcome for the person needing care.

These teams will look very different for each person. Most holistic teams have family members, although that is not always true. Some have a treasured family pet—a very valuable member. Others have an entire health-care team, such as the older adult in a nursing home who has the advantage of an interdisciplinary team (IDT). This is a team of professionals, such as the dietitian, physical therapist, nurse, pharmacist, social worker, and others, who work toward the best condition for the resident. They meet at least monthly to discuss each resident, and both the resident and family members are invited to attend.

The premise is that you, the nurse, will work closely with the team members who are most

This elderly woman fell and broke her hip 10 days after this picture was taken. Her son and grandson were instrumental in her recovery. Of course, her great-grandson brought her great joy when his parents brought him to see her at the hospital and nursing home.

important to the older adult. The focus of the teamwork should be to provide care, health promotion, and, if possible, cure. This means that you will advocate for the 15-year companion, Suzie the dog, to make regular visits to the nursing home. If you have a home health patient who needs assistance with getting into bed at night, you need to work to make arrangements with family, neighbors, or friends for the necessary assistance. If the person to whom you give care has six adult children and you get calls from each one each week, you need to be grateful that there are children who are willing to be involved.

A holistic nurse doesn't wait for the varied team members to come to the nurse. Instead, it is essential to be on the lookout for any sign or mention of the people who will make a difference in the life of the older person. I remember a blind woman who was brought to the hospital for terminal care. She was brought in an ambulance, and consequently none of her personal things accompanied her. She had no children, and her spouse was deceased, but she did have a dear older friend and neighbor. One morning I entered this woman's room and found her crying. With a bit of encouragement, she told me that she missed having her pictures with her. She had several treasured photos of her and her hus-

band, and she liked to hold them and think about the wonderful life she and her husband had shared. She was blind, right? But, she still wanted those pictures! It was then that I located her neighbor, who brought her pictures to the hospital. I know that being able to hold her pictures assisted this woman in having a better quality of life before her death. It simply made her happier.

Some nurses would dismiss the need to be concerned about pictures for a blind woman, and others would not take the time to locate her friend. A holistic nurse would do both things because of the reality of caring about *every* aspect of *every* person in his or her care. Holistic care is a powerful concept and works best when complemented by the nursing theory of human caring.

HUMAN CARING

The Science of Human Caring is a nursing philosophy that was developed by Dr. Jean Watson, former Dean and Distinguished Professor at the School of Nursing, University of Colorado. Dr. Watson's theory is taught worldwide and serves as the basis of both teaching and caregiving for many of the world's nurses. Watson proclaims that a theory assists us, as nurses, to "see" what it is we do more clearly (1988). It is her hope that those studying and using her theory of nursing will see the world of health care in a "new and different lens." She wants us to be open to new ideas, based on caring, and put them into our practice as nurses.

Watson (1988) focuses on looking at the person to whom a nurse gives care as a whole human being, with attention needed for the body, mind, and spirit. This theory calls upon you, as a nurse-to-be, to use your imagination and creativity to solve problems in ways that are personal for the people to whom you give care.

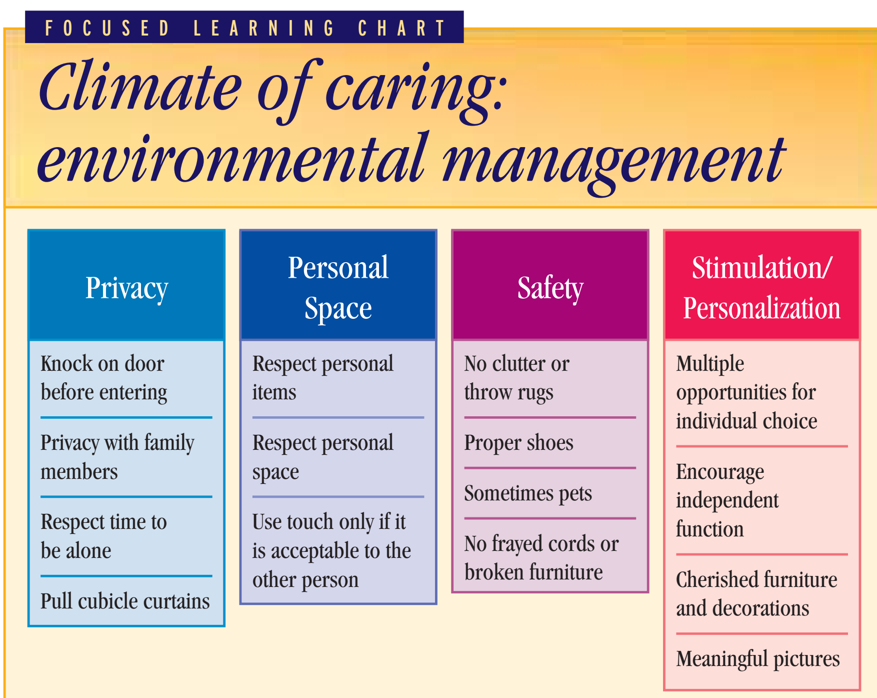
When you base your nursing care on the foundation of caring, you will:

1. View all humans as a valued person to be cared for, understood, nurtured, and assisted.
   Scenario:
   You are working in a nursing home that takes care of a variety of older adults. After a thorough orientation to the facility, which includes their philosophy of human caring, you are assigned to work on the admissions unit. This is where all new admissions go for the first 3 days to evaluate where they should be placed to receive care specifically suited for their physical and emotional needs.
   The police bring in a 76-year-old intoxicated man to be admitted. The police tell you he is homeless and an alcoholic. He is dirty, smelly, and uncooperative. His hair is matted, and his beard is overgrown and crusted with food. He has been incontinent, his eyes are bloodshot, and he is drooling. The police remove his handcuffs and quickly leave the area.
   Your faculty person may want to discuss the following questions in class. I have listed some brief comments to start the group interaction. Please think about this situation and prepare more detailed answers to the questions.
   Questions:
   - "What is the reaction many people would have about being assigned to admit this man?"

   Fear, disgust, negativism, anger.
   - "What is your reaction as an employee who is practicing The Science of Human Caring?"

   Look beyond the physical problems and into the mind and spirit of the man. This is done by understanding, by nurturing, and by assisting this human in need.
2. Place an emphasis on the human relationship and the relationship the person has with the environment.
   Questions:
   - "How can you put the relationship you have with this man as the highest priority?"

   Be gentle and quiet. Use his name (i.e., Mr. Lango, not Fred). Reach out and touch him if possible; make eye contact. There are many more things you can do. Think about the possibilities and be prepared to discuss them. Remember to use your imagination and creativity.
   "What can you do to make the environment more conducive to the needs of this person?"
   - Like you, the environment should be quiet, with minimal stimuli. Do not allow a group of people into the room. You may want one more person because Mr. Lango is drunk, but more than that will be upsetting and perhaps fearful for him. Do not rush him. Be prepared for him to be upset. Use patience.
3. The Science of Human Caring theory focuses on the human-to-human relationship. Dr. Watson refers to this as transpersonal caring. Put simply, it means that you focus on the other person while you are with him or her.


FOCUSED LEARNING CHART

Climate of caring: environmental management

Privacy	Personal Space	Safety	Stimulation/ Personalization
Knock on door before entering	Respect personal items	No clutter or throw rugs	Multiple opportunities for individual choice
Privacy with family members	Respect personal space	Proper shoes	Encourage independent function
Respect time to be alone	Use touch only if it is acceptable to the other person	Sometimes pets	Cherished furniture and decorations
Pull cubicle curtains		No frayed cords or broken furniture	Meaningful pictures

You are not thinking about the medications you need to pass or what you will do for lunch! You are thinking about the patient or resident in your care totally and completely. The focus of transpersonal caring is to promote health and healing.

Question: Treat the following as an essay question.

List three to four examples of transpersonal caring that you could use with this resident. Do not use the behaviors listed in previous answers. Instead, think of YOU and how YOU could react to Mr. Lango. Some people would need to overcome a repulsion of his external appearance; some would need to overcome their fear of a person who is drunk. You need to control these thoughts so you can focus on him. Is he frightened? Hallucinating because of the alcohol? Hungry? In pain? Does he have any wounds? Why is he drooling and incontinent? There is much for you to do to promote his healing, and it will require your entire focus to be on him.

There is much more to Dr. Watson's nursing theory, but for the moment, concentrate on the three concepts we just discussed. In summary, they are:

1. All human beings are valuable, and as a nurse, you have the responsibility to assist, nurture, and provide care for them.
2. It is essential to focus on the human relationship you have with all persons in your care, as well as their relationship with the environment.
3. Developing a human-to-human relationship is critical to being a caring nurse.

Why Study Caring?

Many nurses and other health-care providers tell me they are caring already and ask why they need to study it. I understand the question they are asking. Yet I often see acts of uncaring behavior, as demonstrated by the absence of the human-to-human connection. Here are just two examples.

Example One:

One thing I often see are nurses with lists in their hands as they move quickly from room to room to reassure themselves of the safety of their patients or residents. Many, many times I have seen a nurse go into a room and say "good morning" without looking at the person and acknowledging him or her personally. Then, with list in hand, the rushed nurse checks the intravenous solution (IV), the bladder catheter, and any dressing or wound, says "good-bye," and leaves the room. Everything the nurse did should have been done, but something very serious was missing. There was no human connection, no transpersonal caring; the nurse was not at all holistic in his or her approach.

Notice how this LPN is touching the resident as well as looking directly into her eyes. She is down to the resident's level so the resident can both see and hear as the LPN talks to her. What else does the LPN's nonverbal communication tell you?

How could the same things (checking critical items) be done in a caring mode? First, on the same list with the IV and dressing information should be the person's name. Note it as you go into the room and use it. My personal rule of thumb is to use Mr. or Mrs. the first time I meet an older person. Then, if individuals ask me to use their first names, I do, but only if invited to do so. This is a respectful way to communicate. Look the person in the eye as you say "good morning." Really look at the person's face and see if it has good color, if there are grimaces from pain, or if the person seems sad or depressed. When you get close enough to the person, reach out to touch an arm or a hand if it seems appropriate. This demonstrates an effort to use transpersonal caring, and it also gives you the opportunity to feel if the skin is dry and hot or cold and clammy. Some of these things can be done while you are walking into the room, and none of them take any extra time. Once you have connected with the person (human-to-human connection), you can check the IV, the wound, and the catheter. Then lean close so the older person can both see you and hear you, and tell the individual "everything is all right," or "I need to check with the registered nurse (RN)," or whatever is appropriate. Be honest and pleasant in all of your communications. Let the person know approximately when you will return.

Example Two:

Once when I had students at the local homeless center for clinical experience, an elderly man came into the center complaining of severe pain in his right shoulder. The other faculty person and I sat him down and removed his coat, which caused him a great deal of pain. We had a student take his vital signs and carefully role-modeled acceptance and concern for this dirty and disheveled person. The decision was made to call the paramedics, as his pain was severe.

From the moment they came through the door, the two young, male paramedics who came to the center could be heard complaining about being there. Their comments were something like, "This will just be some old bum who wants a hot meal and a bed for the night." They obviously were not happy. I introduced them to the gentleman with the shoulder pain, and the paramedics roughly took off his shirt so they could examine it. This action caused a great deal of pain for the older man. At this point, I intervened. I asked the paramedics to step around the corner with me. They knew I was a faculty person and willingly obliged me. I shared with them my point of view about valuing all people, respecting the elderly, and the standards of professional behavior (which they seemed to have forgotten). They were a bit shame-faced when they returned to the elderly man, but they carefully assessed his shoulder and determined it

POINT OF INTEREST

When speaking to older adults, some people address them as "honey," "dearie," or "sweetie." This is an example of the caregiver treating the patient or resident as a child. It is called paternalism. Think for whom those comments are generally reserved; it is children. You may hear others use such terms, but you should talk to gerontological patients as the older adults they are rather than as children. It is a matter of respect.

POINT OF INTEREST

One of the basic concepts of pain management is that the level of pain is whatever the person says it is. It is common to ask the person with pain to rate it on a scale of 1–10. Ten should be considered the worst pain imaginable, like a leg amputation without anesthesia. It sometimes happens that nurses decide the pain is not as severe as the patient states it is. This is not the nurses' role. You need to care about and work to understand the pain as the patient describes it. Then work with others on the health-care team to manage the pain effectively.

was broken by the way it was hanging. That older man was genuinely in pain and deserved to be treated with the highest level of professional care. Truly caring behavior cannot allow prejudice, negative judgments, or disdain into the relationship.

Expanding the Concept of the Science of Human Caring

To truly be a caring person, as defined by Watson, you need to use her principles in all aspects of your life. I do not know your personal or family environment, but I do know you can choose to behave in any way you wish. I have been screamed at by family members of older adults, but I never scream back. I simply let them "get it out." While they are screaming, I observe them and really listen to their words so I can understand the problem. When the screaming is done, the person generally is crying with sorrow or fear. I keep in mind that there is "a reason for every behavior," and I consider it my responsibility to learn the reason for the behavior before I react.

This one application of caring theory in your personal life will improve your ability to relate well to the people you care for the most. Other examples are to really listen to people when they are talking and respond thoughtfully. Caring people "get into it" and help others when they need it. This could mean to cook a meal for a sick neighbor, work with the community to make a vacant lot a safe play area, or tell your mom you love her. (Being a mom, I really like that idea!) I am simply saying that to be a caring nurse, you need to be a caring person, too.

CRITICALLY EXAMINE THE FOLLOWING:

Take 5 minutes to think about nothing except how you feel about people with lesser resources for health care. What I mean by that term is those people without insurance, people who live at or below the poverty level, people who do not speak English, homeless people, and/or people with disabilities. These groups of people are often referred to as marginalized people. That means they are on the "margin" of society and not really in it. Their situations can be somewhat desperate, as with the man with the broken shoulder in Example Two. Can you honestly value each person to whom you give care? Are you willing to use transpersonal caring in your health-care delivery to everyone? Are you willing to make the human-to-human connection with every individual who counts on you for safety and care?

After you have thoughtfully considered how you feel about these questions and any others that come to you, discuss your thoughts with others. They could be classmates, friends, or family. It is an intriguing topic of conversation if you approach it earnestly.

CONCLUSION

I am confident that you can see how holism and caring complement each other. If you are caring, you look at the body, mind, and spirit of the person. If you are holistic, you are looking at the entire person. Both approaches look at how the environment affects the person and work with the individual to make the environment more healing. Family members and other loved ones are also essential to delivering both types of nursing care. There is much more to both of these concepts. My goal is for you to have an understanding of the basic principles of each approach to nursing care. Then it makes sense for you to discuss, think about, and put into practice the things you have learned. If you can gradually incorporate the material in this chapter into your daily caregiving, you will be the type of nurse you would want to take care of the people you love most. Best wishes for the journey!

CASE STUDY

You have been out of school for 1 year, and although you have learned a great deal as you have been working, you are aware there still is much to learn. You enjoy your job at the Country Meadows Nursing facility, where you work full time on the day shift. It is a bright, open place that actually is surrounded by country meadows.

You work on the locked Alzheimer's Disease (AD) Unit and have learned to love the residents there. Even though there is a great deal of agitated behavior, you understand the phrase, "There is a reason for every behavior." This is because you take the time to carefully observe and listen to residents to understand what is going on inside their minds. Then you act on what you have seen and understood. You seem to do this naturally, based on your knowledge of holistic and caring nursing care, and have received compliments from your nurse manager on your skills.

The nurse manager has hired a new certified nursing assistant (CNA), and she has asked you to orient him to your philosophy of care for persons with AD. You have worked with him for two shifts and are concerned about some of his behaviors. You have noticed the following:

1. He consistently calls the residents "honey," "dearie," and "sweetie."
2. He is impatient when the residents are slow in walking, eating, or asking for things.
3. He refuses to learn their names.
4. You noticed one resident who did not have her glasses on or teeth in, and it was 10:00 a.m.
5. He actually got into an argument with an older man who was confused and wanted to leave the building.
6. He does not listen to you or treat you with respect.

Make a narrative summary of your thinking regarding the following questions. Be prepared to submit your answers to your faculty person. Add more ideas and comments to your paper than what is listed in the solution. Apply the principles you read in this chapter. Expound on the list noted in the solution. Use it as a foundation of thinking only.

How does the CNA's behavior conflict with your holistic and caring philosophy?

What are you going to do about the problem?

Solution

How does the CNA's behavior conflict with your holistic and caring philosophy?

It seems that he has not embraced either concept into his caregiving, even after you have role-modeled and discussed appropriate behaviors for him.

1. He is not respectful. Examples are the "cutsie" names he uses rather than learning the residents' names and his disrespect toward you.
2. He does not listen. An example is the argument he got into with a demented resident. If he would have listened to the resident, he would have understood the "reason behind the man's behavior."
3. He is not caring. An example is his impatience with the slowness of older persons.
4. He does not give good technical care. This CNA not only is NOT caring or at all holistic, but he doesn't give good physical care! We know this because of the glasses and teeth that were not in place by mid-morning.

What are you going to do?

It is only day 2 and there already are many problems with this employee. You are a relatively new LPN, but you know how nursing care should be delivered. His care is dangerous. What if he got into another argument with a resident and hit the person? It is a serious point of concern.

You have role-modeled for him and tried to explain things to him, yet he hasn't changed. This indicates that he doesn't want to change and, therefore, probably won't. His lack of respect for you also is a point of concern in terms of how decisions are made on the unit. There will be many times when he will need to do what you tell him to do. You must question if he actually will do what you ask. Again, this puts residents at risk.

You should carefully document his actual behaviors, both positive and negative. Then make an appointment with the nurse manager BEFORE he comes to another day of work. Carefully and objectively explain everything to her and leave the decision as to what to do with her. If she asks you to assist in continuing to evaluate or teach him, do as you are asked in a caring manner. If the CNA is terminated, that is the responsibility of the nurse manager and not you.

STUDY QUESTIONS

Select the best answer to each question.

1. Gerontological nursing refers to the nursing care of:

- **a.** the "old-old" population.
- **b.** people who are older and in need of assistance.
- **c.** those age 65 and older.
- **d.** a specialized body of knowledge regarding holistic and caring principles of nursing.

2. Older adults constitute:

- **a.** 12.3% of the U.S. population.
- **b.** 8.4% of the population.
- **c.** 25% of the population.
- **d.** 10% of the population.

3. The underlying concept of holism is:

- **a.** to include family and pets in the care plan.
- **b.** to enhance the humanity of both the nurse and the person receiving care.
- **c.** to identify team members who will make the nursing care easier.
- **d.** to look at the patient's face and note how he or she looks.

4. The purpose of a nursing philosophy is to be able to:

- **a.** think like a philosopher.
- **b.** have something positive to write on a job application.
- **c.** talk to other nurses about philosophy.
- **d.** have a personal conviction of the type of nursing care you will give to others.

5. The Science of Human Caring is:

- **a.** an internationally accepted philosophy of nursing.
- **b.** authored by Dr. Jean Watson, former Dean and Distinguished Professor at the University of Colorado.
- **c.** a philosophy that addresses the body, mind, and spirit of all human beings.
- **d.** a philosophy of nursing that calls for the practice of transpersonal caring.

2 The Aging Experience

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Define the term *ageism*.
2. Discuss six common theories of aging.
3. Identify age-related changes in the following body systems:
   Cardiovascular
   Respiratory
   Musculoskeletal
   Integumentary
   Gastrointestinal
   Genitourinary
   Neurological
   Special senses

INTRODUCTION

The aging experience is a significant part of both personal and societal living. Throughout most of human history, only 1 in 10 people could expect to live to the age of 65 years. Today, 80% of Americans can anticipate reaching that age or older (Eliopolous, 2005). In fact, two-thirds of all men and women who have lived beyond the age of 65 in the entire history of the world are alive today. Sometimes called "the graying of America," this dramatic change in our population has many ramifications in politics, economics, health care, recreation, and entertainment. All facets of life, not just health care, are affected by the fact that many more older adults are living today than lived in the past.

People aged 65 years and older consitute 12.7% of the population in this country — that is more than one in every eight Americans. There are many numbers I could share with you in this section of the chapter, but I find most students do not want to read demographic data unless they have to in order to pass a test. I would prefer you learn the importance of the numbers rather than just memorize them.

Here are two important pieces of demographic information that will impact your practice as an LPN:

1. The older, white population will grow more slowly than before, and in the next 40 years, it will begin to decline by comparison with African American and other ethnic minority groups. Current minority populations are projected to represent 25% of the elderly population in 2030.
2. The fastest-growing segment of the population in this country is people who are older than 85 years of age.

   Projections indicate that the size of this age group will double between 2000 and 2040. At present, there are more people having their 85th birthday every day in this country than babies being born.

THE IMPACT OF AGING ON NURSING

The great increase in the number of older people means that nursing practice must be different from what it has been in the past. Dr. Robert Butler (1969), a geriatric specialist, said that all graduates going into health-care work today will spend 75% of their working lives caring for older people. Current national statistics state that 65% of all patients in acute-care hospitals are age 65 or older, as are 83% of those in home care and 92% of those in nursing homes. Tim Porter O'Grady, a nursing futurist, said in the year 2000 that if a nurse was not preparing for a job in gerontology, that nurse was not preparing for the nursing jobs of the future. The graying of America calls for gerontologically qualified nurses who can work in diverse health-care settings.

CRITICALLY EXAMINE THE FOLLOWING:

Before reading the next section, take the time necessary to complete this critical thinking exercise. Critical thinking is an essential component of nursing. These exercises are a positive way to begin to develop that all-important skill.

How Will It Impact Your Nursing Practice to Have:

1. Increasing numbers of old-old people as your clients?
2. Increasing numbers of nonwhite, older adults as your clients?

I am going to answer the questions as though I were a student. It is hoped that this will assist you in considering how you will answer the questions. Your faculty person may request this assignment to be turned in at the next class session, or it may be used as a point for class discussion. However it is used, it is an opportunity for you to critically think and then compare your thinking with your classmates. Here are my responses:

1. When I planned on going to nursing school, I wanted to be an obstetrical nurse. I was excited to think about working in labor and delivery, and I cannot imagine anything nicer than working in the newborn nursery. However, if the population of older people, especially the very old, is growing, I need to consider working in gerontology. If that is where I am going to be because of the need for nurses, I am going to become very good at taking care of fragile old-old or elite-old people. They sound like my type of challenge!
2. I live in Utah, where 95% of the population is white. I will have an adjustment to make when my patients are not mostly white and of the same working-class, emigrant society. What I need to learn about are the cultures of other ethnic groups so I can be an effective nurse and meet their needs on a high level.

The purpose of this book is to assist you to meet that objective.

Health care has changed in various ways because of the number of people who are aging. As a group, older citizens are a very powerful political force; they have influenced the actions of Congress and the President on health-related issues and will continue to do so. A few years ago, Congress passed legislation providing insurance coverage for catastrophic medical events for those under Medicare, which added a relatively small amount to the cost of Medicare insurance paid by recipients. The new plan, however, was unacceptable to older adults, and as a result of numerous calls and letters, Congress was persuaded to rescind its legislation.

Older adults want and expect to have a say in the kind of health care they receive, where they receive it, and from whom. They are better educated than any other generation of older adults and, therefore, have the knowledge to make more sophisticated demands on the health-care system. For instance, demand is growing for home-care services from older people who need assistance and nursing care but prefer to be cared for at home.

This population of new clients in the health-care system requires you, the nurse, to consider them in a new way. Never before have nurses had to care for such a large number of older adults who have survived the Holocaust, two world wars, the Korean and Vietnam Wars, the Great Depression, and rock and roll! Because the survival experiences and life skills of these elderly people are new to health care, they require society to address them in a new way.

Home health care is one of the health-care changes that elderly people have demanded as part of their health-care options. People want to stay at home and be near family, friends, and the things that are familiar to them.

ATTITUDES TOWARD AGING

The study of aging is a very important part of nursing. Many myths, stereotypes, and prejudices about old age exist in our culture, and nurses need to be able to separate myths and prejudices from fact. Modern researchers are intently studying the aging experience (another indication of the importance of this topic in today's world). This chapter draws from their findings to represent a realistic picture of the processes and effects of aging. Myths and prejudices about old age are pervasive in our society. Browsing through a greeting card display reveals some very good examples of the stereotypes and fables of aging:

"I won't say you're old," reads one greeting card, "but in horse years, you'd be glue on this envelope."

"Happy birthday, Hot Stuff! Who says people our age can't still live in the fast lane?" reads another. The inside message: "Voila! Adult diapers with racing stripes."

As the contents of many of the cards imply, old age conjures up images of rocking chairs, dentures, memory loss, and incontinence. People laugh at the humor in the birthday cards, but a serious societal danger lurks in such negative and prejudicial images. Stereotypes, myths, and distortions concerning aging and old people lead to actions that discriminate against the aged. American culture glorifies youth. Print and television advertising, clothing fashions, and other expressions of the desirable norm all push the image of zestful youth. Because today's adults have grown up in this culture, they pick up its values and prejudices without realizing it.

One of the authors of this chapter joined a tour group led by a sincere, well-intentioned young man. He tried to exchange a friendly word with every person in the group. He spoke to a healthy-looking man, who may have been in his late 70s, in a raised voice as though he assumed that the man was hard of hearing. "What did you used to be?" he asked. After a pause, the older man replied, "I still am." The behavior exhibited by the young tour guide is an example of ageism.

POINT OF INTEREST

It was Dr. Robert Butler, mentioned earlier, who designed and defined the words *geriatrics*—the medical study of older adults—and *gerontology*—the nursing study of older adults. You need to know the definitions of both words in order to discuss gerontological issues knowledgeably.

AGEISM

The term *ageism* was coined in 1968 by Robert Butler (1969) to describe negative attitudes and practices that were directed toward the aged. He defined ageism as a systematic stereotyping of and discrimination against people simply because they are old. Ageism is very similar to racism and sexism, which discriminate against people because of skin color and gender. As a society we are outraged by acts of racism and sexism, but we seem to accept ageism as a norm for behavior. Old people are categorized as confused, rigid in thought and manner, and old-fashioned in morality and skills. Yet older adults are as individual and unique as are people of all other age groups. It simply seems easier to place them in a negative category and ignore them. Ageism allows the younger generation to see older people as different; thus, they subtly cease to identify with their elders as human beings.

In the decades since Dr. Butler first wrote about ageism, a steady improvement in attitudes toward the aged has been seen. This change partly resulted from general public education, increased attention in the media, and broadening of education about gerontology in colleges and

PRIORITY SETTING 2.1

As Robert Butler has said, you will spend 75% of your career taking care of older adults. Therefore, the priority you need to take from this chapter is that of recognizing and combating ageism. Why is that the priority I chose? Ageism is a powerful, negative form of discrimination.

Because you are going to be giving care to older adults, you need to also be their champion and assist them in combating this negative influence in their lives.

When you read Chapter 7 on culturally specific care, you will realize that many cultures revere and value their elderly citizens. In China, when an older member of the family can no longer be left alone during the day, the extended family organizes a way for one member of the family to stay home and give the necessary care to the older person. The remaining members of the family support the caregiver. That is not the societal attitude of this country.

How can you meet this priority of recognizing and fighting ageism?

- Start with becoming acutely aware of what ageist behavior is. It could be something as simple as not laughing at the discriminatory cards that mock older people and the aging process. They simply are not funny. Look for age-based discrimination. Once you can recognize it, you can begin to change within yourself if that is needed.
- Look at older adults as "wise and wonderful." They really do have the wisdom of the ages. Just think of all the problems they have solved by living in a war-torn and tumultuous world (world wars, the Great Depression). They deserve to be heard, so listen!
- Be patient with older people. Their bodies are wearing out because of the NORMAL process of aging. Don't hold that against them.
- Along with patience, speak up, move in close so you can be seen, touch if it seems appropriate, smile, and learn to enjoy your time with someone older. You may need to start with enjoying your grandparents or older aunts and uncles. Both generations have so much to offer each other. Don't be too busy to take advantage of this opportunity.
- Be brave! Speak up when someone says or suggests doing something that is ageist. You don't need to be aggressive, but you should state your opinion. You don't need to defend what you say, as the statement should speak for itself.
- Read about ageism, ponder what you read, talk to others about it, consider how you would like to be thought about and treated when you are older. If you don't like what you foresee, how can you change it?

universities. Seriously negative attitudes toward the aged still exist. They appear subtly, covertly, and even unconsciously. Like racism and sexism, ageism is still persistent.

An example is the cosmetic industry, which thrives on the sale of products that eliminate age spots, smooth away wrinkles, conceal gray hairs, and make one look younger than one's actual age. Growing old is represented as a calamity, and being old as having a dreaded disease. The last years of life are pictured as time spent in death's waiting room.

In reality, elderly people do not offer a panorama of doom and death. Many senior citizens live well into their 80s and 90s with "youthful vigor," in relative physical comfort and safety, and in good health. Many others do have chronic health problems, but because the problems are well managed and well controlled, such people consider themselves healthy and lead active, fulfilling lives. Still others have significant limitations that affect their independence and activity, but they are able to enjoy a rich and varied existence because they live with family members or in other protected environments.

Negative images of the nursing home, envisioned by some people, are in part an expression of ageism. Most nursing homes give excellent care to a frail and vulnerable population that cannot be cared for elsewhere. Another point of information, unknown by many people, is that only 5% of those older than 65 years of age are in nursing homes at any one time (Eliopolous, 2005). Today's nursing home is characterized by a concept of *rehabilitative,* not *custodial,* care, a perspective that calls for nursing interventions intended to support the highest possible level of independence despite physical and cognitive limitations.

It is easy for society to judge, criticize, and ignore an older person. Do an internal examination to determine if you are ageist. Do you get impatient when an older person is in front of you driving on the freeway? I tell my gerontology students that they will not pass the class until they have conquered that type of impatience. I give them assignments to sit down and unhurriedly talk to a well elderly person. I suggest they go to lunch or shopping, even at the grocery store. The students are encouraged to ask the person about living with ration cards, going to war, or being left a widow or widower after 50 to 60 years of marriage. The ageism in our society has kept most of us from knowing about the aging process and respecting those who survive it. It is time for that to change!

An important concept to remember is that of the uniqueness of the individual. Just as every child and every middle-aged adult is unique in some way, so is the older adult. The mistaken belief that one old person is just like another is an expression of ageism, and this perception can lead to potentially harmful treatment. Doctors and nurses sometimes treat older patients as they might treat a child, calling them by their first names without asking how they wish to be addressed or, worse yet, calling them "honey" or "dearie." Caregivers often are guilty of "infantilizing" the elderly. It is easy to see how such treatment increases dependence and frailty, rather than fostering independence, even for a person with limitations. Not all old people are cranky and gloomy, although the man or woman who was cranky and gloomy at age 40 is probably more so at 80. People tend to become more and more like themselves as they age. All who work in the health-care field need to examine their own attitudes and biases about older adults in general and about frail or ill older adults in particular in order to successfully battle ageism.

THEORIES OF AGING

There are people who have spent their lives researching what are known as the theories of aging. These theories are a scientific effort to

CRITICALLY EXAMINE THE FOLLOWING:

What are three things you can do to overcome your personal ageism?

1.
2.
3.

What are three things you can do to assist others in overcoming their ageism?

1.
2.
3.

I will not answer these questions because I do not think you need an example. It is more important for you to share your thinking. Spend time pondering the issue of ageism. Really grasp what it means for you on a personal level. This can be done by talking to your colleagues and peers and, more importantly, by talking to older people.

assist people to understand what contributes to aging in a positive or negative manner. You, as a nurse, need to understand the basic theories in order to assist and support your older adult patients and residents to live healthier lives. There are both physiological and psychological theories that will assist you in understanding aging. Even though there are many theories available for study, the following are three from each category that will assist you in giving effective nursing care.

Physiological Theories of Aging

Genetic Factors

This theory is easy to understand if you critically examine yourself and your family members. You already know that you may have inherited your hair and eye color, height, and body size from your ancestors. There are many other things you also may have inherited, such as musical or athletic ability. Have you considered that the aging of your body also is inherited? This theory says that it is. Interview your grandparents or older aunts and uncles. Are their siblings still alive? How long did their parents and grandparents live? I know of a family in which all of the men died before the age of 50 with heart disease, but the women lived to be in their 70s. I know a family of six sisters who all went through menopause at age 52. I have a friend whose mother had 11 brothers and sisters; they all lived to be in their 80s.

This theory claims that animals and humans are born with a genetic program that predetermines their life span (Hayflick, 2001). This may seem discouraging to those who are working hard to obtain or maintain optimum health. But a healthy diet, exercise, and stress control, among other things, will certainly support a higher quality of life if not add to one's longevity.

Just as nurses interview people about their family history regarding diseases, it would be appropriate use of this theory to ask about their parents and siblings and their aging process. This information may assist you in working with the patient/resident. The most important aspect of this theory is for you to recognize that it is one way to accept aging as the inevitable process it is. With that acceptance, you should develop an additional acceptance of the normal and abnormal aspects of aging and the eventual death of each of us. According to this theory, it is predetermined and, therefore, inevitable.

CRITICALLY EXAMINE THE FOLLOWING:

Spend time with your parents or older relatives and discuss the genetic factor theory with them. Ask questions about your ancestors and identify traits that you may have inherited from them. Inquire about the longevity of your ancestors as well as their major diseases. When you have enough information, predict how long you will live and the predominate diseases you will have. Justify what you predict from your family history. Prepare the information into one paragraph that could be read in class.

Wear and Tear

If you were to go to a senior citizen center or a nursing home dayroom, you would easily identify the basis for the wear and tear theory. As people age, their body parts show the effects of the complex and sophisticated work the body does through the years. People will be walking with canes or walkers; some will be on oxygen; others will simply moan when they get up from a chair. Like all fine-tuned machinery, body parts wear out or become less effective. Knees need to be replaced because of the lack of cartilage that comes with aging, joints develop arthritis, and hips break because of decreased bone mass or lack of balance leading to a fall.

Think of all the running and jumping you did as a child. Perhaps you were an athlete during high school. Think of how you use your body now that you are in school. The body is well used and sometimes abused, and its parts simply wear out.

Understanding this theory should assist you in accepting that older adults walk slower, hear less effectively, and need to stop and rest and overall do things at a slower and safer pace. If you understand and accept this theory, you will accept the changes that require your attention in giving care to specialized, older people.

Nutrients

There is an entire chapter (Chapter 6) in this book about nutrition. Its focus, of course, is on nutrition for older persons. However, when considering the nutrient theory, you should focus on your own nutritional intake. This theory states that aging and the quality of aging depend on a person's nutrition intake over the span of their life. This is easy to understand because, as a

health-care worker, you recognize the negative effects of obesity, lack of exercise, and high cholesterol, all of which are attributed to food consumption. The quart of chocolate ice cream, mountain of french fries, and large steak are not ways to promote a successful aging process. The theory states that good nutritional intake at any age will assist in improved health as one ages. The longer you eat healthy foods, the longer you will live with a better quality of life. Now is a good time to start.

Whenever you are giving care to an older person, you should examine the individual's eating habits and determine if you can teach her or him something new that will improve health. Ask the nurse manager about having a dietitian visit the person or arrange for fresh fruits to be available for snacks if that would help. Again, you need to take care of yourself and share your knowledge with those you love. Teach them the things you will learn in the nutrition chapter and apply the principles to yourself as well. There is little in life that is better than a healthy old age!

This 82-year-old woman has always played the piano and organ, and currently she plays every Sunday at her church. Now that she is older, she is better at it than ever before in her life. Which psychological theory does this demonstrate?

Psychological Theories

Developmental Tasks

Eric Erickson (1963) is famous for his eight stages of personal development of people. He begins with infancy and progresses through old age. His focus is on ego development, which gives people the strength to manage their lives. The task for old age, according to Erickson, is Integrity vs. Despair. If older people can find meaning in the life lived, they will have the ego integrity to adjust and manage the process of aging. If they do not have integrity, they will be angry, depressed, and feel inadequate; in other words, they will feel despair.

You may encounter older persons who are feeling despair. They complain constantly and keep saying they wish "this" or "that" had happened in their life. Also frequently heard is the phrase "if only…" Such people need your time and acceptance of them and their lives. Ask them to talk about their life experiences and reinforce the valuable things they have done. Help them to see what they have contributed to the world. Your efforts should focus on identifying the actions in their life that will assist in building the feeling of ego integrity.

Subculture Theory

This theory defines older people as a subculture. In anthropological terms, this indicates that older people have their own cultural norms and standards. This includes attitudes that cross over to multiple members of the group as well as beliefs, expectations, and behaviors that make them different from others.

You will study the cultural and ethnic differences in people throughout your education. It is important to understand people, their differences, and their needs. This theory indicates that the elderly are another group worthy of your study. You need to observe older people and note their similarities. They will not be the same, as, like all people, they are strongly individualized, but they will exhibit similarities. In reference to this theory, you need to note their similarities. An interesting political group is the Gray Panthers. This group of older adults has the power to influence votes on the national level as well as locally. They are a power that you should examine to help understand this theory.

Continuity Theory

In simple terms, this theory states that as people change, their basic personality and behavioral patterns do not change. For example, if you are

POINT OF INTEREST

If you want to learn more about the Gray Panthers, simply log onto their Web site at *www.graypanthers.org.* You will find it interesting.

an angry person at age 20, then you will be even better at being angry at age 70. The same is true of a teacher, who will find a way to keep teaching as he or she ages. A loving mother will find a way to still mother people (perhaps her grandchildren or children in the neighborhood), musicians will keep playing, and athletes will still keep trying to win.

The continuity theory recognizes the unique and individualized characteristics of people and their ways of adapting to aging. To you, as a younger person, the theory suggests that you should seriously ponder what you want to be doing in your old age and make some decisions now, because what you are doing now is what you will be doing 40+ years from now. This theory is easy to apply to your practice. You simply need to talk to the older person and the family members about what type of person your patient was in his or her youth or adulthood. Then you will know what type of behavior to expect now that he or she is an older adult. Don't try to change older people; rather respect them for who they are.

THE NORMAL AGING PROCESS

Since the early 1950s, much research has taken place in both Europe and the United States on identifying and classifying common physiological and psychosocial changes that occur as people grow older. These changes have been termed *normal* because they represent alterations in body structure and function that occur gradually throughout life. In this context, aging is seen as a natural process, and the changes associated with it are considered to be expected and continuous. If you are curious about your potential normal aging changes, you need to look at your grandparents. What acute and chronic diseases do they

FOCUSED LEARNING CHART

Theories of aging

Physiological Theories	Psychological Theories
Genetic Factors *Born with a genetic program that predetermines life span.*	**Developmental Tasks** *Eric Erickson defined eight developmental tasks from infancy to old age. The task for old age is integrity versus despair.*
Wear and Tear *All life is a fine-tuned machine. Body parts wear out as they age.*	**Subculture Theory** *Defines old people as their own subculture with cultural norms and standards.*
Nutrients *Aging and the quality of life depend on the person's nutritional intake over his or her life span.*	**Continuity Theory** *People change physiologically as they age, but their basic personality and behavioral patterns do not change.*

have? At what age do people in your family die? Do the men go bald; do the women develop osteoporosis? We all will age until we die. To me, that comment makes aging the desirable choice between the two. I would sooner grow old than die young.

To fully understand the normal aging process, nurses must realize that aging is a normal developmental event and that patterns of aging vary dramatically among older adults. Although the profession studies normal age changes that are universal, every person ages in a particular, individualized way. No two individuals are alike; in fact, the number of ways in which people age may be seen as equal to the number of people who have lived into old age. As individuals age, they become more diverse, not more alike. Thus, the range of "normal" aging characteristics is wide, and each individual exhibits a unique interplay of physical, social, and environmental influences that define the personal aging experience.

Often, older adults do have a chronic or acute illness superimposed on age-related changes, but development of disease is not a normal part of aging. It is essential for you, the LPN, to understand this perspective and develop a positive approach to normal aging. It also is important to remember that most older adults live actively and independently in the community and cope successfully with age-related changes and chronic illnesses (remember that only 5% of them are in nursing homes). Health for older adults, then, might well be defined as the ability to function at an individual's highest potential despite the presence of age-related changes and risk factors.

Essential facts about the normal aging process can be summarized as follows:

- As individuals age, they become more diverse, not more alike.
- Age-related changes develop in each individual in a unique way.
- Normal aging and disease are separate entities.
- Normal aging includes both gains and losses and does not necessarily indicate decline.
- Successful adaptation to the aging process is accomplished by most older adults.

NORMAL PHYSIOLOGICAL CHANGES ACCORDING TO BODY SYSTEMS

Specific age-related changes are described in terms of the body systems with which they are associated. Common functional changes experienced by older adults as a result of physiological alterations also are discussed. The term *function* refers to the older adult's ability to perform activities of daily living (ADLs) and independent activities of daily living (IADLs) and takes into consideration the quality of life of the individual. As the older adult experiences an increase in the number and intensity of age-related changes, functional independence is often jeopardized. Nursing approaches to prevent losses and promote self-care in light of age-related changes also are considered in this section.

The Cardiovascular System

The cardiovascular system loses its efficiency with age, but because older adults require less oxygen both at rest and during exercise, many people effectively compensate for changes in circulatory function. However, the high incidence of cardiovascular disease in the older population often makes it difficult to distinguish normal age-related changes from those related to sickness. One of the "good news" facts about cardiovascular disease and the elderly is that it is no longer the number one cause of death as it has been for decades. Older adults now know more about taking care of themselves, which improves their cardiovascular system. Cancer is now the leading cause of death in older adults.

Age-Related Changes

Heart

- Cardiac muscle strength is diminished.
- Heart valves become thickened and more rigid.
- The sinoatrial node, which is responsible for conduction, is less efficient, and impulses are slowed.

POINT OF INTEREST

Function is the ability to take care of one's ADLs—basic personal needs, such as eating, dressing, washing, toileting, and moving. Function also refers to the ability to live independently in one's community, performing IADLs including cooking, shopping, taking medications properly, cleaning, traveling locally, and managing finances.

Blood Vessels

- Arteries become less elastic.
- Capillary walls thicken and slow the exchange of nutrients and waste products between blood and tissues.
- The greater rigidity of the vascular walls increases both systolic and diastolic pressures.

Blood

- Blood volume is reduced owing to an age-related decline in total body water.
- Bone marrow activity is reduced, which leads to a slight drop in levels of red blood cells, hematocrit, and hemoglobin.
- Heart contractions may be weaker, blood volume decreases, and cardiac output drops at a rate of about 1% per year below the value of 5 L normally found in a younger person.

In summary, with normal aging, some atherosclerosis is expected as well as decreased cardiac output, but cardiovascular response remains adequate if cardiac disease is not present.

Respiratory System

Respiratory functioning shows minimal age-related decline in healthy older adults. The age-related changes that do affect the respiratory system are so gradual that most older adults compensate well for these changes.

Age-Related Changes

Skeletal Changes

- The rib cage becomes rigid as cartilage calcifies.
- The thoracic spine may shorten, and osteoporosis may cause a stooped posture, decreasing active lung space and limiting thoracic movement.

Accessory Muscles

- Abdominal muscles weaken, decreasing both inspiratory and expiratory effort.
- The diaphragm does not appear to lose mass.

Intrapulmonary Changes

- Lung elastic recoil is progressively lost with advancing age.
- Alveoli enlarge and become thin, and although their number remains constant, the number of functioning alveoli decreases overall.
- The alveolus-capillary membrane thickens, reducing the surface area for gas exchange.

Functional Changes

Structural changes in the respiratory system affect the rate of airflow into and out of the lung as well as that of gas exchange at the alveolar level. Because of limited elastic recoil, residual volume increases. This means that less ventilation occurs at the bases of the lungs and more air and secretions remain in the lungs. In addition, the shallow breathing patterns of older adults, secondary to postural changes, contribute to this reduced airflow. Decreased chest muscle strength contributes to a less-effective cough response and places the older adult at greater risk of pulmonary infection. The shallow breathing pattern also affects gas exchange. Oxygen saturation is diminished. For example, the partial pressure of oxygen in alveoli (PAO_2) is about 90 mm Hg for a healthy young adult, whereas a value of 75 mm Hg at age 70 years would be acceptable. This decline may result in a decreased tolerance for exercise and the need for short rest periods during activity.

Musculoskeletal System

Most older adults experience alterations in posture, changes in range of motion, and slowed movement. These changes account for many of the characteristics normally associated with old age.

Bone Structure

- Loss of bone mass results in brittle, weak bones.
- The vertebral column may compress, leading to reduction in height.

Muscle Strength

- Muscle wasting occurs, and regeneration of muscle tissue slows.
- Muscles of the arms and legs become thin and flabby.
- Muscles lose flexibility and endurance with inactivity.

Joints

- Range of motion may be limited.
- Cartilage thins, so that joints may be painful, inflamed, or stiff.

Functional Changes

Loss of muscle mass is a gradual process, and most older adults compensate for it well. Regular exercise has been shown to reduce bone loss and to promote increased muscle strength,

The second woman from the left is 85 years old. Three times a week she calls her friends, who are much younger, and they go to Curves, a women's exercise facility. Such commitment to maintaining one's health is a positive attitude for older adults.

as well as to improve flexibility and muscle coordination. Conversely, immobility and sedentary lifestyles lead to loss of muscle size and strength.

Loss of bone mass and bone density results in osteoporosis and porous, brittle bones that are at greater risk of fracture. This problem can be due to estrogen deficiencies and low serum calcium levels; therefore, calcium supplements and estrogens are often prescribed. Recent research, however, has raised some questions about the use of estrogen therapy. This should be discussed with the older person's physician. In summary, changes caused by osteoporosis, lack of joint motion, and decreased muscle strength and endurance may affect the functional ability of the older adult. An effective exercise program, together with adequate diet and a healthy outlook that includes independence and an active lifestyle, can reverse or slow down musculoskeletal changes. The phrase "Use it or lose it!" directly applies to the older adult's musculoskeletal functional ability.

Integumentary System

Changes involving the skin and hair probably are symbolic of the aging process more than those of any other system. The formation of wrinkles, the development of "age spots," graying of the hair, and baldness are constant reminders of growing old. In addition, no other system is so highly influenced by previous life patterns and environmental conditions, particularly exposure to the sun.

Age-Related Changes

Skin

- The skin loses elasticity, leading to wrinkles, folds, and dryness.
- The skin thins, giving less protection to underlying blood vessels.
- Subcutaneous fat diminishes.
- Melanocytes cluster, producing the skin pigmentation known as age spots.

Hair

- Decreased activity of hair follicles results in thinning of the hair.
- Decreased rate of melanin production results in loss of original color and graying.
- Women may develop hair on the chin and upper lip.

Nails

- Decreased blood flow to the nailbed may cause nails to become thick, dull, hard, and brittle, with longitudinal lines.

Sweat Glands

- Decreases in size and number occur.

Functional Changes

Intact skin is the first line of defense against bacterial invasion and minor physical trauma. Age-related skin dryness and decreased elasticity increase the risk of skin breakdown and skin tears, leading to increased potential for injury and infection. Body temperature regulation is impaired by decreased sweat production. Because of this, older adults may not exhibit diaphoresis with elevated body temperatures.

Conversely, the loss of insulation in the form of a fat layer may make older adults feel cold. They often ask for extra sweaters when younger adults are quite comfortable with the ambient temperature. Nurses need to be aware of temperature discomforts when bathing, dressing, or examining the older adult and respond appropriately to the older adult's concern.

Age-related changes in the integumentary system affect the essential mechanisms of body protection and temperature regulation and also greatly influence one's perception of aging. Earlier health practices related to nutrition, grooming, bathing, and physical activity as well as genetic, biochemical, and environmental factors are powerful determinants of integumentary status. The older adult who has followed a healthy lifestyle often takes pride in the moistness and softness of aging skin and reveals newfound beauty in gray hair and wise wrinkles.

Gastrointestinal System

Changes in the gastrointestinal (GI) system, although not life-threatening, often cause the greatest concern to the older adult. Indigestion, constipation, and anorexia are common GI problems that greatly affect functional status.

Age-Related Changes

Oral Cavity

- Reabsorption of bone in the jaw may loosen teeth and, thus, reduce the ability to chew.
- People with dentures must have them checked regularly to maintain a proper fit.

Esophagus

- The gag reflex weakens, causing an increased risk of food aspiration.
- Smooth muscle weakness delays emptying time.

Stomach

- Decreased gastric acid secretions may impair absorption of iron, vitamin B_{12}, and protein.

Intestines

- Peristalsis decreases.
- Weakening of the sphincter muscles leads to incompetent emptying of the bowel.

Functional Changes

The slowing of peristalsis and the loss of smooth muscle tone delay gastric emptying so that a feeling of "fullness" is present after eating only small amounts of food. In addition, delayed gastric emptying time and reduced gastric acid secretions may lead to indigestion, discomfort, and reduced appetite. Frequent small meals, rather than three large ones, may be better tolerated. Decreased peristalsis also contributes to slower transit time in the large intestine and allows more time for water reabsorption and hardening of the stool. Because of this factor, the nurse must recommend a diet adequate in fiber and fluids.

Fatigue, discomfort, activity intolerance, and sensory losses may make food preparation difficult for the older adult living at home. This problem could result in a nutritionally inadequate diet. In summary, effective GI functioning creates peace of mind for the older adult and greatly influences well-being.

Genitourinary System

Changes in the genitourinary system affect the basic bodily functions of voiding and sexual performance. These issues are often difficult for the older adult to discuss. A commonly held belief is that genitourinary problems, such as incontinence and decreased sexual response, are normal results of aging. They are not, but the belief that they are often delays the older adult from seeking treatment. Helping the older adult to maintain optimal genitourinary function is often a challenge for the nurse.

Age-Related Functions

Renal Function

- Renal blood flow decreases because of decreased cardiac output and reduced glomerular filtration rate.
- Ability to concentrate urine may be impaired.

Bladder

- Loss of muscle tone and incomplete emptying may occur.
- Capacity decreases.

Micturition

- In men, increased frequency due to enlargement of the prostate is possible.
- In women, increased frequency may be caused by relaxation of the perineal muscle.

Female Reproduction

- The vulva may atrophy.
- Pubic hair may fall out.
- Vaginal secretions diminish, and vaginal walls thin and become less elastic.

Male Reproduction

- Testes decrease in size.
- Prostate may enlarge.

Functional Changes

Despite decreased renal blood flow and the loss of kidney mass, the genitourinary system continues to function normally in the absence of disease. Functional impairments result from decreased bladder capacity and include urinary frequency, nocturia, and retention of urine. These changes may eventually cause dysfunction, leading to infection, urgency, and incontinence. Although urinary incontinence is not a normal outcome of the aging process, loss of perineal muscle mass may contribute to one of the most common forms of incontinence in women, stress incontinence. This involves leakage of urine that occurs with coughing, sneezing, laughing, or lifting. Pelvic floor exercises comprise an effective strategy to strengthen muscle tone and prevent involuntary leakage. Vaginal changes may lead to painful intercourse, vaginal infections, and intense itching.

Enlargement of the prostate, which occurs in most elderly men, is most often benign. It can, however, cause urinary retention, frequency, overflow incontinence, and, eventually, renal damage. Therefore, older men should have regular examinations of the prostate.

Changes in voiding, particularly incontinence, and changes in sexual response may dramatically alter genitourinary function and contribute to embarrassment and general discomfort for the older adult. By demonstrating sensitivity and acceptance, the nurse can effectively intervene to improve genitourinary functional response.

Nervous System

Age-related changes in the nervous system affect all body systems and involve vascular response, mobility, coordination, visual activity, and cognitive ability. Interestingly, most misconceptions about normal age-related changes involve the nervous system. For example, there is a misconception that mental decline or "senility" is inevitable with aging or that intellectual capacity diminishes with age. The nurse needs to teach older adults that general decline of neurological function is not an automatic response to aging and that, in the absence of disease, the older adult's neurological system functions adequately.

Age-Related Changes

Neurons
- Neurons are steadily lost in the brain and spinal cord.
- Synthesis and metabolism of neurotransmitters are diminished.
- Brain mass is lost progressively.

Movement
- The kinesthetic sense is less efficient.
- Balance may be impaired.
- Reaction time decreases.

Sleep
- Insomnia and increased night wakening may occur.
- Deep sleep (stage IV) and rapid eye movement sleep decrease.

Functional Changes

As motor neurons work less efficiently, reaction time slows and the ability to respond quickly to stimuli decreases. Research studies indicate that although response time may be prolonged, older adults are willing to give up speed for accuracy and tend to respond more slowly but with greater precision. There appears to be little correlation between brain atrophy and cognitive loss. Older adults are generally well oriented to time, place, and person, with minimal changes in memory performance despite decreased synthesis of neurotransmitters and diminished brain size.

Older people are particularly at risk for falls, owing to a slower reaction time in maintaining balance and the potential for hypotensive reactions secondary to decreased blood volume. Resulting symptoms of dizziness, light-headedness, and vertigo contribute to impaired balance. Nurses should allow the older adult adequate time for position change; dangling at the bedside and standing briefly before ambulation may be indicated.

In general, older adults sleep less at night but take naps during the day, so that cumulative sleep time is usually adequate. These frequent awakenings may cause restless sleep and abrupt wakefulness that are often troubling to the older adult. Thorough sleep assessment is necessary to determine actual sleep time. Additionally, afternoon exercise and a decrease in stimulants at bedtime may be suggested by the nurse. Environmental changes, such as noise control and regulation of room temperature, may be helpful.

Common age-related changes of the nervous system, particularly slowed reaction time, affect movement, sleep, and cognition, the functions of which are vital to optimal performance of activities of daily living.

Special Sense Organs

The sensory organs of sight, hearing, taste, touch, and smell facilitate communication with the environment. Loss of sensory function, particularly vision and hearing, severely alters the older adult's self-care abilities and quality of life. Age-related changes that result in loss of sensory function may be the most difficult for a person of any age to accept and cope with effectively. The nurse must be extremely sensitive to sensory changes and their impact on each person.

Age-Related Changes

Vision

- Ability to focus on close objects is diminished.
- Increased density of the lens occurs, and lipid accumulates around the iris, causing a grayish yellow ring.
- The eyes' production of tears decreases.
- The pupils decrease in size and become less responsive to light.
- Night vision decreases, and the iris loses pigment so that eye color usually becomes light blue or gray.

Hearing

- The ability to hear high-frequency tones decreases.
- The cerumen contains a greater amount of keratin so that it hardens and becomes more likely to become impacted.

Taste

- Ability to perceive bitter, salt, and sour tastes diminishes.

Touch

- Ability to feel light touch, pain, or different temperatures may decrease.

Functional Changes

Despite normal age-related changes in vision, most older adults have adequate visual function to meet self-care activities using corrective lenses. Because dark and light adaptation takes longer, simple activities, like entering or leaving a theater or going to the bathroom at night, put older people at risk for falls and injury. Yellowing of the lens makes vision for low-tone colors (violet, blue, green) difficult; use of yellow, orange, or red colors on signs or on bedroom walls increases the older adult's ability to read.

Decreased production of tears by the eye may contribute to irritation and infection; artificial tears are often prescribed. Functional hearing changes result initially in an inability to hear high-pitched tones.The nurse should speak in a normal tone of voice without shouting and without increasing pitch. Because it takes more sensory stimulation to trigger the taste experience, older adults may use more salt, for example, to effectively produce a salt taste on their food.

Sensory changes have a profound impact on the functional ability of older adults. The nurse must always determine whether the patient uses corrective lenses or a hearing aid and ensure that the older person has these assistive devices available at all times.

Later in this book, the reader will be able to compare abnormal physiological changes of older adults with the normal changes explained here. You, as a future gerontological nurse, should have a thorough understanding of both aspects of physiological aging.

CONCLUSION

This chapter has pointed out the importance of understanding the older adult in today's society. As the number of aged individuals increases, and as more and more older adults require nursing care, you need to develop a strong knowledge base in gerontological nursing content. It is equally important to explore the myths, stereotypes, and prejudices about old age to begin the process of seeing older adults as unique individuals who have special histories and life experiences. Understanding the various theories of aging can promote a more positive attitude toward the process. Normal aging changes each person in a unique way. As you acquire the specific knowledge and skills to be an effective caregiver of older adults, it is hoped that you will embrace the attitude that all older adults are unique and should be encouraged to function at their full potential. With this critical understanding, we will comment again that you are the generation of nurses who will define the application of gerontological nursing. Best wishes with the task!

CASE STUDY

Ms. B., 76 years old, lives in a duplex with her 83-year-old sister. Last year, the sister had a mild stroke, leaving her with left-sided weakness. Ms. B. manages the household and coordinates her sister's care, including home health aides, physical and occupational therapy, and visits to the doctor's office.

Ms. B. describes herself as healthy. She also comments, "Okay, I had cancer of the colon 2 years ago, but I had surgery and some chemotherapy too, and now I'm okay. Oh, I sometimes get constipated, but that has nothing to do with the cancer."

She states that she tires more easily these days and tries to rest every afternoon. Still, she maintains a full schedule of grocery shopping, visiting friends, cooking and cleaning, and caring for her sister's needs. She has no breathing problems, and her appetite is excellent. "I can't eat as much as I used to at each meal, but my sister and I have a snack in the afternoon and at bedtime."

She does complain about nocturnal voiding two or three times a night and has had two urinary infections this year. "Sometimes I dribble urine, and I use those pads."

Both sisters are always cold; their home is kept very warm, and they always seem to be wearing sweaters and heavy stockings. Every Sunday is beauty day at the B.'s residence, when they apply face and hand cream to dry skin, style their thinning hair, and care for their nails, which are getting thick and brittle. Both claim that they have become shorter in the past few years; Ms. B. often feels weary at night due to joint pain. She has learned to adjust her daily schedule to changes in endurance. She says, "No matter where I go, I take my time, sit down, and pace myself. I know where every bench and restaurant is in south Philadelphia."

Ms. B. has noticed that she needs to wear her glasses all the time when reading or paying bills; she invested in 100-watt lightbulbs for every lamp "because we both need stronger light to read by these days." She is never without her sunglasses to avoid glare; in fact, every shade is always lowered at their house during the day. Ms. B. claims, "I don't think as clearly lately as I used to; it takes me longer to figure things out and make decisions." But she continues to manage the household and lead an active life.

"I have my friends, my neighborhood, my home, and, of course, my sister. We have been together all of our lives. We care about each other, and we do pretty well, taking each day as it comes, each day expecting another good day."

Discussion

1. What age-related changes has Ms. B. experienced?
2. Would you consider Ms. B. to be a healthy older adult? Explain.

Solution

1. Ms. B. has experienced age-related changes in all the following areas:

Cardiovascular
Decreased activity tolerance
Fatigue with increased activity

Musculoskeletal
Loss of muscle strength
Height loss
Joint pain

Integumentary
Dry skin
Brittle, thickened nails
Thinning hair

Gastrointestinal
Delayed gastric emptying leading to fullness
Reduced GI motility

Genitourinary
Urinary retention, which may contribute to infection
Urgency and stress incontinence

Nervous
Delayed reaction time

Special senses
Diminished ability to focus on close objects
Inability to tolerate glare
Poor vision in reduced light

2. Ms. B. is a healthy older adult because she functions at an optimal level despite the presence of age-related changes. She feels good about her life and about her coping skills. She expects continued "good days."

STUDY QUESTIONS

Select the best answer to each question.

1. Your client is 84 years old. What normal change in vital signs would you expect to assess?

a. A higher-than-normal temperature

b. A slower pulse

c. A shallower breathing pattern

d. A lower blood pressure

2. Immobility or sedentary lifestyles have what effect on the older adult?

a. Loss of muscle size and strength

b. Decreased serum sodium levels

c. Loss of skin elasticity

d. Thinning of cartilage in joints

3. Mrs. Jones, aged 86 years, complains of fullness after eating only small amounts of food. This is primarily due to which gastrointestinal change?

a. Delayed gastric emptying time

b. Increased gastric acid secretions

c. Hypertonicity of gastric muscles

d. Loss of ability to chew

4. Mrs. Smith, aged 79 years, is admitted to the hospital. Based on your understanding of normal age changes in the nervous system, what behavior might you expect Mrs. Smith to exhibit?

a. Decreased intellectual function

b. Forgetfulness and confusion

c. Lack of orientation to time and place

d. Longer response time to questions

5. Which of the following statements most accurately describes normal aging changes in the older adult?

a. As individuals age, they become more diverse.

b. Most older adults experience chronic illness and functional impairment.

c. Age-related changes are similar in each older adult.

d. Normal age changes most commonly describe decline and loss of function.

3

The Use of the Nursing Process and Nursing Diagnosis in the Care of Older Adults

Kathleen R. Culliton

Learning Objectives

After completing this chapter, the student will be able to:

1. Describe the nursing process as a problem-solving technique in the context of the older adult's assessment, plan of care, nursing interventions, and nursing documentation.
2. Identify the use of the nursing process minimum data set (MDS) and resident assessment protocols (RAPs) in developing nursing care plans for residents in nursing facilities.
3. Use the nursing process to develop a care plan for the presented case study.

INTRODUCTION

Licensed practical nurses (LPNs) work in a variety of care settings. Each setting may require the practical nurse to function in a different capacity, yet each practice area expects you to be involved with the assessment, planning, implementation, and evaluation of older adults and the care they receive.

PRIORITY SETTING 3.1

There is a great deal of information in this chapter, and all of it points you toward the behaviors and thought processes of a licensed nurse. One of the unwritten objectives for you in attending school is to learn to think like an LPN. This chapter provides the foundation for that type of thinking. Therefore, your priority for this chapter is to learn and put into practice the nursing process.

It is critical that you learn to think like a nurse. Using the nursing process in your everyday life will assist you in such learning. Remember the five stages of the process:

- Assessment
- Nursing Diagnosis
- Planning
- Implementation
- Evaluation

I suggest that you purposefully think in those five stages. It would work in most situations. Fixing dinner makes a good example. You need to assess the number of people who will be eating and their likes and dislikes, as well as the food you have on hand. Your nursing diagnosis would be the selection of food you choose to serve to a specific number of people, adjusting for likes and dislikes, of course! Then you plan the actual meal, implement the plan by serving the meal, and then evaluate the meal by obtaining feedback from those who ate it.

I know this seems simplistic, but you need to think like a nurse. By actually going through the steps several times a day, you soon will think that way automatically.

ENVIRONMENTS OF CARE

Home Care

A relatively new practice area for LPNs is working in home care. Practical nurses in home care work under the direction of a registered nurse. They provide nursing care such as changing dressings, monitoring blood glucose levels, administering medications, and assessing the status of chronic disease processes in the older adult's home.

Hospital Care

LPNs work in a variety of capacities with the acutely ill older person who is hospitalized. Often, they are paired with a registered nurse to form a care team in providing nursing care. Other care delivery models may require the LPN to have specific tasks on the unit, such as treatments or passing medications for all of the patients on the unit.

Long-Term Care Facilities

The LPN may be employed in many types of long-term care facilities. Skilled nursing facilities and nursing facilities were previously thought of as nursing homes. They generally provide a high level of nursing intervention. Assisted-living facilities provide care to older persons who may need assistance with activities of daily living (ADLs) but who do not require complex, skilled intervention (Eliopolous, 2005). Continuing care retirement communities have several levels of care, including those offered in a skilled nursing facility, assisted living, and independent living apartments. Wellness clinics are frequently provided for residents living in independent apartments. LPNs could be employed in any one of these long-term care settings.

In the long-term care environment, the practical nurse collects admission data, provides input to the plan of care, carries out the nursing interventions that are outlined in the plan of care, and evaluates the effectiveness of these interventions in meeting the goals of the older adult's care plan. Often, the LPN confers with the interdisciplinary health-care team (IDT) to share observations and clarify the plan of care. Very often, the LPN in these settings is responsible for working with nursing assistants to be sure the plan of care is carried out. Practical nurses even call physicians to clarify orders and to report changes in the resident's health

This woman soon will be discharged from the nursing home where she has been for the past 8 weeks because of a fractured hip. While at home, she will receive both nursing and physical therapy as home care. Because of the multiplicity of services available to her, she spent only 5 days in the hospital and will be home much quicker than she would have been a decade ago.

status. The practice of LPNs in nursing facilities is the practice model referred to in this chapter.

THE NURSING PROCESS

An LPN walks into a resident's room and finds the person with a supper tray in place. The resident is unable to talk and is turning blue. The nurse thinks that the resident is choking. Quickly, the nurse moves the meal tray out of the way and uses a two-handed thrust under the resident's diaphragm to attempt to dislodge the food that is obstructing the airway. After the nurse does the abdominal thrusts, the resident is assessed for respiratory movements. If the person is breathing again, the nurse takes a deep breath, cuts the resident's meat into smaller pieces, and observes the resident eating the rest of the meal. If the resident is not breathing, the nurse may attempt another abdominal thrust or reposition the resident so another abdominal thrust can be done from behind.

This short scenario is an example of the nursing process (Fig. 3.1). When the LPN entered the room and saw the older person with hands clenched on throat and turning blue, the nurse was collecting data. In a split second, the nurse identified the resident's problem as choking. The nurse's next thought was to set a goal for this resident's care: the resident will expel the food that is causing the choking. With the goal of expelling the lodged food, the nurse designs the plan from nursing knowledge and immediately implements abdominal thrusts. After the nursing intervention, the nurse evaluates the situation to determine whether the resident has expelled the food. If the resident has not, the nurse must rethink and redesign the plan and immediately implement the revised nursing actions.

The nursing process is a problem-solving model that describes what nurses do. It identifies the way nurses approach patient care and recognizes the ongoing and changeable nature of the care that nurses provide, care that is based on the individual needs of the patient.

Nurses are faced with many patient or resident care problems every day. The nursing process provides a structure for nurses to plan and give high-quality, individualized care.

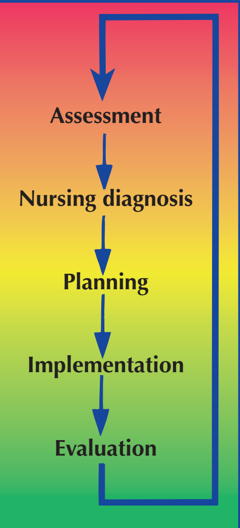


FIGURE 3.1. Nursing process model. The circular nature of this model demonstrates that the process is ongoing.

Assessment

The first step in the nursing process is to collect all of the information the nurse will need to clearly identify the older person's strengths and current and potential problems. Usually, the assessment starts with the call or written summary from the agency or department that is transferring the older adult to your nursing care area. The information that it is important to receive before the actual transfer of the person includes:

- Name, age, and insurance identification numbers
- Medical diagnoses, advanced directives, and disease prognosis
- Family support
- Need for equipment (Does the person need special equipment, such as a special bed, oxygen, intravenous [IV] setup, or feeding pump?)
- Functional ability (How does the person transfer, ambulate, move in bed, bathe, toilet, and eat?)
- Medications (Which prescription and over-the-counter medication does the person take?)
- Cognitive ability (Is the client oriented? How is the person's memory?)
- Special needs (Is the person depressed or at risk for skin breakdown or other health risks?)

This information is very important for the preparation of the older person's bed and room and makes the transfer to your care as smooth as possible.

Once the older person is transferred, the nurse makes a focused assessment that culminates in a comprehensive assessment. The admission assessment includes observations, physical examination, review of laboratory values, interview of the older adult and his or her family, and a nursing history.

In 1987, the federal government enacted legislation that set minimum standards for the assessment and care-planning processes in nursing facilities certified for Medicare reimbursement. This legislation is known as the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). This was followed by OBRA 1990, which clarified some of the questioned areas of OBRA 1987. The minimum data set (MDS) and resident assessment protocols (RAPs) were a part of the legislation that had been implemented across the country in nursing facilities that accept Medicare and Medicaid funding as reimbursement for the care they provide. The MDS and the RAPs are two components of the mandated assessment process entitled the Resident Assessment Instrument (RAI).

Although these children are only "playing nurse," they are illustrating what each reader of this book needs to do—practice, practice, and practice physical assessment skills until you have confidence in them.

The MDS provides an outline of the most essential information that must be collected about every resident admitted to a nursing facility. Nursing observations, physical assessment, health history, interview of the older adult and the family, and completion of the RAPs added to the MDS make a comprehensive assessment. (An example of a comprehensive assessment is included in the case study at the end of this chapter and in the Appendix at the end of the book.)

What does a nurse do with all of the information that has been collected during assessment? The MDS refers care providers to a list of problem areas that must be addressed in the plan of care. Each of these problem areas also has a RAP that lists areas that require further assessment and consideration before designing the plan of care (Box 3.1).

Frequently, the RAPs are not actually incorporated into the assessment process. These protocols, however, extend the assessment from the minimum information of the MDS and offer a more thorough review of the problem area identified by the MDS.

The Nursing Diagnosis

Developing the nursing diagnosis is a primary responsibility of the registered nurse. It involves the use of diagnostic reasoning to reflect the

FOCUSED LEARNING CHART

Resident Assessment Instrument (RAI)

Federal law requires all facilities that have Medicare or Medicaid residents to have a Resident Assessment Instrument (RAI) that has minimum data sets (MDSs).

Essential information that must be collected on residents	Resident Assessment Protocols (RAPs)	Information is used for:
Nursing observations	Areas that require further assessments before designing care plans	Meeting federal requirements
Physical assessments	Specialized assessments done by IDT members	Referring IDT members to the list of problems to be addressed
Health history		
Interviews with older adult and family		

BOX 3.1 Eighteen Problem Areas Identified from the Minimum Data Set

Delirium
Cognitive loss/dementia
Visual function
Communication
Activities of daily living: function/rehabilitation potential
Urinary incontinence and indwelling catheter
Psychosocial well-being
Mood state
Behavior problem
Activities
Falls
Nutritional status
Feeding tubes
Dehydration/fluid maintenance
Dental care
Pressure ulcers
Psychotropic drug use
Physical restraints

older person's strengths, problems, and potential problems. The registered nurse considers the assessment data and organizes them to decide whether they meet criteria for a specific nursing diagnosis. The North American Nursing Diagnosis Association (NANDA) has identified diagnoses that are widely accepted and understood by multiple disciplines and are viewed as the national standards for nursing diagnoses. The NANDA diagnoses are not specific to older people, but they are useful in providing consistent expression of nursing diagnoses for all disciplines and in all settings. An example of a NANDA diagnosis is the following: *Comfort altered, Pain, related to: degenerative joint disease.*

In the long-term care setting, nurses often prefer to use nursing diagnoses that incorporate the MDS language and format.

An example of an MDS-related nursing diagnosis is the following: *Potential for joint pain due to degenerative joint disease.* Common nursing diagnoses for older adults include:

- Self-Care Deficit
- Physical Mobility, impaired
- Nutrition, altered: less than body requirements
- Injury, high risk for
- Urinary Elimination, altered
- Constipation
- Thought Process, altered
- Skin Integrity, impaired: high risk for

It is the responsibility of the registered nurse to ensure that nursing diagnoses address the comprehensive assessment. The nursing diagnosis is an important part of the nursing process and addresses the potential and actual problems of the older adult.

Nursing Diagnosis and Medical Diagnosis

There are two basic ways to communicate the nature of an older adult's health problems. One way is by medical diagnoses, and the other is by nursing diagnoses. Medical diagnoses are made by a physician and describe a disease or a disease process. Diseases are diagnosed by identifying a specific group of signs and symptoms. For example, diabetes mellitus is diagnosed when a person has elevated fasting blood sugar levels, weight loss, thirst, and a large urine output. A person who has an area of dead brain tissue on magnetic resonance imaging (MRI) and computerized tomography (CT) scans, along with speech and swallowing difficulty and left-sided paralysis, would be diagnosed with a cerebrovascular accident (CVA). Both of these medical diagnoses are common for older adults and communicate information to the nurse about what physical or psychological processes are happening to the person.

The major problem with planning care based only on medical diagnoses is that they do not describe the individual problems of the older adult or the impact the disease has on the person's day-to-day life. Nursing diagnoses, on the other hand, are specific to the individual older person's nursing care needs and frequently relate to the areas in which the older person has difficulty functioning.

For example, an obese person who is newly diagnosed with diabetes mellitus may have the following nursing diagnoses:

- *Nutrition, altered: more than body requirements and knowledge deficit related to poor dietary practices.*

A long-term diabetes patient may be experiencing problems with a heel ulcer that will not heal. In this case, the nursing diagnosis would be as follows:

- *Skin Integrity, altered.*

Both of these people have the same medical diagnoses but different health-care needs, as shown in their nursing diagnoses.

Planning

After organizing the assessment data and noting the nursing diagnoses identified by the registered nurse, the practical nurse, working with the older adult, the family, and the health-care team, begins the planning part of the nursing process. The planning portion of the nursing process includes setting priorities, identifying goals and outcomes of care, and designing and documenting interventions.

Setting Priorities

The nurse reviews the nursing diagnoses and places them in priority order. Remember the example at the beginning of this section? Removing the lodged food so the resident could breathe would be a higher priority than putting on the resident's shoes!

One of the most popular models used to assist the nurse in setting priorities is Abraham Maslow's hierarchy of needs. This framework gives life-sustaining needs the highest priority. These needs are followed by safety and security needs, love and belonging needs, self-esteem needs, and self-actualization needs.

Because the nursing process is focused on the older person as an individual, it also is necessary to consider the priorities of the resident. Often, a resident will state that the highest priority is to go home. The resident may refuse treatments, medications, and activities that will maintain personal health because no one is assisting in the patient's discharge. Although discharge may not be realistic (at this time), you, as the nurse, will probably be more successful in providing nursing care if the plan of care addresses discharge to home as a high priority.

This is an example of how the nutrition nursing diagnosis can be considered:

- *Nutrition, altered: less than body requirements*
  Resident refuses to eat and drink.
  Discuss with the resident what is usually eaten at home and how it is prepared.
  Review how the person's current health status would affect the ability to buy food, prepare it, and eat at home.

Discuss strategies and plans for ensuring that the resident is able to eat after returning home.
Include the resident's food preferences in meals.

Goal Setting or Identifying Outcomes

After identifying the priorities for the resident's care, the nurse identifies goals or outcomes for each of the nursing diagnoses. Setting goals is something that most of us do all of the time. Sometimes our personal goal may be to clock out on time or to survive a busy day. The goals that are part of the planning process, however, describe the specific resident outcomes and identify the goals that direct nursing care. To direct care and describe outcomes, goals must be:

- *Measurable*—measurable outcomes need to be identified. "Eating 100% of a meal" can be measured, whereas it is difficult to measure "appetite will improve."
- *Realistic*—the goal must fit in with the resident's abilities. "The resident will recall the correct date and time" is probably an unrealistic goal for a person with Alzheimer's disease.
- *Specific*—the goal should identify certain behaviors or conditions to aid in their attainment and evaluation. "The resident will feel better" is not specific. It could be better worded as, "The resident will state that he has less nausea."
- *Timely*—a time frame needs to be established for the attainment of each goal. "The resident will walk 100 feet" does not specify a time frame for achievement of this goal. Adding "by the end of December" provides a time frame.
- *Attainable*—the goal should be written in such a way as to communicate a motivating factor to the resident and the nursing care staff. For an older adult with left hemiplegia, a goal such as "The resident will be independent in self-care by the end of the year" may be a strong motivator to work harder at the occupational and physical therapy sessions.

In nursing facilities, the documentation regulations under OBRA 1987 and OBRA 1990 require that the status of goal attainment be systematically addressed. These documentation requirements are the monthly summaries (a comprehensive review of outcomes every 30 days) and the quarterly reviews (comprehensive interdisciplinary review of the resident's plan of care every 90 days) (Box 3.2). With new admissions or specific insurance carriers, the nurse may be required to conduct monthly comprehensive assessments of the outcome of care. This provides a 30- or 90-day time framework in which goals can be designed. It also helps the nurse think about what is realistic in that specific time frame. For a resident who is rehabilitating after having a hip replacement, "Ambulate independently" may be a realistic goal in 6 months. "Stand and walk 10 steps with a walker" may be a more realistic goal for 30 days. The following are examples of goals:

- The resident will eat more than 75% of each meal for the next 30 days.
- The resident will toilet independently when reminded to go to the bathroom for the next 90 days.
- The resident will attend one activity daily for the next 90 days.
- The resident will have no signs and symptoms of a urinary tract infection for the next 90 days.
- The resident's supplemental oxygen needs will be decreased to 1 L in the next 30 days.

Look back at these goals. What do you notice about them? Each goal identifies something that the resident will or will not do or will or will not experience. The resident's behavior is the major focus of goals as outcomes. Nursing care is not part of the goal. "Bathe the resident" is a nursing intervention, not an outcome or a goal. Nursing standards also are not part of the goal statements. "Administer all medications within 30 minutes of their ordered time" is a nursing standard, not a resident goal.

POINT OF INTEREST

Did you notice how many times the term *resident* was used in the previous explanation on outcomes? In the 1987 OBRA Act, the federal government determined that persons living in a long-term care facility are to be referred to as residents. The reason is because they live there; they are residents of the facility.

BOX 3.2 Assessments Needed for Each Nursing Home Resident

Comprehensive Admission Assessment including Resident Assessment Instrument (RAI)

1. Minimum data set (MDS)
2. Resident assessment protocols
3. Ongoing nursing assessment

Annual Reassessment including RAI
Significant Change In Status Assessment including RAI
Quarterly Assessment including part of MDS

Designing and Documenting the Plan of Care

Once the goals or outcomes of care are identified, the practical nurse, along with the other members of the IDT, begin to plan the activities that will help the older person reach the goals. The planning phase involves discussion and pen-and-paper activity. Discussing and documenting the plan of care allows input from all members of the team to be communicated to all staff members who are providing care for that resident. Standards of nursing practice and federal regulations require that each resident have a written, comprehensive, and interdisciplinary plan of care. The plan of care includes the problem or potential problem to be identified, the actions or interventions to be taken to address the problem, the person or discipline responsible for each action, and the goals to be achieved. An example of interventions in an interdisciplinary plan of care follows:

- Document percentage of food eaten at each meal—nursing
- Feed resident and assess swallowing ability—speech therapy
- Review dietary preferences—dietary services
- Promote feeding of self—restorative nursing

The focus of this chapter is on developing interdisciplinary plans of care using the nursing process. As you can see, all disciplines caring for the resident need to be represented in an actual plan of care. This is an important criterion for planning interventions: planned interventions must complement the interventions of other therapies. For example, it would be confusing for the resident to be ambulated with a walker by physical therapy and encouraged to walk with two canes by the nursing staff.

It is critical that members of all disciplines discuss and develop the components of the interdisciplinary plan of care so that confusion among the staff does not occur. Residents who are asked to perform one way in physical therapy and another way on the nursing unit can become confused as to how they should perform. A coordinated approach between physical therapy and nursing helps residents improve quickly and maintain function longer. A coordinated approach among all disciplines enhances the effectiveness of the care given to the resident and minimizes duplication of efforts.

Nursing interventions also must consider the safety of the resident. "Administering a diuretic and a sleeping pill at bedtime" is an unsafe nursing action. The resident may fall while going to the bathroom at night if still groggy from the sleeping pill. Transferring a resident who is able to stand only with the assistance of one staff member may place that resident at risk of falling.

CRITICALLY EXAMINE THE FOLLOWING:

Identify the correctly stated resident-based outcomes or goals in the following list. When the outcomes or goals are not properly expressed, explain what is wrong.

1. The resident will walk more in the next 90 days.
2. The nurse will toilet the resident every 2 hours for the next 30 days.
3. The resident will have no areas of skin breakdown in the next 90 days.
4. The resident's nutrition will improve.
5. The resident will drink 1500 mL a day for the next 90 days.

The correct answers and rationales follow.

1. This goal is not measurable. It would be better stated as follows: "The resident will walk 100 ft in the next 90 days."
2. This is a nursing intervention rather than a goal. It would be better stated as follows: "The resident will void when toileted by the nursing staff every 2 hours for the next 90 days."
3. This is a realistic, specific, and attainable goal. The outcome of care can be measured.
4. This is a noble goal, but it is not specific or measurable. It would be better stated as follows: "The resident will gain 2 lb in the next 30 days."
5. This is a realistic, specific, and attainable goal. The outcome of care can be measured.

Selected nursing interventions should help to attain the identified goal. If a resident's goal is to "lose 1 lb a week," giving "dietary supplements between meals and at bedtime" would not assist in achieving this weight loss. When the resident's goal is "will ambulate 100 ft by the end of the month," a nursing intervention must state that the nursing staff will assist the resident to ambulate.

Nursing interventions also must be realistic for the resident, staff, resources, and equipment. A reality in the workplace is that there often is not extra time for staff to talk to the residents. Therefore, providing 30 minutes of one-on-one time discussing pain every shift is an unrealistic intervention. Stating that each staff member "will ask the resident about hip pain whenever he or she interacts with the resident" is a more realistic intervention.

To be successful and effective, nursing interventions must be developed with input from the certified nursing assistants (CNAs). CNAs are important members of the interdisciplinary team. Nursing assistants spend more time with clients in nursing facilities, assisted living facilities, retirement communities, and sometimes in the client's home than any other member of the IDT. They can offer important specific information for the assessment of the client. Because CNAs are so familiar with the daily routine and functioning of the clients, they can offer pertinent, realistic suggestions for individualized interventions to deal with specific problems. They also are frequently the first people to notice subtle changes in residents' conditions that may indicate onset of a new problem or success or failure of an intervention. A care plan meeting, including representatives of all disciplines, is generally held to discuss assessment information and develop the interdisciplinary plan of care. The CNA, who works with the resident to be discussed, must be invited to this meeting and arrangements made to facilitate the CNA's attendance. The time away from the unit for the CNA is minimal compared with the value of the CNA's input into the care-planning process.

Successful nursing interventions require the resident's input and should be important to the resident. A resident may not want to "lift weights to strengthen and increase flexibility of his arms" but may be very willing to "comb his hair and wash his face." "Encourage the resident to drink 1000 mL of water" may not work as well as "encourage the resident to drink 1000 mL of fruit juice and water."

Nursing interventions also must include continuing assessment and monitoring of disease processes and effects of medications and treatments. If a resident has an IV, the IV site must be "assessed every shift for signs of infiltration, irritation, and infection." If a resident is receiving therapy with digoxin (Lanoxin), the "apical pulse must be taken and recorded before each dose." Residents with congestive heart failure (CHF) should be "assessed for edema and dyspnea."

Remember that the plan of care is part of the resident's permanent record. It needs to be routinely reviewed and updated as the resident's health status improves or declines. The monthly and quarterly review times provide an excellent opportunity to revise the care plan to ensure that the resident is receiving appropriate nursing care.

Implementation

Implementation is the part of the nursing process that nurses do best. Being at the bedside of the resident providing care is one of the most rewarding aspects of being a nurse. Implementation means actually putting the plan of care into action. Along with providing the nursing care that has been outlined in the resident's nursing care plan, the LPN continues to collect data that can be used to update and revise the plan of care.

Many interventions from the plan of care are assigned to CNAs. This is another strong reason to have CNAs attend the care plan development meeting. If the CNAs have an opportunity to provide input into the plan of care and they are present when it is discussed and developed, they will be more likely to carry out the interventions than if they are merely told what to do or handed a care plan to read.

Because nursing assistants on all shifts cannot attend the care plan meeting, a major challenge for the practical nurse is communicating the plan of care back to all CNAs. A variety of communication techniques can be used. Some facilities provide nursing assistants with written assignments that list all of the interventions for each resident. Many facilities place the plan of care in a book and make it available to the staff. Very often, however, the book is rarely consulted. Meeting regularly with nursing assistants to discuss the plan of care, giving each CNA written assignments with information on the plan of care, and using primary CNAs who care for the same residents each day will ensure the implementation of the plan of care. This will make it a working document rather than a useless piece of paper completed only to comply with regulations.

This woman was admitted to a nursing home with limited mobility, weakness, mild confusion, and heart failure. Her stated goal was to be strong enough to hold her great-grandchildren and to sit up and talk to her grandchildren, who ranged in age from 15 to 43. The MDS indicated several other goals to implement for her optimum health. As you can see, her priority goal as well as those identified through the MDS were met.

Another difficult aspect of implementation is that it must be documented. Charting is an important part of implementing the plan of care. Documentation of interventions requires recording not only that the intervention was done but also the resident's responses to the intervention. An entry such as the following provides no information about the resident's response to the treatment:

12/16/06 1420 Wet to dry saline packing to coccyx ulcer

A better picture is given in the following chart:

12/16/06 1420 Wet to dry saline packing to coccyx pressure ulcer. Ulcer is 3 × 2 cm and 1.5 cm deep. Ulcer margins are pink, and there is granulation tissue evident. Small amount of yellow serous drainage on old packing. Resident complained of pain when old packing was removed and new packing inserted. Two small (6-mm) scabs on left buttocks from tape irritation. No redness or drainage noted.

Every visit with the resident is an opportunity to reassess your nursing diagnoses and their implementation. A simple model that can be used to document the nursing process with nursing interventions and resident responses is presented below:

Assessment What the nurse observed and assessed
Objective measurements (blood pressure, laboratory values)
What the resident did (response to nursing intervention)
What the resident said
Action What the nurse did (nursing interventions): treatments, turning the resident, giving a medication, increasing the oxygen flow rate, hanging a tube feeding, inserting a catheter
Plan What the nurse plans to do: call the doctor, call the family, reassess with the next treatment, refer resident to social services

The assessment–action–plan charting format is simple, yet it sets up a framework for documenting the nursing process in a narrative format.

CNAs also may be involved in documentation and may provide information for the practical nurse's documentation. Flow sheets that include interventions from the plan of care and activities from the resident's day can be completed by nursing assistants. Flow sheets can be used to document such interventions as ADLs, walking programs, bowel and bladder training programs, and dietary intake and feeding programs. Results and trends from the flow sheets can be incorporated into the LPN's regular progress charting.

Evaluation

Evaluation is the final step in the nursing process. The main purpose of evaluation is to decide if the resident has met the identified goals and to assess the outcomes of the nursing care provided. Remember how, in the discussion of implementation, the importance of assessing the resident and documenting the resident's responses to care was emphasized? The chart and resident assessments are reviewed as part of evaluation.

When goals have been stated in measurable terms, the LPN should be able to review all of the data and decide whether the goal has been met, has been partially met, or remains unmet. This is a straightforward look at the resident's response to the nursing interventions. The evaluation of goal achievement needs to be documented in a monthly summary, a quarterly review, or the nursing notes.

Evaluation also requires that the nurse review the nursing process. This helps to keep the plan of care up to date and reflects changes in the resident's health status. It also is an opportunity to decide which nursing interventions were ineffective (Box 3.3).

The reassessment of the resident and the plan of care in evaluation really addresses the dynamic strength of the nursing process. Although it follows specific, organized steps, no step excludes collecting more data. This is done by assessing the resident, updating goals and interventions, and conducting an ongoing evaluation of the outcome of the care that is provided. Nurses seem to use the nursing process even when they do not identify it as such. Here are some examples.

Mary Jones always was incontinent during the 1:00 a.m. rounds. The nursing staff decided to toilet her at 12:30 a.m.

In this example, the nursing staff assessed incontinence as a problem. Their unstated goal was, "the resident will not be incontinent at 1:00 a.m. rounds." Their intervention was to toilet the resident 30 minutes before she was usually incontinent. After toileting the resident at 12:30 a.m., the resident would be checked for urinary incontinence at 1 a.m. If she was not incontinent, the goal would be achieved and the staff would continue to toilet the resident at 12:30 a.m. to maintain that outcome. If the resident was toileted at 12:30 a.m. and she still was incontinent at 1:00 a.m., the staff may decide to toilet the resident at midnight. The care plan and charting examples provided in Figure 3.2 demonstrate the use of evaluation.

As this example shows, evaluation is ongoing and takes place daily, not just at the mandatory reassessment intervals. Thus, evaluation does not take place only when the quarterly assessment is due. Would you continue to carry out an intervention that was not working for 3 months until the quarterly review was due? Many people help you evaluate the plan of care each day. Residents give you information by their behavior and by telling you if an intervention is helping or not. Families tell you about changes they notice. Nursing assistants frequently note subtle changes in residents and may alter interventions to accommodate the change in the residents.

Making daily changes in the actual care given is common. Translating these changes into the written plan of care is less common. For the sake of communication and consistency among all staff, it is very important to be sure that the written plan of care is updated to reflect the actual care you want to be given.

BOX 3.3 Significant Change in Resident's Status

Decrease in level of functioning in two or more activities of daily living

Decrease or increase in the ability to walk or the use of hands to grasp small objects

Decline in health status that is not responsive to treatment

Changes in behavior or mood that cause daily problems in assisting the resident to achieve goals

COMPUTERS AND THE NURSING PROCESS

More and more nursing facilities throughout the country are installing computers to help nursing staff complete the MDS assessment and care plans. The practical nurse may be asked to enter MDS data directly on the computer or to complete the written form while another nurse enters the assessment data on the computer for all residents. Many different kinds of software are available that can be used by nurses to complete the MDS, RAPs, and care plans. Each software program is somewhat different, and generally no one program will do everything that you want it to do.

If you have never worked on a computer before, you may be fearful of using it for your assessment and care plans. Completing the MDS and the care plan on the computer, however, has many benefits that warrant overcoming your fears. One of the most time-consuming portions of the MDS is computing the triggers, that is, identifying the potential problem areas that need to be further assessed through the RAPs. Most MDS software packages compute the triggers in a matter of seconds. Completing the interdisciplinary care plan on the computer saves the nurse from a great deal of handwriting and lends itself to regular updating without further lengthy handwriting. Some software packages will print out nursing assistant forms that include all the interventions from the plan of care assigned to the nursing assistant. These forms can be used as assignment sheets that communicate the plan of care to the CNA.

Nursing Diagnosis Problems Addressed	Goals Outcomes of Care	Nursing Interventions	Evaluation
Physical Mobility, impaired related to musculoskeletal impairment as manifested by inability to transfer and ambulate without assistance	Resident will increase ambulation with walker in PT to independent use with minimal supervision in 90 days	■ Assess and document: Orthostatic BPs (lying/sitting/standing) ROM and strength of legs and arms Walking ability with walker and amount of assistance needed ■ Have walker in resident's reach at all times and use for all transfers and walking in room ■ Physical therapy for quad-strengthening exercises and ambulation with walker ■ Put on jogging pants for daily physical therapy	

DOCUMENTATION

October 11, 2006, 1:45 p.m.: Resident is transferred from bed to wheelchair with assistance of one. Uses walker to steady himself when standing. Ambulates with hold-on assistance from physical therapist using a walker. Ambulated two steps without hold-on assistance before becoming unsteady. Orthostatic BPs lying—138/82, sitting—110/80, standing—106/76, complained of being light-headed when he sat up. Dizziness passed in 5 minutes. Instructed to move slowly from lying–sitting–standing positions and not to move to another position until any dizziness or light-headedness passes. Will review medications and fluid intake for possible causes of orthostatic hypotension.

FIGURE 3.2. Sample care plan.

CONCLUSION

As an LPN, you have major responsibilities for delivering meaningful nursing care to residents in long-term care facilities. Your responsibilities include the management of care given by nursing assistants, working with the IDT, completing documents required by the federal government, and delivering excellent care to the frail and vulnerable people in your care. It is essential that you understand and become highly skilled in the content of this chapter. Best wishes as you proceed to meet that objective.

CASE STUDY

Resident Admission

December 1, 2006, 1 p.m.: Mr. B., 82-year-old white widowed male, is admitted to Room 112 of Quality Care Health Facility from Mercy Hospital via ambulance accompanied by daughter-in-law. Admitted with diagnosis of fractured left wrist, multiple hematomas and abrasions, Alzheimer's disease, diabetes mellitus, and a history of CHF. Dr. Ben Johnston notified of admission and verified orders. Dietary notified of 2 g sodium/no concentrated sweets diet. Medication orders faxed to the pharmacy:

furosemide (Lasix) 40 mg q.d. for CHF and COPD
digoxin (Lanoxin) 0.125 mg q.d. for CHF
potassium chloride (K-tabs) 2 tabs q.d. for CHF
glipizide (Glucotrol) 5 mg q.a.m. for diabetes
oxazepam (Serax) 20 mg q.h.s. for insomnia
haloperidol (Haldol) 1 mg b.i.d. for agitation
ducosate (Dulcolax) sodium suppository q.d. prn constipation
acetaminophen (Tylenol) gr 10 q.4h. p.r.n. pain
hydrocolloid gel (DuoDerm) to open area on coccyx change q.o.d.
mupirocin (Bactroban) to abrasions b.i.d.
nystatin (Mycostatin) ointment to perineal rash b.i.d. 3 to 10 days
Ace wrap and splint to left wrist at all times
return to clinic in 2 weeks

Son has durable power of attorney for both financial and health-care decisions and has signed the advanced directive form for "Do Not Resuscitate." Resident has a living will, and his wishes are known to his family.

Daughter-in-law reports that he has no known allergies, wears bifocals and reads large-print Reader's Digest occasionally, has upper and lower dentures, does not use a hearing aid, and has minimal difficulty hearing unless in a noisy room. Uses a cane to ambulate. Height, 5′9″; weight, 124 lb.

Mr. B. is alert and oriented to self and daughter-in-law but states that it is 1936, that the season is winter, that the month is September, and that he is in Denver. Since his wife died 6 months ago, he has been living with his son and his family. His daughter-in-law has been his principal caregiver. Caring for Mr. B. has been quite stressful at times. He does not strike out but repeatedly asks the same questions over and over, even when the question has been answered. His daughter-in-law took a leave of absence from her job because Mr. B. could no longer stay in the house alone without becoming very anxious. He would call friends on the phone repeatedly and ask for his deceased wife. He would often go for walks and get lost.

Mr. B. was admitted to Mercy Hospital after he had fallen on an uneven sidewalk four blocks from home and suffered a concussion, multiple facial hematomas, abrasions on his right arm and shoulder, a fractured left wrist, and a large hematoma on his left hip. His daughter-in-law had been in the basement folding laundry when Mr. B. left the house. The family is expressing much guilt over the decision to place Mr. B. in a long-term care facility, but they admit that he would be safer there.

Mr. B. is able to walk with his cane but favors the left hip when he stands and is very unsteady. He forgets where he is and cries out for help. He is able to dress himself but must have supervision to remind him of what he is doing. Mr. B. is able to feed himself but has not been eating and has lost a significant amount of weight in the past 3 months. Mr. B. has been generally continent of his bladder and bowel except while in the hospital, where he was incontinent of both.

Mr. B. was an accountant before he retired, and he would often spend hours with a paper and pencil "doing the books." He has always enjoyed classical music and was quite an accomplished pianist. He had season tickets to the ballet and the opera and would go often before his wife died 6 months ago.

CHF = congestive heart failure; COPD = chronic obstructive coronary disease; b.i.d. = twice daily; p.r.n. = as needed; q. a.m. = every morning; q.o.d. = every other day; q.4h. = every 4 hours; q.h.s. = before bedtime, every hour of sleep.

Physical Assessment

General Appearance	*Thin white male*
Head and Neck	White hair. Scalp dry with multiple areas of white dry flaking. Face symmetrical, two 5-cm hematomas on left cheek and jaw. Two-centimeter hematoma on left forehead, skin also is dry. Eyes are clear with no drainage, conjunctivae pink, pupils are equal at 5 mm and react briskly to light, consensual, and accommodative. No drainage from nose; patient is able to breathe through both nostrils. No drainage from ears. Did not appropriately respond when asked in a whisper to raise his arm. Oral mucous membranes are pink and dry. No denture irritation noted. No saliva pooling noted between gum and cheek. Tongue pink with no coating; remains at midline when extended from mouth. Throat dry with no pharyngeal drainage or redness noted; no cervical lymph nodes palpable; no thyroid nodules or enlargement palpated.
Chest	Symmetrical chest movements. Breath sounds clear throughout except for expiratory crackle in base of left lower lobe that cleared with cough. Apical pulse: 78 and regular. No extra heart sounds noted. Back has multiple waxy, light brown to medium brown, 2- to 3-cm, flat, raised lesions. Moderate kyphosis of spine.
Abdomen and Buttocks	Large (8 × 12 cm) hematoma over left hip and left lower abdominal area. Hard stool in rectum. Active bowel sounds in all quadrants. Abdomen soft. No masses palpable. A 2- × 1.5-cm stage 2 pressure ulcer over coccyx that is oozing serous drainage. Three small fluid-filled vesicles in gluteal fold of right buttocks.
Genitourinary	Normal male genitalia. Urinary meatus reddened. Urine dark amber and foul smelling. Fiery red rash noted on inner aspects of both upper thighs and scrotum.
Extremities	Full range of motion (ROM) of shoulders, elbows, right wrist, and fingers. Left wrist is splinted with a rigid plastic splint and wrapped with an Ace bandage that he is constantly unwrapping. Radial and brachial pulses strong and equal bilaterally. Healing abrasions noted over lateral aspect of left upper arm and left shoulder. Limited ROM of both hips with complaints of pain with movement of left hip. Full ROM of both knees and ankles. Femoral and popliteal pulses strong and equal bilaterally. Left pedal pulse weak and 1+ pitting edema noted in left ankle. Right pedal pulse strong and right ankle edematous with no pitting noted. Homans' sign not present bilaterally, and no complaints of calf tenderness to palpation. One-centimeter eschar noted along medial nail of the left great toe. No drainage noted, but there is slight redness around the eschar.

December 6, 2:00 p.m.: Mr. B. was found in another resident's room, pulling clothes out of the closet. This is a daily occurrence. Mr. B. cannot explain why he is in the other resident's room and does not know the way back to his room. He yells at his roommate to get out and yells randomly at other residents in the facility. When he is in his room, he cries for help but does not have any requests or needs when the staff members answer. He went 3 days without having a bowel movement and was incontinent of stool in the hallway 30 minutes after being given a suppository. Mr. B. attends activities when asked to go, but he often leaves the activity early. He naps for 1 to 2 hours in the afternoon and is awake frequently at night, when he has to be reminded to stay in bed. He was found one night stuck between the side rails and incontinent of urine.

The MDS for Mr. B. is shown in Figure 3.3.

784393

MINIMUM DATA SET (MDS) — VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

1. RESIDENT NAME: George T. Blair
2. GENDER: 1. Male 2. Female — 1
3. BIRTHDATE: 10 - 15 - 1924
4. RACE/ETHNICITY: 5
5. SOCIAL SECURITY AND MEDICARE NUMBERS: 005 06 7800; 005067800A
6. FACILITY PROVIDER NO.: 54019
7. MEDICAID NO.: N
8. REASONS FOR ASSESSMENT: 1
9. SIGNATURES OF PERSONS COMPLETING THESE ITEMS: A. Jones, R.N. 12/2/2006

Code "NA" if information unavailable or unknown.

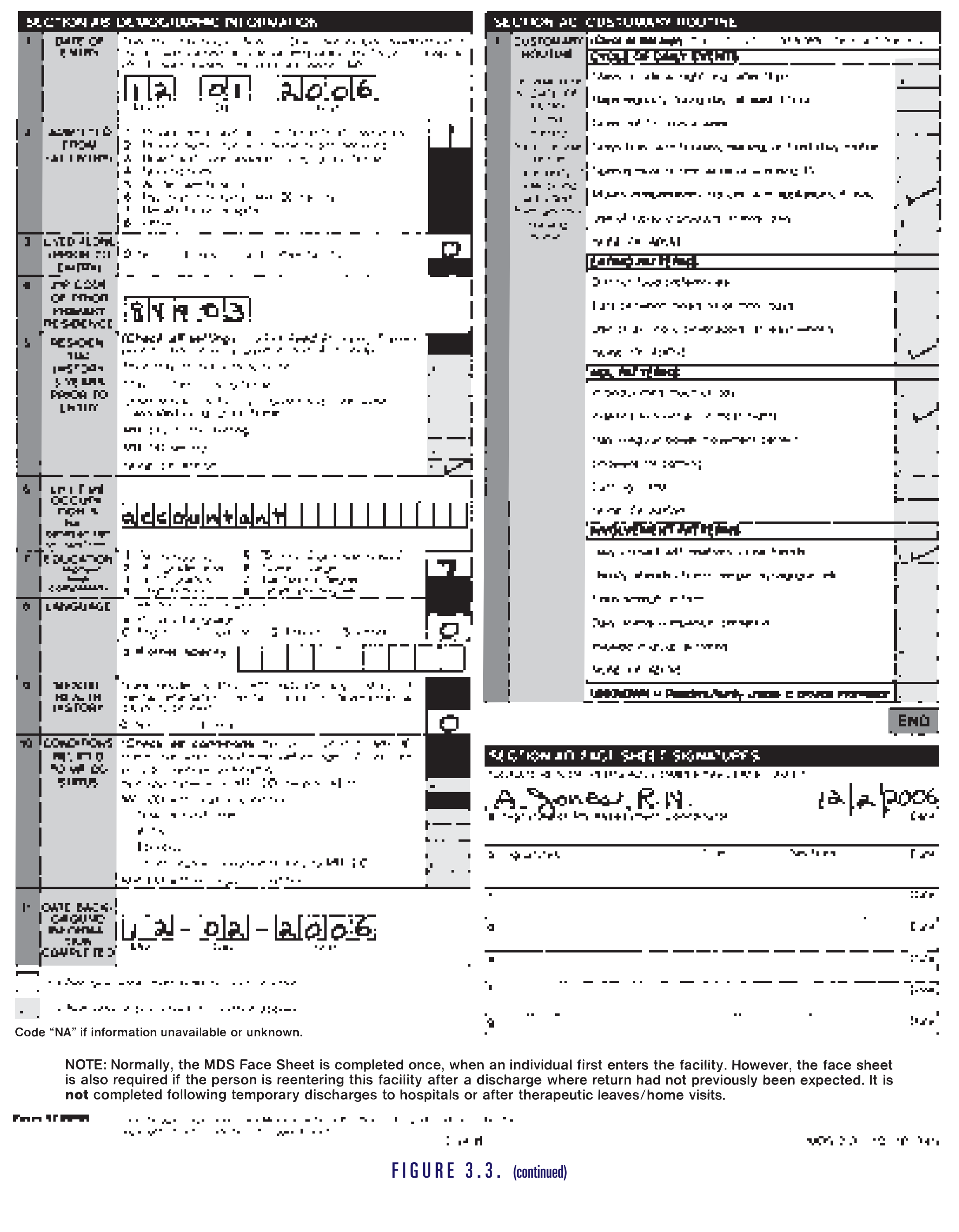
TRIGGER LEGEND

1 - Delirium
2 - Cognitive Loss/Dementia
3 - Visual Function
4 - Communication
5A - ADL-Rehabilitation
5B - ADL-Maintenance
6 - Urinary Incontinence and Indwelling Catheter
7 - Psychosocial Well-Being
8 - Mood State
9 - Behavioral Symptoms
10A - Activities (Revise)
10B - Activities (Review)
11 - Falls
12 - Nutritional Status
13 - Feeding Tubes
14 - Dehydration/Fluid Maintenance
15 - Dental Care
16 - Pressure Ulcers
17 - Psychotropic Drug Use
17* - For this to trigger, O4a, b, or c must = 1-7
18 - Physical Restraints

Form 1728HH

1 of 8

FIGURE 3.3. Sample minimum data set.



George Blair 784393

MINIMUM DATA SET (MDS) — VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY: 12 - 01 - 2006
2. ADMITTED FROM (AT ENTRY)
3. LIVED ALONE (PRIOR TO ENTRY): 0
4. ZIP CODE OF PRIOR PRIMARY RESIDENCE
5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY
6. LIFETIME OCCUPATION(S): accountant
7. EDUCATION (Highest Level Completed)
8. LANGUAGE: 0
9. MENTAL HEALTH HISTORY: 0
10. CONDITIONS RELATED TO MR/DD STATUS
11. DATE BACKGROUND INFORMATION COMPLETED: 12 - 02 - 2006

SECTION AC. CUSTOMARY ROUTINE

SECTION AD. FACE SHEET SIGNATURES

A. Jones, R.N. 12/2/2006

END

Code “NA” if information unavailable or unknown.

NOTE: Normally, the MDS Face Sheet is completed once, when an individual first enters the facility. However, the face sheet is also required if the person is reentering this facility after a discharge where return had not previously been expected. It is **not** completed following temporary discharges to hospitals or after therapeutic leaves/home visits.

FIGURE 3.3. (continued)

Resident George Blair   Numeric Identifier 784393

MINIMUM DATA SET (MDS) — VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME: George T. Blair
2. ROOM NUMBER: 112
3. ASSESSMENT REFERENCE DATE: 12-14-2006 (Month / Day / Year); 0
4a. DATE OF REENTRY: [illegible]
5. MARITAL STATUS: 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced — 3
6. MEDICAL RECORD NO.: 784393
7. CURRENT PAYMENT SOURCES FOR N.H. STAY: [illegible] ✓
8. REASONS FOR ASSESSMENT: [illegible]
9. RESPONSIBILITY/LEGAL GUARDIAN: [illegible] ✓
10. ADVANCED DIRECTIVES: [illegible] ✓

SECTION B. COGNITIVE PATTERNS

1. COMATOSE: 0. No 1. Yes (If yes, skip to Section G) — 0
2. MEMORY: a. Short-term memory OK — 1; b. Long-term memory OK — 1

SECTION B (continued)

3. MEMORY/RECALL ABILITY: ✓
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING: 3
5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS: a. 1; b. 1; c. 0; d. 0; e. 0; f. 0
6. CHANGE IN COGNITIVE STATUS: 0. No change 1. Improved 2. Deteriorated — 0

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING: 1
2. COMMUNICATION DEVICES/TECHNIQUES: ✓
3. MODES OF EXPRESSION: ✓
4. MAKING SELF UNDERSTOOD: 1
5. SPEECH CLARITY: 0
6. ABILITY TO UNDERSTAND OTHERS: 2
7. CHANGE IN COMMUNICATION/HEARING: 0

Code "NA" if information unavailable or unknown.

FIGURE 3.3. (continued)

Resident: George Blair — Numeric Identifier: 284393

SECTION D. VISION PATTERNS

1. VISION

2. VISUAL LIMITATIONS/DIFFICULTIES

3. VISUAL APPLIANCES

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

VERBAL EXPRESSIONS OF DISTRESS

SLEEP-CYCLE ISSUES

SAD, APATHETIC, ANXIOUS APPEARANCE

LOSS OF INTEREST

2. MOOD PERSISTENCE

3. CHANGE IN MOOD

4. BEHAVIORAL SYMPTOMS

5. CHANGE IN BEHAVIORAL SYMPTOMS

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/INVOLVEMENT

2. UNSETTLED RELATIONSHIPS

3. PAST ROLES

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE

a. BED MOBILITY

b. TRANSFER

c. WALK IN ROOM

d. WALK IN CORRIDOR

e. LOCOMOTION ON UNIT

f. LOCOMOTION OFF UNIT

g. DRESSING

h. EATING

i. TOILET USE

j. PERSONAL HYGIENE

FIGURE 3.3. (continued)

George Blair

784393

A = 1, 2, 3 or 4 = 5A

1, 2, or 3 = 17*

SECTION H. CONTINENCE IN LAST 14 DAYS

1, 2, 3 or 4 = 16

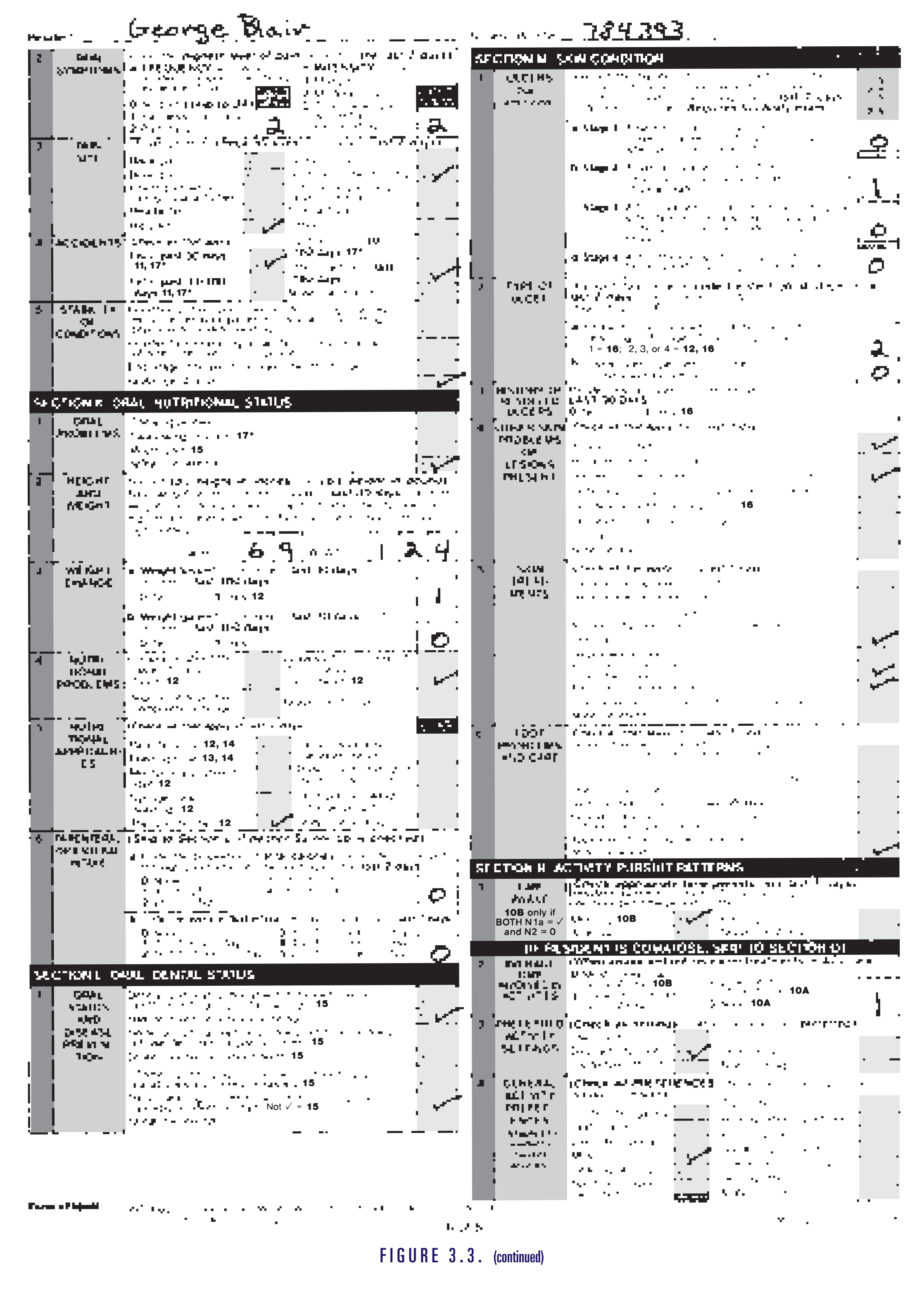
2, 3 or 4 = 6

SECTION I. DISEASE DIAGNOSES

Dehydration 276.5 = 14

SECTION J. HEALTH CONDITIONS

FIGURE 3.3. (continued)



George Blair

384393

SECTION K. ORAL/NUTRITIONAL STATUS

SECTION L. ORAL/DENTAL STATUS

SECTION M. SKIN CONDITION

SECTION N. ACTIVITY PURSUIT PATTERNS

IF RESIDENT IS COMATOSE, SKIP TO SECTION O

FIGURE 3.3. (continued)

Resident George Blair Numeric Identifier 784393

SECTION O. MEDICATIONS

(NOTE: For **17** to actually be triggered, O4a, b, or c MUST = 1-7 AND at least one additional item marked **17*** must be indicated. See sections B, C, E, G, H, I, J, and K.)

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

SECTION R. ASSESSMENT INFORMATION

A. Jones R.N. (O,P,Q,R) 12-14-2006

M. Moeller LPN (G,H,I,M) 12/14/2006

A. Miller TRT (N) 12/14/2006

A. Schmidt MSW (E,F) 12/14/2006

TRIGGER LEGEND

1 - Delirium	5B - ADL-Maintenance	10A - Activities (Revise)	14 - Dehydration/Fluid Maintenance
2 - Cognitive Loss/Dementia	6B - Urinary Incontinence and Indwelling Catheter	10B - Activities (Review)	15 - Dental Care
3 - Visual Function	7 - Psychosocial Well-Being	11 - Falls	16 - Pressure Ulcers
4 - Communication	8 - Mood State	12 - Nutritional Status	17 - Psychotropic Drug Use
5A - ADL-Rehabilitation	9 - Behavioral Symptoms	13 - Feeding Tubes	17* - For this to trigger, O4a, b, or c must = 1-7
			18 - Physical Restraints

FIGURE 3.3. (continued)

CASE STUDY *(continued)*

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY — 784393

Resident's Name: George T. Blair — Medical Record No.: 784393

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     - Nature of the condition (may include presence or lack of objective data and subjective complaints)
     - Complications and risk factors that affect your decision to proceed to care planning.
     - Factors that must be considered in developing individualized care plan interventions.
     - Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.)
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP Problem Area	(a) Check if Triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	✓	Mood + behavior problems \ Admit note, Nsg notes	✓
2. COGNITIVE LOSS	✓	Poor STM + LTM \ Nsg. notes	✓
3. VISUAL FUNCTION	✓	Wears glasses \ Admit note	✓
4. COMMUNICATION	✓	Difficulty making needs known + following directions \ Nsg. notes	✓
5. ADL FUNCTIONAL/REHABILITATION POTENTIAL	✓	Assist c ADL's \ Nsg. notes	✓
6. URINARY INCONTINENCE AND INDWELLING CATHETER	✓	Incont. of urine \ Admit note, Nsg. note	✓
7. PSYCHOSOCIAL WELL-BEING	✓	Verbally abusive \ Nsg. note	✓
8. MOOD STATE	✓	Expressions of distress \ Nsg. note	✓
9. BEHAVIORAL SYMPTOMS	✓	Wandering + rummaging behaviors \ Nsg. note	✓
10. ACTIVITIES			
11. FALLS	✓	Falling, lost wts \ Admit note	✓
12. NUTRITIONAL STATUS	✓	Wgt. loss, spec. diet \ Admit note, Nsg. note	✓
13. FEEDING TUBES			
14. DEHYDRATION/FLUID MAINTENANCE	✓	Constipation \ Nsg. note	✓
15. ORAL/DENTAL CARE			
16. PRESSURE ULCERS	✓	Coccyx pressure ulcer \ Admit note	✓
17. PSYCHOTROPIC DRUG USE	✓	Haldol, and + Diazepam HS \ Admit note, Nsg. note	✓
18. PHYSICAL RESTRAINTS			

B. 1. Signature of RN Coordinator for RAP Assessment Process: A. Jones, R.N. — Date: 12 / 14 / 2006 (Month / Day / Year)

2. Signature of Person Completing Care Planning Decision: A. Jones, R.N. — Date: 12 / 14 / 2006 (Month / Day / Year)

FIGURE 3.3. (continued)

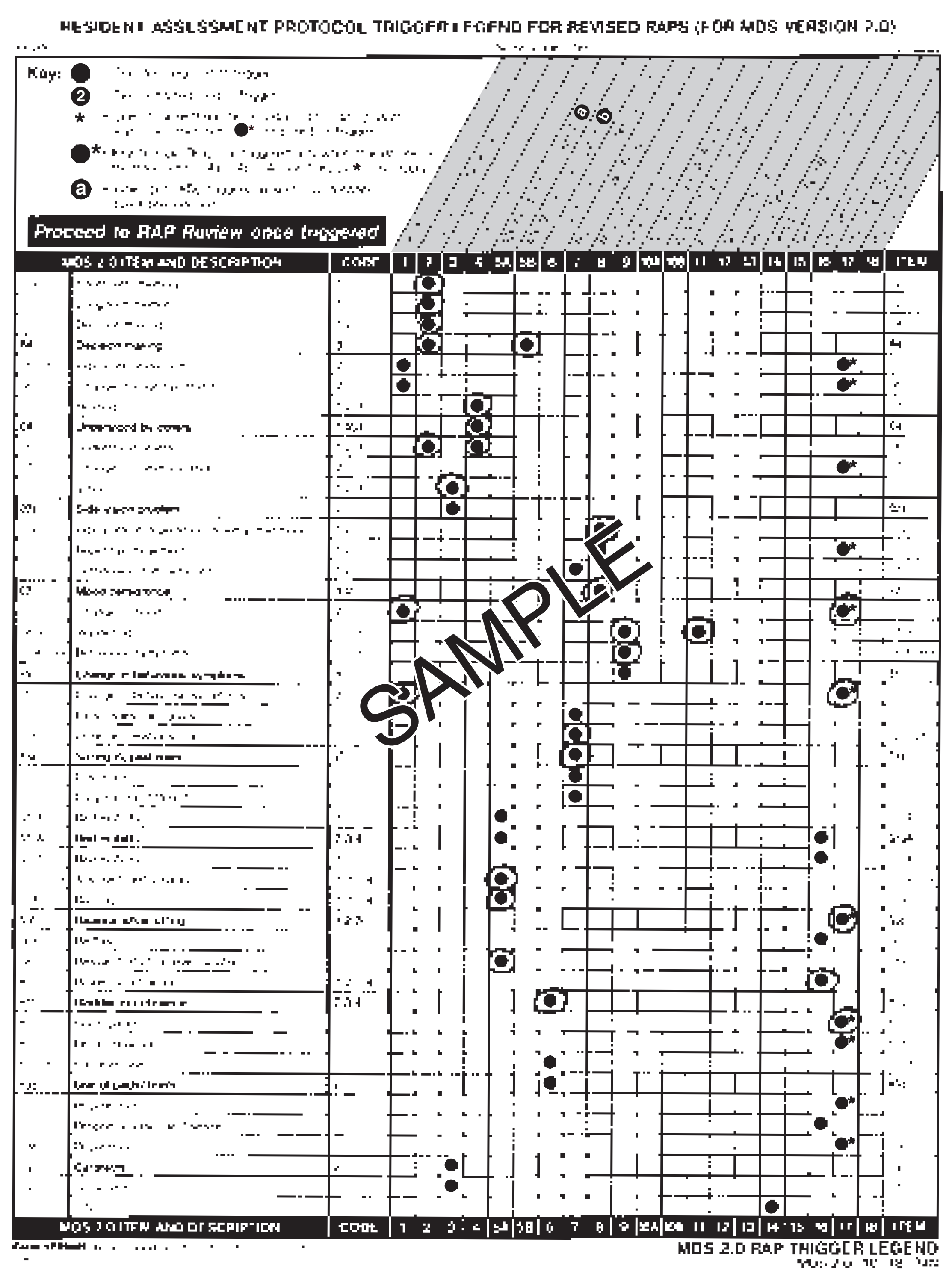


FIGURE 3.3. (continued)

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

Proceed to RAP Review once triggered

MDS 2.0 ITEM AND DESCRIPTION | CODE | ITEM

MDS 2.0 10/18/94H

FIGURE 3.3. (continued)

Discussion

Use the following nursing diagnoses to organize your assessment data and develop a nursing care plan for Mr. B. Be prepared to submit your care plan in class.

1. Nursing Diagnosis: *Self-Care Deficit* related to confusion manifested by inability to perform ADLs independently secondary to Alzheimer's disease and fractured wrist.
   ADL FUNCTION/REHABILITATION POTENTIAL
   VISUAL FUNCTION
2. Nursing Diagnosis: *Injury, high risk* for related to altered mobility as manifested by unsteadiness and wandering, secondary to hip injury and Alzheimer's disease.
   FALLS
   BEHAVIOR PROBLEMS
3. Nursing Diagnosis: *Nutrition, altered: less than body requirements* related to lack of appetite as manifested by significant weight loss in last 30 days secondary to Alzheimer's disease.
   NUTRITIONAL STATUS
   DEHYDRATION/FLUID MAINTENANCE
4. Nursing Diagnosis: *Urinary Elimination, altered* and *Incontinence* related to confusion mobility as manifested by not going to the bathroom to void secondary to Alzheimer's disease.
   URINARY INCONTINENCE AND INDWELLING CATHETER
5. Nursing Diagnosis: *Thought Processes, altered* related to inaccurate interpretation of environment as manifested by inability to state season, date, and remember names of staff members, inability to follow commands secondary to Alzheimer's disease, and possible use of antipsychotic and sedative medication.
   DELIRIUM
   COGNITIVE LOSS/DEMENTIA
   COMMUNICATION
   MOOD STATE
   BEHAVIOR PROBLEM
   PSYCHOTROPIC DRUG USE
   PSYCHOSOCIAL WELL-BEING
6. Nursing Diagnosis: *Skin Integrity, impaired* related to a fall and being restrained in bed during hospitalization manifested by hematomas, abrasions, blisters, and stage 2 coccyx pressure ulcer.
   PRESSURE ULCER
7. Nursing Diagnosis: *Constipation* related to decreased fluid intake as manifested by bowel movements hard and difficult to pass and use of suppository secondary to Alzheimer's disease, altered nutrition intake, and dehydration.
   DEHYDRATION AND FLUID MAINTENANCE
   NUTRITIONAL STATUS

STUDY QUESTIONS

Select the best answer to each question.

1. The nursing process is:

- **a.** A type of standardized care plan
- **b.** A framework for providing nursing care
- **c.** A procedure that registered nurses use to make care assignments
- **d.** An instinctive method of providing care

2. The steps in the nursing process are:

- **a.** Admission, inpatient care, and discharge
- **b.** Assessment, intervention, and documentation
- **c.** Assessment, nursing diagnosis, planning, intervention, and evaluation
- **d.** Admission, physical examination, interview, nursing history, and planning

3. Nursing diagnoses differ from medical diagnoses because they:

- **a.** Address the problems of the older person
- **b.** Are written in language that nurses understand
- **c.** Are standardized for any person who is receiving nursing care
- **d.** Are designed to address the medical treatment plan

4. When setting priorities during the planning stage of the nursing process, it is important to consider:

- **a.** The needs of the physician
- **b.** The needs of the family
- **c.** The needs of the nursing staff
- **d.** The needs of the resident

5. Evaluation of the nursing care plan is documented by means of:

- **a.** The nurse's notes
- **b.** The resident care plan
- **c.** The doctor's orders
- **d.** Revising the admission note

4

Legal and Ethical Considerations Regarding the Elderly Person

Mary Ann Anderson
Alicebelle Rubotzky

Learning Objectives

After completing this chapter, the student will be able to:

1. Compare and contrast the terms *legal* and *ethical*.
2. Define the guiding principles of a restraint-free environment.
3. Outline the role of the licensed practical nurse (LPN) in using advanced directives and informed consent.
4. Describe the legal definition of elder abuse and the LPN's role in reporting it.
5. Express an understanding of the ethical responsibility of working with older adults in meeting their sexual needs.

INTRODUCTION

Health-care decisions that are made daily across the nation are based on the legal and ethical definitions of health care. Advances in technology, increased resources, newer drug therapies, and other modalities of treatment continue to bring with them both ethical and legal problems and solutions to the health-care system that are unprecedented. While the legislators and ethics committees of this country debate the merits of treatment approaches, health-care providers deliberate every day as to their own direct care role and often wonder if it is one of help or hindrance. As a licensed practical nurse (LPN), you will be involved in making ethical and legal decisions that potentially are very complex. This chapter will assist you in understanding ethical and legal issues that relate specifically to the challenges facing older adults and their care.

CRITICALLY EXAMINE THE FOLLOWING:

What do you value in life? Your values create the foundation for your ethical behaviors. Make a list of the three things you value most in life in the left column. In the right column, put an example of a nursing situation in which that value would be either tested or proved. Be prepared to discuss your ideas in class. This is an example of how your submission should look.

My Values	Nursing Application
1.	1.
2.	2.
3.	3.

ETHICS

Ethics is the study of moral actions and values. It is based on the principles of conduct that govern both individuals and groups. Many people envision ethics as dealing with principles and moral concepts that determine what is good or bad behavior. The problem with this concept is determining who decides what is good and what is bad. Is this decision one for the older adult, the nurse, the family, or an outside group like an ethics committee?

A broader definition of ethics considers the value system of a person and the relationship of those values in determining what is good for an individual or group. It is important for LPNs to understand their own value systems and the ethical framework underlying the work performance that springs from it. The personal values of all the persons involved in making health-care decisions for older adults form the most important aspect of the nurse's delivery of ethical health care.

Patient's Bill of Rights

The Patient's Bill of Rights is a document adopted by the American Hospital Association in 1973 (Box 4.1). It outlines the ethical behavior that is seen as appropriate and proper for care of those who are patients in a hospital. Each nursing home must, by federal law, have available a similar document that discusses the rights of residents. Other organizations, such as the American Nurses' Association, American Dental Association, and National Respiratory Therapy Association, have ethical codes that guide the practice of each professional and are consistent with patients' and residents' bills of rights. Professional organizations also publish standards of care that identify an ethical and legal model of practice. These models are often used in legal cases to determine the acceptable level of care.

The bill of rights for all individuals is based on that person's right to make decisions regarding health-care treatment. It is designed to serve as a model that defines acceptable behavior toward those in your care. All work done with persons of every age and condition should be based on the principles in the Patient's Bill of Rights. Please read and review the Bill of Rights in Box 4.1. It should be the foundation for the work you do with elderly people. It has a very special significance when dealing with the older adults who may be struggling with the stress of a new situation, poor short-term memory, or chronic disease.

The Law

The legal system is based on rules and regulations that guide society in a formal and binding manner. These are human-made rules capable of being changed by the legislative and judiciary systems of this country, whose officials are elected and appointed as representatives of the public. The law gives you, the health-care provider, a general foundation for guiding your work; it may or may not complement your personal value system.

BOX 4.1 A Patient's Bill of Rights

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
   Except in emergencies, when the patient lacks decision-making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.
   Patients have the right to know the identity of physicians, nurses, and others involved in their care, as well as when those involved are students, residents, or other trainees. The patient also has the right to know the immediate and long-term financial implications of treatment choices, insofar as they are known.
3. The patient has the right to make decisions about the plan of care before and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and hospital policy and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the hospital provides or transfer to another hospital. The hospital should notify patients of any policy that might affect patient choice within the institution.
4. The patient has the right to have an advance directive (such as a living will, health-care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision maker with the expectation that the hospital will honor the intent of that directive to the extent permitted by law and hospital policy.
   Health-care institutions must advise patients of their rights under state law and hospital policy to make informed medical choices, ask if the patient has an advance directive, and include that information in patient records.
   The patient has the right to timely information about hospital policy that may limit its ability to implement fully a legally valid advance directive.
5. The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the hospital will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records.
7. The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.
8. The patient has the right to expect that, within its capacity and policies, a hospital will make reasonable response to the request of a patient for appropriate and medically indicated care services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a patient has so requested, a patient may be transferred to another facility. The institution to which the patient is to be transferred must first have accepted the patient for transfer. The patient must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.
9. The patient has the right to ask and be informed of the existence of business relationships among the hospital, educational institutions, other health-care providers, or payers that may influence the patient's treatment and care.
10. The patient has the right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct patient involvement and to have those

studies fully explained prior to consent. A patient who declines to participate in research or experimentation is entitled to the most effective care that the hospital can otherwise provide.

11. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by physicians and other caregivers of available and realistic patient care options when hospital care is no longer appropriate.

12. The patient has the right to be informed of hospital policies and practices that relate to patient care, treatment, and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. The patient has the right to be informed of the hospital's charges for services and available payment methods.

These rights can be exercised on the patient's behalf by a designated surrogate or proxy decision maker if the patient lacks decision-making capacity, is legally incompetent, or is a minor.

Patient's Bill of Rights was first adopted by the American Hospital Association (AHA) in 1973. This revision was approved by the AHA Board of Trustees on October 21, 1992.

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Ideally, the care you give is both ethical and legal. However, it is possible for a legal approach to care to seem unethical to you because it conflicts with your value system. This is when ethical–legal dilemmas occur. For example, the law recognizes the right of a competent person to refuse therapy. All individuals have that right regardless of the health-care system's agreement or disagreement with the decision. For example, an older adult has the right to refuse to have a pacemaker replaced. Such replacement is essentially a benign procedure with minimal risk, and not to have it done amounts to a death sentence. However, it is the person's right to accept or refuse the therapy. Your values do not change the principles of the law.

Another example is shared by Dr. Jean Watson, nurse theorist. Dr. Watson's theory is The Science of Human Caring and is explained in detail in her book *Nursing: Human Science and Human Caring—A Theory of Nursing* (Watson, 1988). In it she emphasizes the importance of valuing persons as individuals and avoiding objectifying them. She explains that a nurse gives legal care when going into a person's room to perform a complicated dressing change and assesses the wound site, removes the old dressing, and replaces it with a new dressing. The law does not indicate that the nurse needs to talk to the person or to explain the procedure or the healing process. However, for that care to be ethical, the nurse must take the time to talk to the person and treat the person as a human being rather than an object with a wound to dress. Another very simple example is that of bathing persons with dementia. Federal law requires that persons in nursing homes be kept clean. However, it is possible for a nursing assistant to give a resident a bath that is abusive by allowing no protection of modesty, not waiting for the water to warm, or being verbally abusive. This could be described as a legal, but unethical, bath. In the midst of the time pressures of health-care's complex world, one must be careful to determine the difference between legal and ethical care. Nurses experience both legal and ethical issues in their work every day. It is important to be able to distinguish between ethics and the law.

Laws can be developed and passed on national, state, and local levels. Nurses are influenced mostly by national (federal) laws and state laws. Examples of federal laws include the Patient Self-Determination Act of 1990, which requires asking people if they have living wills, durable power of attorney, or advance directives. There also is the Health Insurance Portability and Accountability Act (HIPPA), which includes regulations about patient privacy. This law was enacted in April 2003.

Nurse practice acts are state laws that tell the requirements for licensure and the limits of nursing practice. Every nurse needs to be familiar with the nurse practice act in the state where she or he is practicing. The nurse practice acts are somewhat different from state to state, so if you practice in more than one state, you need to know the differences.

FOCUSED LEARNING CHART

A comparison of ethics and the law

Ethics	The Law
Study of moral actions and values	Rules and regulations that guide society in a formal and binding manner
Principles of conduct that govern individuals and groups; generally complement your personal values	Provides a binding foundation of rules that will guide your work; it may not complement your personal values
Critical to examine and understand your own value system in order to give ethical care	Must understand and apply the law to every nursing care situation

Note: The highest level of nursing, that of holistic caring, can be given only when both ethical and legal care are administered.

Each hospital and nursing home has its own policies and procedures that must be in compliance with the state and federal laws. An employee of each hospital or nursing home is a representative of that agency and is expected to follow all of the rules and regulations. Failure to do that is a reason for being terminated from your job. If an employee believes that laws are being broken by the agency's rules and regulations, there is a citizen's duty to report this to the agency authorities, such as your supervisor, and/or the legal authorities, such as the Department of Health. Such a situation can lead to a serious legal and ethical dilemma. It is best to be certain of your facts before you take on such a serious risk. Consult a person who knows more about the law than you do. You also can consult a textbook or an attorney or do a Web search before you take any action.

PRIORITY SETTING 4.1

The priority for this chapter is for you to always identify the nurse practice act for the state where you are practicing nursing, as well as the rules and regulations at your place of employment. You are responsible for knowing the law and the policies that determine your practice. No one else can assume that responsibility for you.

ACTS OF NEGLIGENCE, MALPRACTICE, AND OMISSION

Two legal terms that are important to nurses are negligence and malpractice. Negligence is the failure of anyone to use care and caution to prevent harm to other people. Malpractice is the negligence on the part of a professional person in providing care to another person. Negligence and malpractice can be a failure to be cautious in doing something or failing to do something that needed to be done.

Every person is ethically and legally responsible and accountable for his or her own actions. But professional people, who are licensed to care for others because they have special education, knowledge, and experience, are held to a higher standard than other people. As a nurse, you have

a duty to protect and advocate for the people in your care, as well as provide physical and emotional care for them.

Negligence is failure to exercise adequate care. The determination of negligence is based on the level of performance that is expected of an LPN as determined by the state nurse practice act, the policies and procedures for the facility where the LPN works, and what is considered safe and prudent care by other LPNs. For example, if you start an intravenous (IV) procedure, even in an emergency situation, and you are not IV-certified, you have broken the law, as outlined in the nurse practice act, and you are liable for your behavior even if there is a good outcome from your actions. Why? Because you broke the law. Even if the outcome is good, you could be sued.

If a nurse is accused of malpractice and is being investigated and tried in a court of law, how do judges and juries know the difference between good care and negligent care? The standard of care is the same as that used for negligence.

It is the action that is expected from a reasonable and prudent person under the same circumstances. A prudent, responsible nurse is someone who is careful, thoughtful, and wise about his or her actions. This person also is a professional who renews nursing knowledge by reading, attending workshops and conferences, and simply "keeping up" with the profession.

Sometimes there is a small group of nurses who work together, cut corners, and neglect to follow rules unless someone in authority is watching. Such nurses are not prudent and responsible. A court would not use their behavior as a standard of care. Instead, the court would use expert witnesses, laws, agency rules, current textbooks, and standards of care published by professional organizations to show what a reasonable, prudent nurse would do under the circumstances.

Four conditions are needed to have malpractice or negligence. They are:

1. A duty to the client
2. A failure to meet that duty or a breach of duty
3. An injury or negative outcome caused by not meeting that duty (causation)
4. Actual harm or damages suffered by the person who is receiving care

There are many other nursing issues closely related to meeting the criteria of the law. Negligence and malpractice are among the most serious.

The concept of omission is very straight forward. It occurs when you omit something that is either ordered or expected as a normal part of treatment for a client. Classic examples of omission involve treatment or medication. Omission also could involve failure to notify a supervisor or physician of a situation with a client. Many lawsuits are based on omissions of care.

There are many issues within the realm of nursing that are profoundly affected by both ethical and legal concepts. The purpose of this chapter is to discuss issues closely associated with nursing care of older adults, such as the use of restraints, advanced directives, informed consent, and elder abuse.

USE OF RESTRAINTS

The long-practiced tradition of using restraints was an accepted aspect of nursing care of the elderly until the 1980s. Nursing leaders joined other health-care professionals in drafting legislation and working with legislators to introduce and pass federal laws for reforming care of the elderly in the United States. In 1987, the nursing home reform legislation was added to the Omnibus Reconciliation Act (OBRA) and became the law that was instrumental in dramatically changing and improving care of the elderly. Gradually states wrote and passed their own laws that reinforced the federal law and added improvements for the states. One very dramatic change was the reduction of the use of restraints and the gradual implementation of a restraint-free environment in the care of the elderly.

Nurses who continue to use restraints often believe they are a means of preventing falls and wandering episodes. Evidence never did support that falls are prevented by restraints. Older adults who were restrained to prevent wandering often were seriously injured because of the restraint. Frequently, their injuries were worse than if they had been wandering and fallen. When restraints were used in large numbers, the injuries and deaths caused by the restraints outnumbered the injuries and deaths caused by wandering, even though the restraints were applied carefully and correctly. Most restraint deaths were from asphyxiation from crushing the trachea on a side rail or vest restraint and/or from obstruction of breathing due to being pressed against the mattress between the bed and the side rail.

People fight and strongly resist being tied and shackled, causing death, severe injuries, skin excoriation, bruising, and pressure ulcers. These hard lessons were the reasons nurses took such

This older woman is physically healthy but has episodes of confusion. What are her legal rights? Is there ever a reason to restrain her? Does confusion on any level warrant the use of restraints?

strong political action in the late 20th century to "untie the elderly."

In the remote and rare situation when a restraint seems essential, the decision should be made with the interdisciplinary team (IDT) and must, by law, include informing the family. In hospitals, it sometimes is necessary to restrain a person to maintain life-saving procedures such as a tracheostomy, urinary catheter, or intravenous tubing (IV). A physician's order for application of a short-term restraint requires the nurse to make careful observation and to perform periodic removal, skin care, and range of motion exercises. In an emergency, when it is necessary to protect the older adult or others from danger, a nurse may apply restraints without a physician's order or the IDT assessment and decision making. The circumstances and the observation and care given need to be documented carefully. In all instances, the least-confining restraint should be used.

Other Considerations

The staff in either a hospital or nursing home should have some common strategies for managing confused older people. There may need to be a policy of placing mattresses on the floor or of lowering the bed near the floor to keep a night wanderer from falling out of bed. If wandering occurs more frequently at night or in the late afternoon, then they are the times the staff should be increased so residents can be closely monitored. At present in most facilities, evening and night shifts are times of minimal staffing.

Implementing a restraint-free environment requires the education of everyone on staff, including ancillary people, to the principles of working in a restraint-free environment. Along with the education program, it is important to assist staff to focus on their personal values regarding care for the elderly person. This should help in establishing desirable approaches to care. A restraint-free environment is an innovative care strategy that also requires thought by bright and creative people who feel a commitment to the rights of all people, especially older adults.

INFORMED CONSENT

Another very similar legal and ethical concern is the concept of *informed consent*. The Patient's Bill of Rights clearly outlines a person's right to information before giving consent to treatment. The law says that there needs to be a signature on the consent form. The ethical aspect of this situation is that the older adult and others have the right to all the information available on the treatment or procedure for which consent is being given. Again, the nurse assumes the role of patient advocate. Would you stop a patient from going to surgery if, as you were assisting him or her onto the cart, the patient asked, "Tell me again, what is it the doctor is going to do?" Legal and ethical knowledge says you should.

Obviously, there are better ways to manage this type of situation than to postpone the scheduled surgery. One is to simply be sure ahead of time that the patient has the information needed to make decisions about the health and treatment plan. This can become challenging when the patient is a frail elderly person who is experiencing behavior that ranges from forgetfulness to dementia. Is it enough just to get the signature when you know the person will not remember the instructions? The answer to that question must come from your value system, that ethical aspect of yourself. Do you value the patient and the patient's rights as outlined in the Patient's Bill of Rights? Do you value the principle behind the informed consent rule? It is hoped that you do. If that is so, you have a great deal of work to do to

protect the rights of all persons within your care. That work may involve reporting the forgetfulness or dementia to the nursing manager. In a nursing home environment, it would be important to share that information at the IDT meeting. Talking to the family may be something you do or that is delegated to the social worker. The priority is to ensure that the elderly person has complete information when asked to make a decision regarding health care.

ELDER ABUSE

Occurrences of elder abuse are on the increase in this country. It is estimated that 5% of older adults are abused each year, most often by a close family member. Abuse exists in family homes, nursing homes, and hospitals. It is done by family members, paid caregivers, and strangers. It seems to be a consequence of life in Western society, which moves faster and faster, with more and more demands. Into this scenario comes an increasing number of older people who, as a natural consequence of aging, move more slowly and experience mental changes that require patience from caregivers. This country has never had so many older citizens, and society does not seem adequately prepared to adapt to them and their needs.

Because of this lack of emphasis on understanding and meeting the needs of the elderly, caregivers tend to experience burnout. Accompanying this phenomenon is the tendency to abuse the elder for causing the feelings of burnout and frustration. I believe that elder abuse is the most extreme and destructive form of ageism that can be demonstrated.

Elder abuse is also against the law, and every state in this country has laws against it. Again, it is your responsibility, as a licensed nurse, to determine what the law is in your state, as well as the policies and procedures for handling abuse in the organization where you work. Whatever the particulars of the law are, it will state that you are responsible, under the law, to report all suspected cases of elder abuse.

Elder abuse can occur in many forms. Some of them are:

- Inflicting pain or injury
- Withholding food, money, medication, or care
- Confinement; physical or chemical restraint
- Theft or intentional mismanagement of assets
- Sexual abuse
- Threatening to do any of the above

The composite picture of the person most likely to be abused is a female, 75 years old, who lives with a relative. She is physically, financially, or socially dependent on others. For LPNs who work in home care or in day-care centers, this description should be one to keep in mind. Do any of your patients have unexplained bruises or other markings? Do they seem unusually hungry or frightened? Are they unwilling to talk about their family member, or do they act fearful when you mention the family member responsible for their care? Any of these behaviors could be indications of abuse, and they deserve your attention.

If you are an LPN in a nursing home or hospital, it is critical to be alert for staff members who treat older people in negative and degrading ways. If a confused person is even more confused or is screaming and crying after receiving "care" from a particular staff member, be on the alert. Another cue is when residents have more bruises after a particular staff member has worked than at other times. Residents who are complaining of things being lost may actually be victims of theft. An older adult should not have a fearful countenance when a family or staff member comes near; be on the lookout for such behavior.

It is critical that all cases of suspected abuse be reported to the proper authorities. In all settings, it is proper for you, the LPN, to report suspected abuse to your supervisor. If nothing is done to prevent the behaviors that seemed suspicious to you, it is both an ethical and legal mandate that you find the proper avenue for reporting your information to a legal authority. You will determine the proper protocol for reporting abuse by reviewing the abuse laws in your state and the policies and procedures in your work setting that govern this situation.

In most situations, that elderly person will be moved to a safer environment, or the employee who was performing the acts of abuse will be put on probation, terminated, or arrested. If the abuse is occurring in the home, the situation becomes very complex. The family that allows elder abuse is obviously dysfunctional. Perhaps the abuse is occurring because of parental abuse of the child when the child, now turned caregiver, was younger. Perhaps it is simply a response to the distress of caring for an aging parent. Sometimes, the abused elder does not want to be moved out of the situation because of concern over being moved into a nursing home or other facility. This is a choice the older person is allowed to make. However, in most situations,

Whenever there is a question about elder abuse, immediately contact the social worker or ombudsman at the facility where you work. This social worker specializes in elder abuse investigation.

the family members will be required to receive counseling in an effort to alter abusive behavior.

SEXUAL NEEDS

Another ageist concept in our society is that old people are asexual. Biologically, this is simply not true. Sexual needs are as basic as eating and socializing. The aging process does not remove that need from the physiological schema of older adults. The question is, how do you provide for the fulfillment or manage the needs of older adults for whom you are responsible?

Older people need love, too. I recall attending a conference many years ago in which the presenter, a music therapist, made the statement that every person needs 14 hugs a day. I do not believe that she had any scientific data to validate her point, but when she said it, I believed her! She continued to say that most of society finds old people very unlovable and, therefore, unhuggable. I immediately began a lifelong quest to provide as many hugs to older people as I could give in a lifetime. Older people in our society are touch starved; often people do not readily touch or hug them. Does this flash of unscientific insight bring to your awareness that you can do something positive about meeting this need for older adults in your care? It would be very exciting to see a care plan that said: 14 hugs a day evenly distributed over 24 hours.

A myth that needs to be dispelled is that "dirty old men" are reaching and grabbing inappropriate parts of the female body! This unkind stereotyping is generally directed at an older, confused man. Instead of restraining or isolating that individual, you should assess him from a professional level.

An example of an intervention with an older man whose wife recently died could be sitting with him and asking, "You miss your wife, don't you?" to provoke a discussion of his sexual feelings. After your discussion with this man, you may learn strategies that will help him manage his sexual feelings in a more appropriate manner. Perhaps he needs a picture of his deceased wife that he can keep with him at all times, for instance, in the dining room or when he is in the hallway in his wheelchair. It may take something as simple as teaching the nursing assistants to point to the picture of his wife and ask him to tell them about her to ward off his confused attempts at meeting his sexual needs. Perhaps the solution is more complex, and the nursing assistants need to be taught how to stop his inappropriate behavior in a respectful manner that recognizes sexual needs as normal and confusion as a reality. It is your responsibility, in an ethical framework, to determine the approaches and strategies that will provide for effective management of the sexual needs of the older people in your care.

Another problem that occurs at times is that of masturbation. Masturbation is a normal sexual outlet for people. Teenagers generally masturbate as part of their sexual experimentation. Adults often masturbate as part of their sexual relationships with other persons. It is not abnormal for older people to masturbate. It is something they have either done intermittently or worked hard at suppressing throughout their lives. It is not wrong for an older adult to masturbate; however, because of different levels of cognitive ability, an older person may be participating in this activity in an inappropriate place. Masturbating in the dayroom or in any environment in front of others is not appropriate behavior. If this should occur, it is your responsibility to gently and kindly stop the activity and take the person to his or her room. It is appropriate to leave the person alone there to do as he or she wishes. This approach is an effective one to use if the person is acting out

for attention or is forgetful or confused. If you walk into an older adult's room and the person is masturbating, just excuse yourself and close the door.

Often in nursing home settings, there is controversy about allowing married couples to room together or to have time for conjugal visits. Sometimes it is not wise to have couples room together because one may need more care than the other, and the stronger person becomes worn out trying to administer to every need of the ill or degenerating spouse. Abusive behavior brought on because of dementia could be another reason. But only reasons that would jeopardize the health of one or both of the people involved are valid for keeping a married couple separated. It is normal for married people to live together, and it is normal for married people to have sex together.

Another situation that can occur is that of unmarried, consenting adults having intimate moments. You have the ethical and legal responsibility of protecting demented, developmentally disabled, or mentally ill persons from the sexual advances of others. If that person does not have the ability to make day-to-day decisions, neither does the person have the ability to make the normal, everyday decision to have an intimate relationship. As a licensed nurse, you are responsible for protecting such a person from what could be defined as sexual abuse.

What of those who are not cognitively impaired? Counselors do not go around the halls of high schools or universities to keep teenagers and young adults from holding hands or kissing. Why does society think it is necessary to do that for older adults?

Sexual feelings and expressions are a normal part of living, even if one is old, handicapped, or confused. Every dependent human being has the right to expect protection from sexual abuse, but every human being also has the right to express sexual feelings within the framework of society's norms.

It is your responsibility as a licensed nurse to learn the laws in the state where you practice. This generally requires study through books or on the Internet, but do it you must. The excuse of "I didn't know" is not acceptable in any situation when you have broken the law or violated the nurse practice act.

CONCLUSION

This chapter covers several diverse topics that have legal and ethical ramifications in giving care to older adults. Every topic is one of importance and needs to be addressed by you as a gerontological nurse. Older people have rights, and when these people come into the health-care system, you, the licensed nurse, are the unofficial advocate for them. Their legal and ethical rights are your responsibility. The concepts explained in this chapter should help to provide you with a strong foundation for fulfilling that role.

CASE STUDY

As the 11–7 charge nurse on a 20-bed unit at Cherry Dale Nursing Home, you have had concerns over the staffing on your shift. Often, you have found the nursing assistants restraining residents for their own good without telling you. You have discussed the problem with the nursing assistants and have taught them about the restraint-free environment at Cherry Dale. Despite your efforts, there still is one "old-time" nursing assistant who does not follow the facility's rules and regulations and clearly ignores your instructions.

This is your first charge nurse position as an LPN. You recognize that the nursing assistants see you as an inexperienced nurse. This is especially true of the older nursing assistant. During your first 6 weeks on the job, you believe you have made progress in earning the trust you need from the nursing assistants. However, one or two are still restraining residents at night without telling you.

You discussed this problem with your nurse manager, and she simply told you that you were a charge nurse now and it was your responsibility to follow the policies of the facility. The policy indicates that restraints are not used unless there is a documentable situation that risks the life of the older adult, such as displacement of a nasogastric tube or intravenous needle.

What are the ethical and legal ramifications regarding your current dilemma?

How will you resolve the problem?

Discussion

Because you are the licensed nurse responsible for what occurs on your shift, you are both legally and ethically accountable for the behavior of the nursing assistants who work with you. Because they are violating facility policy, it is as if you were actually performing the act.

It is both unethical and illegal to restrain people without following the criteria discussed in this chapter. When the restraining of older adults occurs, and it also breaks the rules and regulations of the facility, your legal accountability is compounded. It is important you realize that the law is being broken every time the residents are restrained. It does not matter if you know about it or not. The point is that, as the charge nurse, you should know about it! Reporting the situation to your supervisor does not release you from responsibility either. She gave you clear instructions as to what to do; you are to follow the facility's policy regarding restraints. The ethical problems of restraining residents are as serious as the legal ones.

Solution

There is more than one approach that could resolve this problem. The truth is that you may have to use them all before you find an appropriate solution.

Make it perfectly clear to all the nursing assistants that the law is being broken and the act of restraining residents on your shift is a criminal offense. Then …

- Use the experience and wisdom of the nursing assistants to process different solutions to the problem of residents wandering or potentially falling at night. The nursing assistants will appreciate being asked to assist in solving the problem rather than being told what to do. Try all ideas that do not go against the policy of the institution, the law, or your ethical standards.
- Share your creative solutions with the nurse manager. Let her know how prudent and safe the care is on your shift. (Remember that prudent and safe care is the care that most LPNs would give in the same situation.) You also should build a case for additional staffing on your shift, if that is the problem.
- Document the unique approaches of care you use on your shift and share them with the other shifts by means of verbal report and the nursing care plan.

STUDY QUESTIONS

Select the best answer to each question.

1. Ethics is the study of moral actions and values. One of the dilemmas within ethical thinking is concern over:

a. Who decides what is right and what is wrong

b. Whoever pays the bill deciding what is ethical

c. Ethical and legal behavior being the same

d. The rules of ethical behavior changing daily

2. Although you were not IV certified, if you were to find a client bleeding and in need of immediate fluids to save his life, one of the following defines your legal role. Mark the correct answer.

a. Under the Good Samaritan Act, you are required to do all you can to save the person's life, so you would start IV fluids and call the doctor.

b. Call the RN and have her handle it. After all, she has the advanced license.

c. Call an ambulance for immediate transport.

d. Administer first aid, leave a nursing assistant with the resident, and call the physician or the RN.

3. The legal concept of omission in care applies when:

a. The physician has missed a diagnosis, and therefore, you have omitted treatment for it because nothing was ordered.

b. You have intentionally or unintentionally missed an antibiotic dose.

c. Residents are given baths only every other day.

d. The RN does not work the weekend.

4. A restraint-free environment consists of an environment in which:

a. Many of the residents fall or wander, but they do not sue the facility because they want to be without restraint.

b. Mattresses are placed on the floor so residents will not fall out of bed.

c. The least-restrictive device is used on each resident.

d. Restrictive devices are not used for any reason.

5. Elder abuse is a growing concern in modern society. Which of the following statements is correct?

a. It is against the law to threaten abuse as well as to perform abusive acts.

b. Elder abuse includes inflicting pain or injury but not confining an older person.

c. Elder abuse is likely to happen to a male client, over age 85, who lives with a relative.

d. It is the legal responsibility of the RN to report all suspected cases of elder abuse; this is not the responsibility of the LPN.

5

Promoting Wellness

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Recognize aging as a normal process of living rather than a disease process.
2. Describe the role nurses play in health-promotion and disease-prevention activities for older people.
3. Describe key health-promotion and disease-prevention activities appropriate for older people.
4. Understand the importance motivation plays in the older person's ability to participate in health-promotion and disease-prevention activities.

INTRODUCTION

One of the positive aspects of being a gerontological nurse is the variety of ways you are able to work with older people. The role of the licensed practical nurse (LPN) is critical in the care of older adults. You are the person who gives the direct care to most of the older adults who seek out health-care services. Many nurses think only of care given in a nursing home when they consider gerontological nursing, yet you have learned that only 5% of people over age 65 are at these institutions. Where are the others? What type of nursing care do they need? Many older adults need your knowledge and support in order to stay healthy. That is health promotion; something exciting and, for many nurses, something new.

The search for eternal youth has a long history. People have died in their search for the Fountain of Youth, and others have killed for what they thought would prevent them from aging. The legends surrounding the "forever young" concept are taking on a new reality and meaning for this country's aging society because people are living to be older than ever before (remember the 85+ age group and the "elite-old?"). The modern version of the legend of the Fountain of Youth is embodied in the concept of health promotion. The focus is on living longer and healthier, an opportunity offered to today's society that has not existed previously.

Our society emphasizes normal age-related changes and common health problems and diseases experienced by older people. In addition, information is shared on dealing with losses related to aging, the medical treatment of chronic disease, and the financial impact of an aging society. It is my opinion that not enough attention has been given to the positive side of aging and the beneficial effects of health-promotion activities to prevent disease and to slow the effects of chronic disease. Do you think this is another form of ageism? If so, what can you do about it as a nurse?

Current health-care concepts emphasize vitality and independence for older people as a primary concern. Regardless of age, as people laugh more, walk more, eat better, relax more, and think better of themselves and their relationships, they move beyond the neutral point of good health. Many of the complaints associated with the aging process, such as joint stiffness, weight gain, fatigue, loss of bone mass, and loneliness, can be prevented or managed by basic health-promotion activities. One does not have to be free of disease to experience the benefits of health and wellness.

PRIORITY SETTING 5.1

Do you remember Chapter 2, where your priority was to combat ageism? This chapter is a continuation of that idea.
Older adults do not have the availability of health-promotion facilities, personnel, or financial support that other age groups have. Yet, if the health of older persons could be maintained, the medical bills in this country would decrease immensely. That, however, is secondary to the actual improvement in life quality that can happen for the wellness-focused older person.

Your priority for this chapter is to become well informed about wellness facilities and organizations that are specific for older adults. This information will be valuable for you as you render care to older people. You could visit the local senior citizens' center and become familiar with what they offer. The center can refer you to other organizations that assist elders to be healthy. Gather as much information as you can. As a licensed nurse, you need to have a broad spectrum of information available for use as you go about your daily work of caring for others. Assist older adults in recognizing the importance of wellness. Encourage them to be involved in the organizations and activities you find. Teach them about the concepts in this chapter that will assist them in their personal wellness program. Become knowledgeable regarding wellness for older persons, and you will enhance the lives of those in your care as well as become a valuable resource to the health-care team.

Most health-promotion activities focus on exercise, stress management, nutrition, and dealing with substance abuse. In addition, it is important that wellness activities for older adults include relationships and self-care.

CHRONIC DISEASE

As an LPN giving care to older adults, you need to understand the promotion of wellness in a broad sense. This concept needs to go beyond

CRITICALLY EXAMINE THE FOLLOWING:

Reread the last paragraph of the introduction. Your health would improve if you improved the management of your personal exercise, stress management, nutrition, substance abuse, relationships, and self-care. As a student in a very demanding program, you may need to examine your own health promotion critically. Make comments regarding how you can improve your health in the following areas. Be prepared to discuss them in class and relate how what you do for yourself may also assist an older adult.

1. Exercise
2. Stress management
3. Nutrition
4. Substance abuse
5. Relationships
6. Self-care

the vision of physically well, older people living in their own homes independently. More than 80% of older adults experience at least one chronic disease condition, and as many as 50% report three chronic disease conditions. Those older than 85 years of age experience increased difficulty with home management activities and are more likely to depend on assistance in their living situations. Regardless of age, living arrangement, or health condition, the goal for health promotion should be to assist older adults in reaching a state of optimal health—the legendary Fountain of Youth.

The most common health problems of older adults are associated with chronic diseases. The most frequent of these chronic conditions include arthritis, hypertension, heart conditions, hearing impairments, and dementia. Because of these conditions, older people visit physicians more often, are hospitalized more frequently, take more prescription and over-the-counter (OTC) drugs, and experience more functional problems than younger people. The focus of much of this country's medical treatment interventions is *curing* acute conditions. Chronic illnesses, the predominate illnesses of older adults, cannot be cured but instead require management with a focus on caring.

Although coronary artery disease generally is not considered a chronic disease, for this 72-year-old gentleman, it is. He was diagnosed and scheduled for surgery 22 years ago. However, the blood work done before surgery indicated that he had leukemia, which disqualified him from heart surgery. Since then he has lived his life in slow motion. He still goes golfing but rides a cart and sometimes elects to skip a difficult hole. He does his yard work but does the mowing over a 3-day period each week. This man is an unbelievable story of adapting to what has become, for him, a chronic disease.

Treatment Strategies

Management of chronic conditions involves treating symptoms and maximizing the strengths

POINT OF INTEREST

Often, to meet the needs of older adults, nurses seek interventions that come from external sources rather than empowering older people to use their inner sources. Most older people have lived a lifetime of taking care of themselves and their families; they have given service to the community and many have managed devastating challenges. Be sure to use them as a resource.

of an older person. You need to understand the aging process and older adults in general and then advocate and lobby for what they need. For example, for an older adult who suffers from arthritis and who is in severe pain, it is important to treat the symptom of pain. If pain is minimized, the person will be better able to stay active and prevent the further disabling effects of immobility. Nurses are the key people to recognize the symptom (pain) and administer the prescribed treatment (medication). As a gerontological nurse, you must go one step further and consider the impact of the disease and its treatment on the older person's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADL).

What could be done to prevent the onset of pain?
What will be the side effects of the pain medication?

As an LPN, you must recognize the importance of good health and its correlation with functional independence among older people; however, understanding does not always make it clear as to the kind of activities that will promote health and prevent development of further secondary conditions that result in dependency.

ILLNESS/WELLNESS AS A CONTINUUM

If you think of health as a continuum on which illness is on one end and health on the other, you will better understand the importance of health promotion. The point is that everyone wants health, and health-promotion activities are the way to achieve that goal. Physicians and nurses traditionally focus on working with patients who are on the illness end of the continuum or who have symptoms of disease or disability. As a person's health improves, traditional medicine becomes less involved in helping the person reach optimal well-being. In contrast, health-promotion efforts primarily are focused on the opposite, or wellness, side of the continuum.

In more recent years, nurses have begun to use health-promotion efforts even when dealing with people on the illness side of the continuum. For example, special exercise and nutrition programs have been designed for cardiac rehabilitation, exercise and weight-lifting programs for chair-bound persons, and weight management programs for older persons. The remainder of this chapter focuses on health-promotion activities on both the illness and wellness sides of the health continuum.

CRITICALLY EXAMINE THE FOLLOWING:

Talk to one or more elderly persons in an effort to determine the life experiences that have made them "survivors." Each person has had specific life experiences that have made them strong enough to live to an old age. Some examples could be widowhood, WWII, the Great Depression, the German concentration camps, and the Blitz of London. There may be smaller but more personal occurrences, such as death, abuse, and extreme poverty. Engage in at least one conversation with an older person regarding any one or more of these issues and evaluate the personal strength of each individual. Be prepared to discuss your findings in class.

Motivation

If you, as a nurse, want to be successful in promoting healthy choices in individuals in their later years, you need to understand the importance of individual motivation. Desire must be present on the part of the older adult to make a change. It is critical to explore what motivates an older person to eat right, exercise, and avoid unhealthy behaviors on an individual basis. This is true for all people, even yourself.

CRITICALLY EXAMINE THE FOLLOWING:

Motivation is an important concept to understand. You will understand it best if you comprehend what motivates you. Answer the following questions and be prepared to share your answers in class or submit them to your faculty person.

1. What are you wearing today? There is a reason for wearing it; do you know what that reason is? Whatever the reason, it is your motivation to wear it. It could be as simple as the outfit being your favorite color or being the last clean outfit in the closet.
2. Why are you in a nursing program? What is your motivation for being here? Spend time pondering this question. Understanding your personal motivation for such an all-important decision is critical for you to grasp.

As a part of human behavior, motivation is the incentive or drive that causes a person to act. Incentive to take action is based on needs and desires that are both internal and external to the person. For example, an older person may have an incentive to exercise three times a week if it helps the individual experience less discomfort or immobility from arthritis. For some people, the incentive may need to be more than physical wellness. A need also may exist for a mental wellness experience, such as that derived from socialization with others while exercising, for example, in a water aerobic class or with a group doing mall walking.

The nursing challenge is to assist older adults in identifying their own incentives for participation in health-promotion and disease-prevention activities. This allows the nurse to have greater insight into ways to promote health and lessens the frustration experienced from what are often incorrectly referred to as *noncompliant patients.* Compliance occurs only if the individual can personally identify a need or desire to exercise, eat correctly, reduce stress, or make other changes necessary for improved wellness. This is motivation experienced by people in an individual way. Often, assisting to identify the motivation is one way you, the LPN, can help an older adult.

Incentives

Studies have disclosed some of the reasons (incentives) for older people to participate in health-promotion behaviors. These reasons include the following:

- A belief that activities can improve fitness and health
- The enjoyment of socialization
- A belief that activities will help maintain independence
- A desire to feel good and have fun

Knowledge about why a person participates in health promotion (or the incentives for doing so) can be determined through a caring and focused interview. After personal incentives have been identified, you can reinforce them in health-promotion activities. In addition to understanding individual motivation, you will need to help individuals plan their short- and long-term goals for making health changes. The secret to success in health behavior is to help the older adult pick personal goals with care and then learn to enjoy achieving them.

CRITICALLY EXAMINE THE FOLLOWING:

Reread the four reasons listed above. Look at them through the lens of your new knowledge of "ageism." Discuss what you have identified as ageist thinking. Answer the questions listed and be prepared to share your thinking in class.

1. What do you identify as ageist thinking?
2. Evaluate each "reason" and list one "real-world" solution to the ageist thinking you identified. A response for Reason Two could be: I have laugh lines around my eyes. I am going to make the comment, as often as I can, that "I love my laugh lines because they are a measure of the fun I have had over the past 35 years. I want to grow old so I have 35 more years of fun!"

Identifying "real-world" thinking is a challenge to your traditional thinking. Spend some time with this assignment and identify things that you really are willing to do.

Health-Promotion Activities

When older adults have identified an area of health, they have an incentive to maintain or improve their health. The challenge is to locate a properly designed activity. Many current health-promotion activities are biased for youth and have excluded older adults by design. Four reasons underscore why the current focus on health-promotion activities is often inappropriate for older people. They are as follows:

1. The focus frequently is on life extension or on reducing the risks of premature death. For example, if a person stops smoking, reduces fat intake, and exercises, the risk of a heart attack at an early age is reduced. For elderly people who have already lived beyond the average life expectancy, life extension may not be as important as quality of life. Stopping smoking, reducing fat intake, and exercising are important at any age, but for different reasons. The focus must be on health-promotion benefits specific to an older person.
2. Emphasis is often placed on advancing "youthfulness" and preventing aging. Older people recognize that they do not fit the image of youth and have already experienced some results of aging. This does not mean

self-image and appearance are not important to older people, but that the image needs to match the older person's self-perception.

3. Health-promotion programs focus on preventing chronic disease. Among older people, 50% already have three chronic diseases. When these programs focus on management of the symptoms of the disease rather than on its prevention, more older adults have a reason to participate.
4. A focus on self-responsibility for health fails to consider the limitations imposed by personal circumstances. For example, an individual who has a need and desire to walk daily for exercise may live in an unsafe neighborhood. An older adult may have a desire to eat a healthy diet but may be unable to afford the proper food. The external environment may pose barriers to older people that are difficult to overcome. These problems need careful attention.

As you, the LPN, look at the key areas of health promotion for older people, your goal must be to design, plan, and provide activities that are sensitive to individual needs and responsibility. Properly designed health-promotion activities should be:

- Accessible (transportation, time of day, location)
- Enjoyable and social (mental and physical wellness)
- Reasonable (focus on the right activity for the right reason)
- Sensitive to older people's needs (hearing, vision, functional level)

Health-promotion strategies must be based on the belief that the individual is the only one who can choose a path to a healthy life. Consequently, you, the nurse, must be sure that health-promotion activities are individually designed so the pathways exist.

NUTRITION

With advancing age, a person's general health is determined to a great extent by the effects of dietary patterns over the years. Staying physically and mentally active is important to all older adults. They need to understand the role proper nutrition plays in their lives, even in later years.

As bodies age, four changes occur that affect what a person needs to have optimum nutrition:

1. The body's rate of metabolism slows and no longer needs the same amount of energy and food to do the same amount of work. Older adults often comment that they have not changed how they are eating and exercising, but they are now gaining weight. As people age, lean body mass decreases and body fat increases. This may result in weight gain and can lead to obesity.
2. The senses of taste and smell may be less keen. Some or all of an elderly person's teeth may need to be replaced by dental appliances. As a result, older people may find themselves eating different foods and drinking less fluid.
3. Social aspects of eating are important. As people age, they retire, their families grow up and move, and their spouses and friends die. This results in changes in the socialization of eating. One of the most difficult adjustments seems to be cooking for one and eating alone.
4. Environmental factors greatly influence older adults' nutritional habits. Lack of transportation to food stores and restaurants, inability to manage reading labels and shopping, and insufficient money to buy healthy food can be major barriers to eating properly.

Poor dietary habits contribute to many diseases that occur in older persons. Chronic diseases, such as heart disease and cancer, can be slowed, and for some people, prevented, by avoiding obesity and decreasing the amount of fat in one's diet. Studies from the American Heart Association (2001) suggest high cholesterol levels increase the risk for atherosclerosis. The American Cancer Society found marked increases in the incidence of cancer of the uterus, gallbladder, kidney, stomach, colon, and breast associated with obesity.

Osteoporosis affects 25% of women older than 60 years of age. The loss of bone mass and bone strength as a result of this disease leads to broken hips, arms, and legs, and back injuries. Osteoporosis is often referred to as a "silent" disease. Few signs or symptoms appear until a bone breaks. Adding calcium to the diet, a regular exercise regimen, and avoidance of alcohol and smoking are key prevention strategies.

Other chronic problems that are frequent complaints of older people include constipation, urinary incontinence, and arthritis. Nutrition plays a role in each of these conditions.

Although one-on-one teaching may be easier, group learning that incorporates an opportu-

nity for socialization and fun is much more likely to result in positive outcomes. You, as the LPN, may want to organize a group of elderly people in the community to participate in learning nutrition principles. One of the principles that should be taught is that of the food pyramid (see Chapter 6). This information, which is new to some people, replaced the basic four concepts that most older people have been taught.

Health-promotion activities aimed at altering a lifetime of eating habits must be reasonable, and the benefits need to be made apparent. Nurses must clearly understand what motivates the individual. In addition, they must be aware of the unique nutritional needs and problems that accompany later years.

For more specific information on gerontological nutritional principles, refer to Chapter 6.

EXERCISE AND FITNESS

In the 1970s, the fitness movement in the United States began. Not until the late 1970s and early 1980s did society begin to stress the importance of fitness for older adults. Studies continue to emphasize the benefits of exercise and its importance to total health for all ages. The body's responses to exercise are fundamentally the same throughout life. Exercise stimulates the mind, maintains fitness, prevents or slows progression of some diseases, helps to establish social contacts, and generally improves the quality of life.

Fatigue and lack of energy, poor sleeping habits, and poor circulation are common reports of older adults. These problems often result in inactivity. Inactivity leads to muscle wasting and weakening of the bones. This vicious circle results in disabling conditions and functional dependency. If exercise could be packed into a pill, it would be the single most widely prescribed and beneficial medicine in the world. Chronic conditions such as heart disease, diabetes, osteoporosis, arthritis, obesity, and depression are all shown to improve or experience a slowing of progression with regular physical activity.

Physiologically, a regular exercise program can build and maintain muscle strength and endurance and can improve the capacity of the heart, circulatory system, and lungs. The commonly heard phrase "use it or lose it" is the overall theme for exercise and fitness in a person's later years. Exercise programs for people older than 60 years of age should emphasize a regular routine of exercise to expand and increase strength, flexibility, and endurance. This can be accomplished for individuals with a wide range of conditions, from wheelchair- or bed-bound frail elderly patients to the physically active individuals. By-products of a good fitness program include increased energy, buildup of lean body mass, and increased self-esteem.

This woman comes to Curves, a women's exercise club, three times a week to maintain her strength. This type of program has assisted her in losing weight as well as in being stronger. Besides, she says, it is fun to socialize with people that often.

Strengthening

Strengthening exercises help build and maintain muscle condition by moving muscles against resistance. Simple strengthening exercises are needed to promote activity without tiring a person too easily. Muscle strength is also crucial to the support of joints and can help prevent problems related to arthritis. Improving muscle strength is a primary objective in slowing the progression of osteoporosis. Patients confined to bed lose bone mass very quickly. It can be

POINT OF INTEREST

If an older person is able to meet life demands, it is not necessary for the nurse to intervene. The only intervention necessary in this situation is to support the individual in what he or she is able to do.

restored, however, when exercise is resumed. Something as simple as doing range-of-motion exercises while holding a soup can will make a difference in strength for most older adults.

As a nurse, you must be aware of the impact a short-term illness can have on an older person. Something as commonplace as the flu can cause significant weakness and inactivity. Weak muscles lead to falls, which cause hip fractures and other injuries. If older adults are not aware of the importance of strengthening exercises, no incentive will be able to return them to the normal level of function.

Strength-building exercises are important for the patient with diabetes because the exercises help regulate glucose metabolism by increasing muscle mass. The greater the muscle mass, the greater the glycogen level in the muscles will be and the more energy in reserve for periods of exertion.

Flexibility

Flexibility exercises involve slow stretching motions. Medical and fitness experts agree that stretching is the single most important part of an exercise program designed to prevent injuries, reduce muscle tension, and maintain range of motion. As a result of the normal aging process, muscles tend to lose elasticity and tissues around the joints thicken. Flexibility exercises can delay or reverse this process by preventing muscles from becoming short and tight.

All stretching motions should be done gradually and slowly, without any sudden force or jerking motion. You should encourage a variety of stretching exercises for different parts of the body, including arms, shoulders, back, chest, stomach, buttocks, thighs, and calves. All exercise routines should warm up and cool down with 5 to 15 minutes of stretching exercises. As

FOCUSED LEARNING CHART

Significance of strengthening exercises

Effects of Exercise	Exercise Plan Considerations
Builds and maintains muscle strength	Should be designed for the individual
Decreases arthritic pain over time	Should not be too tiring
Strengthens joints	Should promote activity
Slows process of osteoporosis	
The greater the muscle mass, the greater glycogen reserves, which means more energy	
Weak muscles lead to falls and possible fractures	

the older person's range of motion increases, the individual will be able to reach, turn, and move in all directions with more grace and less pain.

Endurance

Endurance-building or aerobic exercises improve the function of the heart, lungs, and blood vessels. A frequent report of older people is "feeling tired." Endurance-building exercises help strengthen the heart to pump blood and the lungs to exchange oxygen and also increase the elasticity of blood vessels. These functions are a vital part of fitness and feeling good. Walking, cycling, and swimming or water aerobics are excellent all-around exercises.

As stated earlier, the basic components of an exercise routine for older people include strengthening, flexibility, and endurance. In addition, attention must be given to the simple act of breathing during exercising. Breathing is a vital part of an exercise program. As a person concentrates on the exercise, it is easy to forget to breathe. The correct breathing technique is to breathe out during vigorous effort or exertion and breathe in as the muscles relax.

Roll breathing is also a good way to reduce tension and to induce relaxation. As a result of changes related to aging, some older people experience a general loss of elasticity of the chest muscles and some postural changes. These gradual changes often affect the way they breathe. This is especially true for frail and bed-bound elderly. The roll-breathing exercises outlined in Box 5.1 encourage deep breathing and are very helpful as a relaxation technique and a component of an exercise program.

A last comment on exercise is a caution for older adults who have not been exercising on a regular basis, who are frail, or who have cardiovascular problems. Anyone with heart problems or high blood pressure, who is overweight, or who has been told to be cautious in personal activity level should have an exercise program prescribed by a physician.

Physical fitness is one component of life that enables people to live it to its fullest. As a nurse, you have a responsibility to understand and teach the importance of exercise and fitness to the elderly population.

Stress

Stress motivates people to act, forces them to think under pressure, and challenges them to be creative, resourceful human beings. The key is to be able to strike a balance between too much stress and not enough, between positive stress *(eustress)* and stress that is harmful *(distress).*

BOX 5.1 Roll Breathing

The object of roll breathing is to develop full use of the lungs. It can be practiced in any position but is best learned lying down, with the knees bent.

1. Place your left hand on your abdomen and your right hand on your chest. Notice how your hands move as you breathe in and out.
2. Practice filling your lower lungs by breathing so that your left hand goes up and down while your right hand remains still. Always inhale through your nose and exhale through your mouth.
3. When you have filled and emptied your lower lungs 8 to 10 times with ease, add the second step to your breathing: inhale first into your lower lungs as before but then continue inhaling into your upper chest. As you do so, your right hand will rise and your left hand will fall a little as your stomach is drawn in.
4. As you slowly exhale through your mouth, make a quiet, relaxing whooshing sound as first your left hand and then your right hand falls. Exhale and feel the tension leaving your body as you become more and more relaxed.
5. Practice breathing in and out in this manner for 3 to 5 minutes. Notice that the movement of your abdomen and chest is like the rolling motion of waves, rising and falling in a rhythmic motion.

Roll breathing should be practiced daily for several weeks until it can be done almost anywhere, providing you with an instant relaxation tool anytime you need one. Caution: some people get dizzy the first few times they try roll breathing. Get up slowly and with support.

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As with all areas of health promotion, it is never too late to improve a technique. Failure to take a healthy approach to dealing with stress can greatly increase the risk of developing or worsening heart disease, cancer, and other chronic diseases.

For most older people, stress is related to three basic areas: environment, body, and mind. Environmental stressors are weather, crime, crowds, time pressures, and the demands of others. The human body can experience stress due to illness, accidents, drugs, lack of sleep, and the normal changes related to aging. Finally, the mind can create stress for people because of negative attitudes and perceptions, boredom, despair, and hopelessness.

Regularly occurring events such as trips to the grocery store, pain from arthritis, and fear of the unknown conditions of retirement may all create stress for older people. Stress-related problems and symptoms include ulcers (stomach pain), high blood pressure (no symptoms), arthritis (joint pain and muscle tension), heart disease (chest pain and difficulty breathing), cancer (increased susceptibility), headaches (constant worry), circulatory problems (cold hands and feet), and backaches (muscle spasm and chronic pain).

One of the most important strategies for health promotion is to help older people recognize their personal reactions to stress and their bodies' physiological responses. Tools used to recognize stress are a stress log or journal of daily stressful situations, life change inventory, and stress control inventory.

After an individual has recognized personal stress and his or her personal response to it, several interventions are available to help relieve it. As a nurse, you should understand and be able to recommend appropriate stress-reducing activities. These activities may be divided into the two categories of quick relaxers and long-term stress management skills.

A quick relaxer is something a person can do in 2 or 3 minutes to relax and counteract symptoms of distress. One of the most important, yet difficult, skills for some older people is learning simply to relax. Learning how to relax helps older people sleep better, control blood pressure, lower cholesterol, reduce headaches, relieve depression, reduce or eliminate use of drugs and alcohol, and smile more. Examples of quick relaxers include roll breathing, progressive muscle relaxation, imagining a pleasant place or situation, eye relaxation, and exercise. The importance of exercise was discussed earlier in this chapter; however, it is worth emphasizing that exercise is the most natural way to relax. For the greatest calming effect, the elderly individual can combine fitness activities with breathing and other mental relaxation techniques.

For some older people, dealing with stress requires more than a few "stress-buster" quickie techniques. If stress causes continuous physical and mental discomfort that results in illness, learning how to deal with the source of stress needs to be a major goal. This assumes that the individual understands what is causing the stress.

Using the four stress management options listed here as a teaching tool is very helpful for many people. The four basic options are:

1. Attempt symptom relief (quick techniques).
2. Accept the stressor (change perception or attitude). *Example:* Your children frequently call you at the last minute to babysit your grandchildren. You may accept the stress and decide you really do not need much time to prepare, so say yes and enjoy! Another choice is to lovingly say no!
3. Alter the stressor (change or alter the source of stress so it is no longer there). *Example:* Make the decision that you will not be able to babysit unless they let you know 1 day ahead of time.
4. Avoid the stressor (remove yourself from the stressor). *Example:* Decide you will not be a babysitter for your grandchildren. After the source of stress has been pinpointed, the older person often can decide whether to accept, alter, or avoid it.

Stress management techniques may not be familiar to many older individuals, even though stress and recognition of stress have been buzzwords for some time. Teaching older people stress management can be done very successfully through either group or individual activities.

LIFESTYLES

Maintaining a healthy lifestyle at any age involves more than getting fit, eating right, and coping with stress. Other challenging issues that people of all ages encounter are relationships, possible alcohol and drug abuse, and self-care.

Relationships

Human life is constantly defined and redefined by our ties to others. The term *relationship* means any significant bonding in which a person

This 65-year-old man goes fishing with his youngest grandson two or three times a week. From Utah, they have traveled to Alaska and Washington to fish, as well as to the many beautiful fishing places in their own locale. Fishing always has been part of this man's lifestyle, but now he has the added close relationship with his grandson.

feels a strong sense of responsibility toward the physical and emotional welfare of others.

As people grow older, the reality is that all relationships eventually end. Whether through divorce or death of a spouse, child, family, friend, or pet, the loss redefines your life. An individual's ability to deal with the process of grief over the losses can result in significant personal and health changes, as well as changes in dealing with others. How strongly these changes affect the rest of one's life depends on how well the person, and those in the personal life of an individual, cope with the loss. How people have coped with change and crisis in younger years predicts how they will deal with these same stressors later.

As years pass, life changes can become increasingly complex. Older adults must deal with changes due to retirement that have major impacts on home life, health, finances, and role changes. In addition, the loss of relationships may be frequent and numerous.

As a nurse, you have an opportunity to help older adults gain insight into loss and life change. Refer to Chapter 9 on End-of-Life Changes. It contains a section on the stages of grief that may be helpful to you in understanding the reactions to loss of older adults. You must assess the effect loss has on a person's ability to function with day-to-day activities. As an LPN, you must ask questions and allow the older person to share concerns. Health-promotion activities that focus on mental wellness can provide an excellent opportunity for older adults to express the concerns they face. The American Association of Retired Persons' (AARP) preretirement program offers a useful notebook that helps lead discussions about the myths, fears, and reality of change as one grows older.

Alcohol, Drugs, and Aging

Abuse of alcohol and drugs among older men and women is a more serious problem than most people realize. Until recently, older problem drinkers tended to be ignored by both health professionals and the general public. The neglect occurred for several reasons:

- This country's elderly population was small, and few older individuals were identified as alcoholics.
- Chronic problem drinkers (those who had abused alcohol off and on for most of their lives) often died before old age.
- Because they often are retired or have few social contacts, older people frequently have been able to hide drinking problems.

POINT OF INTEREST

Throughout my 40+ years of nursing, I always have been a gerontological nurse in my heart. I have had other jobs, but my interest is in the elderly. At some point in my career, I began referring to the elderly persons in my care as "wise and wonderful." It is a simple thing; I don't recall anything special that caused me to start using that term. It just happened because of the respect I developed for the wonderful, old "survivors" with whom I was privileged to work.

Some families may unknowingly accept or encourage drinking in older family members. They may have the attitude that drinking should be tolerated because older people have only a limited time left to live and should be allowed to enjoy themselves. Sometimes the alcohol consumption seems to be an insignificant amount to the family, and they blame the resulting impairment on aging.

The amount, time, and place of alcohol consumption have little significance. What alcohol does to an individual's quality of life and functional ability is the critical issue that needs to be addressed. Older problem drinkers seem to be of two types. The first are chronic abusers, who have used alcohol heavily throughout life. Approximately two-thirds of older alcoholics are in this group. The second type begins excessive drinking late in life, often in response to situational factors such as retirement, lowered income, declining health, or the deaths of friends and loved ones. In these cases, alcohol is first used for temporary relief but later becomes a problem.

The physical effects of alcohol are significant for older people. Alcohol impairs mental alertness, judgment, physical coordination, and reaction time. These problems mimic and exacerbate the deleterious effects of other chronic conditions (dementia, depression, and arthritis) and increase the risks of falls and other accidents.

As people age, they appear to become less tolerant of even small amounts of alcohol, and, moreover, the effect of alcohol on the body may be unusual. For example, the effects of alcohol on the cardiovascular system may mask the pain of an oncoming heart attack. Older people are the greatest consumers of prescription and OTC drugs. The combined use of alcohol and drugs increases the likelihood of a toxic or lethal affect.

Treatment efforts for older alcoholic people have not been fruitful. It is easy to overlook or accept problem drinking as a device that offers enjoyment or comfort. It is much harder to create social alternatives to the life events that lie behind alcoholism.

As a health professional, you may be tempted to rush over or omit assessment questions referring to alcohol intake. Because the nurse often plays a key role in recognizing alcohol and drug problems, you cannot afford to avoid such questions. You always should ask what the impact of this problem may be on the older person's ability to function. It becomes easy to see that the physical, mental, and social impact of drinking could contribute to alcohol dependency.

The primary health-promotion goal is helping older adults and their families recognize when alcohol is a problem. Second, straightforward information must be given to seniors regarding the effects of alcohol, especially in combination with drugs. The nurse must understand the older person's reason for drinking. Health-promotion activities that create social alternatives can be made available to the older person with an alcohol problem.

Because of their critical importance, drug issues are covered extensively in another chapter; however, emphasis on the problem of drug dependency and abuse is important. Drug abuse depends on the relationship of the individual to the drug in question. Harmful drug relationships are frequently termed *overmedication, dependency, abuse, problem usage,* and *habituation.* Regardless of the reason, if an older person misuses a drug or becomes dependent on it, the effects are similar to those of problem drinking. Physical and mental impairments resulting from prescribed or OTC drugs mimic disease states and increase the risk of falls, accidents, and dependency.

One role of health promotion is to offer education and screening regarding drug use. Promoting self-responsibility is the key component. Once again, nurses must assess the impact of drug treatment on the older person's ability to complete ADLs. For example, if your patient cannot afford a prescribed drug, then it probably will not be taken as ordered. If the older adult does not understand what outcomes are expected from the drug treatment, misuse of a drug may ensue by taking it for too long or taking too much of it.

SELF-CARE—TAKING CHARGE

Older adults are best qualified to keep themselves healthy and to know when they are ill. As a nurse, you need to respect and explore what the older person reports as the problem. Do not take charge and deny an older adult responsibility for personal health and health management.

Self-care, self-help, and *self-maintenance* are terms often used interchangeably to describe various aspects of an individual's efforts to maintain optimal health and functionality. From a nursing perspective, the focus is frequently on ADLs, the most basic self-care activities engaged in by older adults. It is not uncommon to see dependence in at least some basic ADLs for older people. Surveys show that as many as 18% of those over 65

years of age who live in the community are dependent in at least one ADL. In nursing homes, the prevalence is as high as 80%. In addition to ADLs, the older person needs to manage IADLs such as selecting a physician and other health-care providers and knowing how and when to access the health-care system.

Regardless of whether the senior is attempting to overcome a functional deficit in ADLs or IADLs, the same self-care skills are needed. The art of self-care involves:

Accepting personal responsibility for your own health
Adopting healthy lifestyle habits with regard to fitness, relaxation, and nutrition
Learning how to make the changes you choose accomplish the things you want them to do

Accepting personal responsibility for health behaviors applies to the "why" of the decision more than the "what." "Self-responsibility" means that the older adult does not rely solely on spouse, children, physician, or nurse to determine "what to do to be healthy." The person must be allowed to think through the options and make each decision. This does not mean a person should not seek the assistance of others, but rather that a need exists to work in partnership with the doctor, nurse, or family (separately or together) to make the best decision.

The self-care concept emphasizes the need for encouraging individuals to take a more active role in maintaining or improving their health. Often, this process is not understood by the client, and it is not easy for older people to accomplish. Health-promotion strategies related to self-care must include helping the older adult understand how to be in charge of personal health decisions. Enabling the older person to be a wise medical consumer and to know how and when to work and communicate as a partner with the health-care team should be a focus of your efforts.

Your role as a health professional is twofold. First, you must offer activities to develop self-care skills, such as one-on-one or group activities that teach how to be an informed medical consumer, or information on prevention and screening guidelines, for instance, for a mammogram or a prostate examination. Then you must ensure that the environment allows for the older adult to use the skills to make choices and assume self-responsibility. For example, if the senior wants to be a partner with the physician in a health decision, the physician should take the time to answer questions and ultimately let the treatment decision be made by the older adult. This same situation applies to nursing. For example, if the senior is expected to be involved in a self-care activity program, you, as a nurse, must be prepared to explain the benefits, procedures, and risks and then be willing to let the senior make the decision.

CONCLUSION

Until recently, older adults' needs have been ignored in the health-promotion movement. Health professionals mistakenly assumed elders had no interest in health-promotion programs. As this country has become more and more a home to an aging society, these views have changed.

As a nurse, you must understand the importance of promoting wellness to all older adults, regardless of the presence or absence of disease. Attainment of a disease-free existence is not a realistic goal. Health-promotion efforts should be directed toward maintaining functional independence for older people.

Older Americans need information about how to lead healthy lifestyles. When such information and opportunity are provided, older people often are willing to make the changes necessary to improve their health. Exercising regularly, maintaining a nutritious diet, managing stress effectively, taking medications safely, avoiding overuse of alcohol, and recognizing self-care as a choice are all behaviors that improve health and the quality of life. Pursuit of high-level wellness in later years is the responsibility of both the individual and society.

CASE STUDY

Mrs. C. is a 65-year-old widow who has lived alone since the death of her husband 2 years ago. She retired 1 year ago from her job of 25 years as a secretary. After retirement, she participated in a health promotion and screening clinic at the senior center. After completing a lifestyle inventory and screening, the following problems were noted in the categories of health promotion:

Nutrition: 10 lb overweight

Exercise: Does no regular exercise

Stress: Cries easily, often unable to sleep at night, complains of fatigue and generally low energy

Relationships: Misses people at work, talks about missing deceased husband

Substance abuse: Takes an OTC sleeping pill and one glass of wine before bed

Self-care: Has not seen a physician since she had a hysterectomy 10 years ago; never had a mammogram and does not perform breast self-examination; cannot recall immunization history but is sure she has not had any in the past 10 years; has never had a flu shot or pneumococcal vaccine; recently had blood pressure taken at a drug store machine, when it was 150/92.

Discussion

1. List additional assessment data that should be known in each of the categories of health promotion.
2. How might you determine Mrs. C.'s greatest concern?
3. What part does Mrs. C.'s motivation play in developing a wellness plan?
4. What conditions or disease states might develop if Mrs. C. continues with no changes in her life?
5. What might be the first priority for Mrs. C.?

Solution

1. Additional information in each category might include:

   Nutrition

   What are her daily eating habits? Type and amount of food and fluids? Does she eat alone?

   Exercise

   What is her normal daily activity level? How does this differ from her daily activity level before retirement?

   Stress

   What is her perception of coping with changes such as death and retirement? Any other physical complaints made, such as fatigue, headaches?

   Relationships

   What family or friends are important to her? In what social activities is she involved? Any hobbies?

   Substance Abuse

   When did she begin drinking wine every evening? When did her sleeping problems begin? Has she always taken sleeping pills?

   Self-Care

   Does she have a primary care physician? Does she understand the importance of exercise, disease prevention? Does she know the danger of combining drugs and alcohol?

2. Asking Mrs. C. "What is your biggest worry or concern in your life at this time?" would be a beginning. Although the nurse may see many areas of concern, Mrs. C.'s own concerns are more critical.
3. If the nurse begins by focusing on what Mrs. C. considers most important, then it is easier for Mrs. C. to understand her own motivation.
4. Some potential conditions include:

   Excess weight, which may lead or contribute to high blood pressure and physical limitation.

   Lack of exercise, which may contribute to weight gain but also worsen arthritis and its effects on mobility.

   Emotional stress, which may lead to depression.

   Relationship concerns, which also may contribute to depression, isolation, and abuse of drugs and alcohol.

   Combination of alcohol and OTC sleeping pills, which may lead to further sleeping problems, alcohol and drug misuse, depression, injury, and further isolation.
5. If Mrs. C. has not seen a physician for 10 years, she needs at least a baseline physical assessment. She has some significant conditions that need to be addressed such as borderline high blood pressure, sleep problems, and weight gain. In addition, she should have a basic screening related to disease prevention.

STUDY QUESTIONS

Select the best answer to each question.

1. Incentives for older persons to participate in health-promotion behaviors include:

- **a.** The belief that they will find the Fountain of Youth
- **b.** The belief that activities will help them die well
- **c.** The belief that activities will help keep them independent
- **d.** The belief that it will please their physician

2. Health-promotion programs appropriate for older people should focus on:

- **a.** Maintaining functional abilities
- **b.** Advancing youthfulness
- **c.** Enhancing chronic illnesses
- **d.** Developing dependence on others for care

3. Basic components of an exercise routine for older people are:

- **a.** Strengthening, endurance, and flexibility
- **b.** Strengthening, dieting, and power walking
- **c.** Strengthening, dieting, and aerobics
- **d.** Strengthening, aerobics, and the food pyramid

4. Age-related changes that affect nutrition include:

- **a.** Increase in the ability to taste
- **b.** Increase in body fat
- **c.** Increase in lean body mass
- **d.** Increased metabolic rate because of aging thyroid

5. Older people with a drinking problem are often ignored because:

- **a.** They have many social opportunities to drink
- **b.** The amount of alcohol consumed may seem small
- **c.** The resulting impairment may seem to be age related
- **d.** So many older people drink

6

Nutrition for Older Adults

Judith Pratt

Learning Objectives

After completing this chapter, the student will be able to:

1. Perform a nutritional assessment on an older adult.
2. Make nutritional food choices by using the food pyramid as a guide.
3. Identify the influence carbohydrates, proteins, and fats have on maintaining a healthy body.
4. Identify the influence vitamins and minerals have on maintaining a healthy body.
5. Discuss therapeutic diets for older adults with special nutritional needs.
6. List the four basic causes of electrolyte imbalance.

INTRODUCTION

A nutritious intake of food is essential at any age to achieve optimal health. However, the amount of foods necessary to promote health changes over the lifespan. Younger persons can "get away" with eating donuts or candy, whereas older persons cannot eat such things without a serious weight gain. This is because of their slower metabolism and, in many cases, their decrease in exercise. The need for foods that contain carbohydrates, proteins, fats, vitamins, and minerals, in the appropriate amounts, must be included in dietary planning. Such foods provide the essential building blocks for health maintenance.

As a licensed practical nurse (LPN), you need to be aware of physical changes related to aging that affect food intake. Examples of these changes could be gastric disorders caused by normal gastrointestinal (GI) changes as well as chronic diseases or illnesses that impact nutritional requirements. Certain foods and medications can cause adverse drug reactions. Older adults may have difficulty chewing or swallowing food because of disease or poor dentition. Sensory changes in seeing, smelling, and tasting foods may influence an older adult's appetite. Loss of appetite also can occur as psychosocial changes bring on depression, dependency on others for meals, and changes in cognitive skills. As you perform nutritional assessments on older adults, you need to think about reasons why they may have nutritional deficits and ways you can assist them and their family with overcoming the problem.

PRIORITY SETTING 6.1

The priority you need to set, which will ensure good nutrition for the older adults in your care, is your commitment to their health. First, learn the information in this chapter. There is quite a bit of detail, but these are only the basics. They are the minimum you need to learn to be effective in promoting nutritional health. Then . . .

1. Learn the information and apply it in your own life.
2. Take a nonthreatening stand and work with others to see that the team does effective nutritional assessments on admission.
3. Support your nurse manager, or even volunteer to assist in putting the pertinent information from the assessments into the care plans.
4. Go further and put up signs so the staff will know what assistance and encouragement each person needs. Examples are: "Offer fluids or juice every 2 hours and record." "Cut up fresh fruit for Mrs. Jonas." "Stay and visit with Mr. Tanaki while he eats. Encourage him to eat more food." "Mr. Welling has a food journal at the desk. Please record all food consumed."

You, as a caring professional, are one member of the health-care team who can work with others to identify and manage nutritional problems that exist with the older adults in your care.

NUTRITIONAL ASSESSMENT

The place where you work may or may not have a nutritional assessment tool, and assessment tools may vary from nursing home to hospital. You need to be mindful of the basics of a nutritional risk assessment so you can perform one successfully wherever you are working. They are the following:

1. Has an illness or the person's condition been responsible for a change in eating patterns?
2. Does the person eat fewer than two meals a day?
3. Does the person's diet include fruits, vegetables, meat, and milk products?
4. Does the person's diet frequently include alcoholic drinks?
5. Does the person have difficulty chewing or swallowing food?
6. Does the person have the resources to purchase food?
7. Does the person eat alone most of the time?
8. Does the patient take three (3) or more medications, either prescribed or over the counter (OTC), each day?
9. Has the person lost or gained more than 10 pounds in the past 6 months?
10. Is the person able to shop, cook, and feed himself or herself (Tabloski, 2006)?

Any of these nutritional risks can lead to malnourishment and can compromise health. You need to report the nutritional risks you identify to your supervisor. Good nutrition is essential to

good health. The reconciliation of the potential problems listed above may not seem essential to your role as a care provider, but it is.

The objective in gerontological nursing is the best health possible for the best possible quality of life. It is humbling to me to think that, for example, five vegetables and fruits a day can make a profound difference in an older person's life. First, there is more energy because of the increase in natural vitamins and minerals. There is more roughage, which results in regular bowel movements (BMs) and the elimination of laxatives. It is challenging mentally to identify different recipes for the preparation of a variety of fruits and vegetables. Finally, well-prepared fruits and vegetables taste good and are colorful on the plate; this can stimulate appetite for some people.

Monitoring weight also is an effective tool in assessing nutritional status. You need to be attentive to any changes in the older adult's weight. If there is weight gain, perhaps the person needs to become more active. It also is wise to check for edema and/or hypertension as these problems could be caused by even greater problems. If there is weight loss, this needs to be reported to the registered nurse (RN).

There are several reasons why an older adult may lose weight. First, you need to be conscious of what is happening in the person's life. Ask yourself, are there changes in health that could cause a weight loss, such as fever, infection, fracture, or a wound? Does the older adult have metabolic changes that affect food absorption, digestion, or elimination? Have you noticed problems in eating such as chewing or swallowing difficulties or an inability to feed self or even to see the food? Perhaps the person has been depressed, or maybe the food does not taste good. If you are doing home care, there could be reasons the older adult cannot purchase, prepare, or eat the food. Be sure to ask the person about any problems related to nutrition. Part of a good assessment would be to ask the older adult why, in his or her opinion, the weight loss is happening (Dudek, 2006; Tabloski, 2006).

NUTRITIONAL NEEDS OF OLDER ADULTS

Regardless of the older adult's health status, he or she will need to have foods that provide calories for energy and nutrients to maintain body functions. The older person's food needs for energy calories will change with age, physical activity, and health status. Nutritious foods are always important for maintaining a healthy body. During an illness, nutritious foods perform a vital role in the body's ability to heal. The critical foods, those that provide energy and nutrients, are divided into three groups: carbohydrates, proteins, and fats. Each of these food groups is required to maintain and repair the body during health and illness. It is important for you to have the knowledge to assess the inclusion of these food groups in a person's diet. This assessment can be done by evaluating if the person's diet includes a variety of fruits and vegetables, meats or other protein-rich foods, and bread and cereals. The assessment can be done by observing what the older adult is eating during mealtime or by keeping a food journal. A food journal is something you can discuss with the RN with whom you work. If you have observed a patient or resident eating minimal amounts of food and/or showing signs of listlessness, you should talk to the RN about the problem and, perhaps, suggest a food journal. A food journal is simply a designated place where the person removing the food tray writes down not only the percentage of the food eaten but the actual food. Then someone like a dietitian, or perhaps you, is assigned to determine if the person is eating enough calories and specific nutritious foods. Sometimes the journal needs to be kept for only 3 days. A week also is common. It is a great way to gather the detailed information needed to assist the older person with good nutrition. The dietitian is an excellent resource when there is a problem with someone not eating nutritious foods.

CRITICALLY EXAMINE THE FOLLOWING:

To help you to be effective in assessing the nutritional status of others, you need to evaluate your own eating patterns and nutritional condition. This will help you be more understanding of the potential difficulty of managing a nutritious menu for older people in your care. The United States Department of Agriculture (USDA) has created a Food Pyramid Guide that will assist you in analyzing your own eating patterns. Use the Internet and go to the www.mypyramid.gov Web site to see how you are doing. Do the self-evaluation. How would you assess your eating habits? What do you need to change to make your diet healthier? Write a one-page summary of your nutritional evaluation and be prepared to submit it to your instructor.

Anatomy of MyPyramid

One size doesn't fit all

Activity

Moderation

Personalization

Proportionality

Variety

Gradual Improvement

MyPyramid.gov

STEPS TO A HEALTHIER YOU

GRAINS | VEGETABLES | FRUITS | MILK | MEAT & BEANS

The federal government's revised food guide pyramid, MyPyramid, is an excellent resource in determining a nutritious diet for older adults. (From United States Department of Agriculture, Washington, D.C., 2005.)

A review of the food groups, carbohydrates, proteins, and fats will help you in your ability to assess and evaluate nutritional needs of older adults. You will recall from your nutrition class that carbohydrates, proteins, and fats are found in a variety of fruits and vegetables, meats, milk, and breads and cereal foods. It is important for older adults to eat a variety of foods with these nutrients to ensure that the body can maintain and repair itself.

Pretend you are a certified nursing assistant (CNA) working two part-time jobs while you are in school pursuing your LPN education. You work 1 day a week for Sea Side Long Term Care Center and 1 day a week for Mountain Top Home Health. You enjoy working for both agencies and have received excellent evaluations from your supervisors. You have cared for the same people for 3 weeks now and have been part of the process of improving older adults' health with attention to good nursing care. You love what you are doing and enjoy applying what you are learning in school to the patients and residents.

You have been caring for Mrs. Salvador for the past 3 weeks. Mrs. Salvador is a 75-year-old Hispanic female resident who has enjoyed good health until about 6 weeks ago. She was the sole caregiver for her husband, who suffered from Alzheimer's disease (AD) for the last 5 years. Mr. Salvador died 2 months ago. Six weeks ago, Mrs. Salvador fell while visiting her husband's grave site. She fractured both her left hip and her left elbow. A week after her surgery, Mrs. Salvador was transferred to Sea Side Long Term Care Center for physical therapy. She needs more physical therapy before she will be able to care for herself at home. You noticed Mrs. Salvador has lost 4 pounds since her admission to the unit. Consider the following questions you should ask when evaluating her weight loss:

1. Was Mrs. Salvador losing weight before her accident?

This couple has learned the value of healthy nutritious food. Their meals focus on fresh fruits and vegetables, sodium restriction, calcium intake through dairy products, and low-fat proteins.

2. What questions should I consider that were in the Nutritional Assessment Tool in this chapter?
3. Does Mrs. Salvador's diet include adequate amounts of carbohydrates, proteins, and fats, as that is what she needs to assist in her healing?
4. What information should you report to the RN?

Carbohydrate Foods

You can begin your assessment of Mrs. Salvador's diet by noting carbohydrate foods she is eating. You may recall from your nutrition class that there are two types of carbohydrates: complex and simple. Complex carbohydrates are those that the body breaks down slowly and that sustain energy over a longer period of time. Complex carbohydrate foods will be more nutritious for Mrs. Salvador. Because she is recovering from surgery to repair her hip and elbow, her body will require more complex carbohydrates to replace the loss of reserved or stored carbohydrates called glycogen. Older adults are healthier when their bodies have a sufficient supply of glycogen reserves. Simple carbohydrates differ from complex carbohydrates in that they are easier for the body to digest and they provide a source of quick energy.

You need to know which foods provide carbohydrates that promote health. Carbohydrates come from grains, beans, nuts, milk, meat, fruits, and vegetables. Honey, molasses, sugar, and syrups also contain carbohydrates. You can assess Mrs. Salvador's carbohydrate intake by evaluating whether or not these foods have been included in her meals and if she has been eating them. The more carbohydrate foods are processed, the more the dietary fibers will be broken down, and some of the carbohydrate nutritional value will be lost. You need to encourage Mrs. Salvador to eat the foods containing fiber to aid in her digestion and to maintain proper bowel function. Remember that simple carbohydrates come from milk and foods high in sugar content, and they are a source of quick energy. These carbohydrates will be valuable for Mrs. Salvador before her physical therapy treatments, for example. The food guide MyPyramid provides a visual representation of the sources of carbohydrates that need to be included in her diet. I am sure the food guide will be helpful to you in teaching Mrs. Salvador what she should be eating.

Protein Foods

Sources of food rich in proteins come from plants and animals. Plant sources of proteins come from grains and include breads, rice, cereals, and pasta. Dried beans and dark green, deep yellow, and starchy vegetables are considered good sources of plant proteins. Proteins that come from animals are milk, cheese, yogurt, meat, fish, and poultry (Nix, 2005). The food guide MyPyramid provides a visual representation of the sources of proteins that need to be included in a

Most older adults eat healthier meals and eat more of the meal if they are eating with family members. This daughter and her son have dinner with grandma three times a week. This assures the grandma of good food and company. She says it really gives her something to look forward to doing.

healthy diet. Frequent use of the food guide will assist you in mastering the information necessary to give meaningful nutritional care to the people for whom you are responsible.

You should assess the protein foods in Mrs. Salvador's diet. In your nutritional studies, you have learned that proteins are the building blocks of the body. Proteins are necessary for building and repairing body tissue and will be important for Mrs. Salvador as she recovers from her accident and subsequent surgery. Proteins are divided into structural and functional categories. The structural proteins contain the amino acids that make up the hair, muscles, tendons, and skin. The functional proteins help the body carry out the activities that are vital to the body, such as moving oxygen through the circulatory system. You can think of hemoglobin as a functional protein. Insulin is a functional protein. Myosin, which is found in muscle tissue and is the reason the muscles can contract, also is a functional protein. The body requires a supply of proteins to repair worn out or damaged tissues and to build up new tissue. They also play an important part in maintaining the body's water balance in metabolic activities and the body's defense system (Nix, 2005).

When using the word *protein*, you need to remember the words *amino acids*. There are thousands of different proteins, and they are all made of various combinations of amino acids. Have you taken a chemistry class? If so, perhaps you can recall that the amino acids in proteins consist of carbon, hydrogen, oxygen, and nitrogen.

Do you recall from your nutrition class that there are two classifications of amino acids? They are essential and nonessential. You should not confuse the words *essential* and *nonessential* amino acids with their value to the body, because both amino acids are important for good health. Nonessential amino acids refer to amino acids that the body can make itself. Essential amino acids are those that the body cannot make itself and must be part of the diet. Both essential and nonessential amino acids are necessary for the body to function properly (Nix, 2005).

If your nutrition class was like mine, perhaps you and some of your classmates became confused about the terms used in the chapter on proteins. There were the terms structural and functional proteins, essential and nonessential amino acids, and then the terms complete and incomplete proteins. The last terms, complete and incomplete proteins, were easy for me to remember because I knew they both referred to the foods that supplied proteins to the body. A complete protein comes from animal sources and contains both essential and nonessential amino acids. Incomplete proteins come from plant sources, but you need to remember that plants do not include both essential and nonessential amino acids. Did your instructor tell the nutrition class that by eating different plant sources during the same meal, the body would get a supply of both complete and incomplete proteins that would provide the essential and nonessential amino acids for building, maintaining, and repairing the body? Think of eating both beans and rice in the same meal. Each of these foods is an incomplete protein food. When they are eaten in the same meal, however, the body is able to use them as a complete protein. This way of obtaining protein for the body is used by millions of people who either like rice and beans instead of meat or cannot afford fresh meat to eat.

Age, gender, chronic diseases, fevers, infections, surgery, and traumatic injury are factors in determining the need for added protein for the body's maintenance and repair. The physician

may order a laboratory test to measure any recovering older person's nitrogen level to determine how well the body is maintaining its tissue. In malnutrition or an illness, the body may not have the proper nitrogen balance to support health. A positive balance of nitrogen indicates that there are adequate sources of protein for the body to use to build and repair tissues. A negative nitrogen balance indicates wasting of muscle tissues and impairment of body organs and their functions. As an example, a nitrogen imbalance will put Mrs. Salvador, the nursing home resident, at risk for infections and other complications (Nix, 2005).

Laboratory tests of Mrs. Salvador's blood and urine samples will test for nitrogen balance. The urine tests measure protein metabolism. An increase in the nitrogen level indicates that excess body tissue is being broken down. A serum hemoglobin, hematocrit, and/or serum albumin measurement will help diagnose protein deficits (Nix, 2005).

When you are collecting urine for laboratory tests that contain the words *creatinine, albumin, transferrin, prealbumin,* or *retinol-binding protein,* you will know the urine is being tested for nitrogen balance. The RN will give you instructions on how the urine should be collected. The letters *BUN* on a laboratory request or report are related to nitrogen balance. Dietary adjustments may be ordered after the laboratory results have been reviewed by the physician. Monitoring Mrs. Salvador's protein dietary intake is critical for managing her nitrogen balance.

Fat Foods

Fats are a group of foods that, when absorbed into the body, serve as a support and protection for the internal organs. Adipose (fat) tissue serves as a buffer or cushion from an external injury. Fats help to sustain the body's temperature. Certain vitamins—A, D, E, and K—are fat soluble. The body must have foods containing fats to absorb these important vitamins. Some fat is required by the body to maintain health.

Fats are found in plants such as beans and nuts and in oils produced from plants. Fats also are found in meat, poultry, fish, shellfish, and eggs. The food guide MyPyramid provides a visual representation of the sources of fats that are heart healthy, vital for a healthy body, and should be included in the diet. Why would Mrs. Salvador require fat in her daily diet? The answer is that fat is required to maintain health, provides a way for fat-soluble vitamins to be effective, and serves as a support and protection for Mrs. Salvador's internal organs.

Remember that you are pretending to be a CNA who works for both a nursing home and a home health facility. One day after your nutrition class, you realize that you are interested in the role played by nutrition in older adults' diets so they can be healthy or improve their health following an illness or accident. You begin to think about the Rice family. You have been working with the Rice family for the past 2 months. Mr. Rice had a stroke 3 months ago and still needs help with bathing. The Rices have enjoyed your visits and requested your services when you are working at the home care service.

Mrs. Rice is interested in her husband's care and is always asking you questions about tips to help him return to better health. Mrs. Rice's care and concern are helping Mr. Rice to assist more in his own care. During your visits with the Rice family, you have been able to observe what foods are routinely being eaten. Mrs. Rice is interested in giving Mr. Rice nutritious meals. However, you have noticed Mrs. Rice includes many foods high in carbohydrates. Mrs. Rice has been overweight most of her adult life. She has not been able to leave home very often and seems to be gaining more weight. You have encouraged Mrs. Rice not to forget to take care of herself. You suggested she see her physician when she started complaining about being thirsty all the time and needing to urinate more frequently (classic symptoms of diabetes mellitus).

You recall information from your nutrition class that research and science indicated that too many carbohydrates in the diet can lead to vascular disease, type 2 diabetes, cancer, arthritis, obesity, and other chronic diseases. Is it possible that Mrs. Rice is at risk for any of these conditions? You know that excess carbohydrates are stored as fat in the body. Excess fat may lead to a change in the body's hormonal system that can suppress the immune system and leave the person at risk for an infection (Insel, Turner, & Ross, 2006). Do you think Mrs. Rice is at risk for an infection?

You understand that chronic diseases may be a result of the person's personal nutritional history. Mrs. Rice has an appointment with her physician in 1 week. You suggest she keep a food journal of all the foods she eats for the next week and share it with her physician. A food journal is an excellent method by which to monitor carbohydrates, proteins, and fats that are included in the daily diet.

Vitamin Foods

You always thought it was interesting how different vitamins were found in carbohydrates, proteins, and fats. You wonder how the vitamins are helping the Rices and Mrs. Salvador maintain and repair their bodies at this time in their lives.

Vitamins are classified as either water-soluble or fat-soluble. Water-soluble vitamins are absorbed in water. As mentioned earlier, fatsoluble vitamins require fats for the body to absorb them. Vitamins' names are taken from the alphabet, letters A through K. With one exception, which you will see shortly, vitamins are not produced by the body and must be extracted from foods (or nutritional supplements). The food guide MyPyramid provides a visual representation of the sources of foods containing vitamins that should be included in the diet.

Vitamin A is a fat-soluble vitamin that comes from animal and plant sources. It is easy to remember plant sources of vitamin A if you think of dark green leafy vegetables and deep yellow or orange fruits and vegetables (Dudek, 2006). Vitamin A is necessary for vision, healthy hair, skin, gums, glands, and other body functions. Studies are in place to determine the role of vitamin A in cardiovascular diseases and cancers (Behan, 2006; Dudek, 2006; Nix, 2005). You will want to follow the research on the role of vitamin A in the diet and encourage the people you are caring for to eat foods that are rich in vitamin A. This information will help them improve or maintain their health. Vitamin A can be stored in the body's fat; hence, a deficit in vitamin A may not be noted for a period of time. Older adults may be taking megadoses of vitamin A, which may become toxic. A symptom of excess vitamin A would be a yellowish orange skin color. Do you think it is important to ask your patients if they are taking vitamin A supplements? Older adults should be cautioned about using megadoses of vitamin A because of the consequences.

There are several classes of B vitamins, and they are all water-soluble. The B vitamins are listed as the B vitamin complex. Vitamin B-1 (thiamin) is necessary for the nervous system to function correctly and to help older adults have an appetite. Older adults who drink excess alcohol or have had a poor nutritional intake may need to have thiamin supplements. Foods rich in thiamin come from whole grains or enriched cereals, nuts, organ meats, and legumes (Behan, 2006; Dudek, 2006; Nix, 2005). Should you ask the Rices and Mrs. Salvador about their use of alcohol? If so, why? The answer is yes, you should, as it is part of a thorough nutritional assessment.

Riboflavin (vitamin B-2) is essential in building and maintaining healthy tissue. Riboflavin is necessary for wound healing as well. Foods rich in riboflavin are milk products, whole grain and enriched breads and cereals, eggs, meats, and leafy green vegetables (Behan, 2006; Dudek, 2006; Nix, 2005). It is easy to understand why riboflavin is important to Mrs. Salvador's and Mr. Rice's diet, isn't it?

Niacin (vitamin B-3) is essential in maintaining a healthy nervous system and skin and in preventing dementia. This is a critical vitamin for someone like Mr. Rice because of his AD, which is seriously affecting his nervous system. Foods rich in niacin are whole grains and enriched breads and cereals that are high in proteins. However, it is possible for older people to have too much niacin in the diet. Symptoms of niacin toxicity are diarrhea, vomiting, gastric ulcers, and liver damage. Older people need to be assessed for vitamin supplements in their diets and encouraged to seek counsel concerning consuming megavitamins because of the multiple toxicity possibilities (Behan, 2006; Dudek, 2006; Nix, 2005).

Pyridoxine (vitamin B-6) assists in the metabolism and the utilization of glycogen that has been stored as a fuel. Pyridoxine is required for brain activity and normal functioning of the central nervous system. Pyridoxine promotes healthy skin. Think about why pyridoxine would be important in maintaining and repairing Mrs. Salvador's and Mr. Rice's bodies at this time. Food sources of pyridoxine are eggs, whole-wheat products, peanuts, walnuts, and animal sources. You need to be aware that pyridoxine can be lost during processing of frozen foods, luncheon meats, and cereal foods. This is important for Mrs. Rice to know, and no one except you will be there to teach her. Toxicity from pyridoxine can occur with the inclusion of mega dietary supplements. The classic symptom of toxicity is lack of muscle coordination. An overdose of pyridoxine has the potential for nerve damage as well.

Cobalamin (B-12) is essential for the production of hemoglobin and for proper nervous system function. Anemia and gastrointestinal and neurological changes can result from insufficient amounts of cobalamin. The best foods containing cobalamin are from animal sources. Older adults who do not eat many animal products may require a supplemental source of cobalamin. The

people you care for may require medical interventions if their diets are low in food sources from animals (Behan, 2006; Dudek, 2006; Nix, 2005).

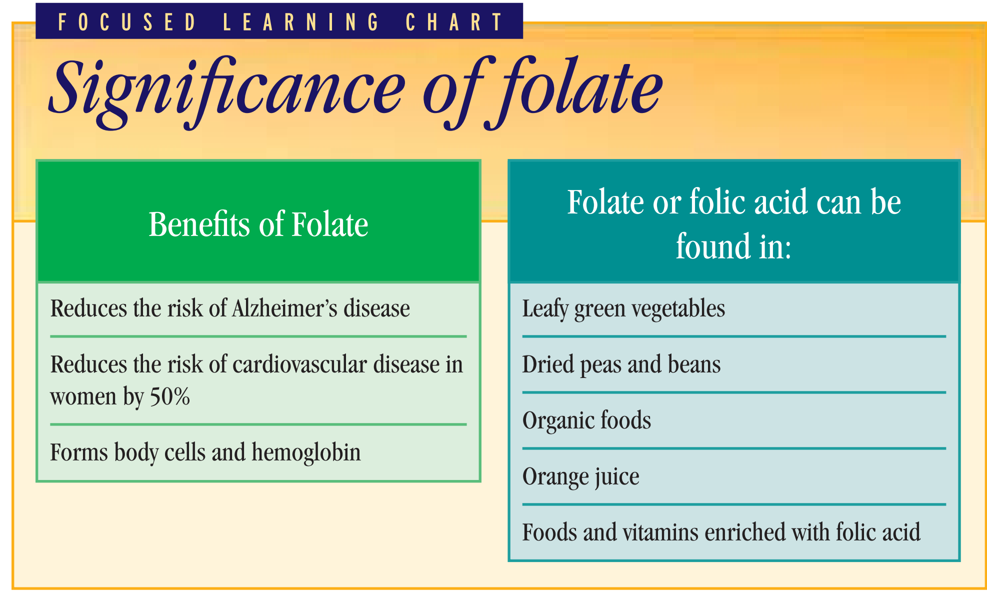
Folate belongs to the B vitamin complex but was not given a number. Folic acid is the most stable form of folate. Folic acid is rarely found in foods but is a supplement in vitamins and in fortified foods. Folate is essential to the formation of body cells and hemoglobin. Folate can be found in green leafy vegetables, dried beans and peas, organ foods, and orange juice. Folate from foods cannot be used well by the body; hence, foods enriched with folic acid should be included in the diet (Behan, 2006; Dudek, 2006; Nix, 2005).

Recent studies indicate that if women get adequate doses of B-6 and folic acids in their diets, they cut their risk of cardiovascular disease by 50%. In addition, a 9.3-year study of 579 older adults suggested that an intake of folate at or above the Recommended Daily Allowance is associated with a reduced risk of AD (Corrada et al., 2005).

Vitamin C is next in the vitamin alphabet list. Ascorbic acid is the name given to vitamin C. Vitamin C is water soluble and is easily lost in cooking. Vitamin C cannot be stored by the body, so there must be a daily intake of food containing vitamin C. The body needs vitamin C to build and repair body tissues and bones and to keep teeth and gums healthy. Lack of vitamin C causes wounds to fail to heal, bones to weaken, and muscles to degenerate and puts the older adult at risk for infections and falling. Many foods are good sources of vitamin C. Citrus fruits, strawberries, kiwi fruit, tomatoes, cantaloupe, and dark green vegetables are only a few of the fruits and vegetables that are rich in vitamin C (Behan, 2006; Dudek, 2006; Nix, 2005).

Vitamin D (cholecalciferol) is one of the fat-soluble vitamins. Cholecalciferol is not actually a vitamin because it is produced naturally by the body. The body can produce its own vitamin D if there is enough exposure to the sun. However, few people have enough sun exposure to produce sufficient vitamin D. Vitamin D is necessary for the absorption of calcium and phosphorus to maintain bone tissue and many other body functions. Without vitamin D, calcium cannot be absorbed. Older adults are at risk for vitamin D deficiencies if they are not eating enough fortified foods. Older adult women who have vitamin D deficiency are at risk for bone loss, which puts them at risk for fractures due to osteoporosis. Vitamin D occurs naturally in very few foods. The sources of vitamin D are the sun, fish oils, and foods fortified with vitamin D. Excessive amounts of vitamin D supplements increase the risk of older adults absorbing more calcium than their bodies need. Increased calcium puts a strain on the kidneys and soft tissues of the body (Behan, 2006; Dudek, 2006; Nix, 2005).

Vitamin E (alpha-tocopherol) is a fat-soluble vitamin. Vitamin E provides protection for many body tissues and prevents red blood cells from being broken down. There is evidence that vitamin E aids in wound healing. There are ongoing studies to determine the role of vitamin E in preventing cancer and heart disease. Foods that are



FOCUSED LEARNING CHART

Significance of folate

Benefits of Folate
Reduces the risk of Alzheimer's disease
Reduces the risk of cardiovascular disease in women by 50%
Forms body cells and hemoglobin

Folate or folic acid can be found in:
Leafy green vegetables
Dried peas and beans
Organic foods
Orange juice
Foods and vitamins enriched with folic acid

rich in vitamin E are peanut butter, nuts, seeds, wheat germ, and vegetable oils. Vegetable oils have been found to be the best sources of vitamin E. Leafy vegetables and animal sources also provide the body with vitamin E. Large doses of vitamin E may interfere with blood clotting; but vitamin E is not toxic (Behan, 2006; Dudek, 2006; Nix, 2005).

Vitamin K is a fat-soluble vitamin. The main roles of vitamin K are blood clotting functions, aiding in bone development, and regulating blood calcium. Foods that supply vitamin K are leafy vegetables, cabbage, broccoli, cauliflower, fruits, and animal sources. Vitamin K is extracted by bacteria in the intestine from food sources that contain vitamin K. Antibiotics that kill bacteria in the intestine may interfere with the production of vitamin K, and complications can occur. Hemorrhaging is a complication of vitamin K deficiency. You should report dark or bloody stools to the RN at any time, but you should be especially vigilant if the older person you are caring for is taking antibiotics. There are no studies to indicate toxicity to vitamin K (Behan, 2006; Dudek, 2006; Nix, 2005).

The food guide MyPyramid provides a visual representation of food sources that are rich in vitamins. Think about all the vitamins and how the body requires these vitamins to build, maintain, and repair itself.

Mineral Foods

Along with the necessity of vitamins in the diet, you also need to recognize the importance of the minerals people require to maintain a healthy body. Minerals are inorganic substances that are found in nature and in the human body. Fifty-four inorganic substances, called elements, have been identified and can be found on a chemical periodic table. Twenty-five of these elements, or minerals, are found in the human body. Minerals make up only a small part of the body but are found in all body tissues and fluids. Minerals are classified according to the amount needed to maintain a healthy body. Macrominerals, or major minerals, are needed in greater amounts than are microminerals, also called trace minerals. Both macrominerals and microminerals are essential for the body (Dudek, 2006; Nix, 2005). Included in the macrominerals are calcium, phosphorus, sodium, magnesium, chloride, and potassium. These minerals are known as electrolytes and can be lost as a result of vomiting, diarrhea, excessive sweating, or urination. The electrolytes must be kept in balance or the older adult is at risk for complications. The food guide MyPyramid provides a visual representation of the sources of food that provide both macrominerals and microminerals.

Calcium is the most prevalent mineral found in the body. Bones and teeth are primarily made up of calcium. In older adults, additional calcium is necessary for the maintenance of bones and teeth. Calcium is required for many other body functions as well. They include blood clotting, muscle and nerve activity, digestion, and maintenance of blood pressure. Ask yourself, "Should Mrs. Salvador and the Rices continue to eat foods that contain calcium?" I hope you recognize immediately that they should simply because of their age. Calcium is best absorbed in connection with vitamin D. Calcium is found in milk and milk products, leafy vegetables, legumes, and fortified food products. Osteoporosis can occur if there is a calcium deficiency. Renal stones are a risk if the body has too much calcium. Mrs. Rice asked you if she or Mr. Rice should take a calcium supplement. This question should be referred to the RN and then the physician. There are many calcium supplements on the market, and Mrs. Rice needs to be advised as to whether they should have a supplement in their diet (Dudek, 2006; Nix, 2005).

After calcium, phosphorus is the most common mineral in the body. Phosphorus combines with calcium in the maintenance of bones. Phosphorus is found throughout the body and is required for metabolism and cell membrane maintenance. Phosphorus helps maintain the body's chemical balance and is necessary for some of the vitamins to be utilized by the body. Phosphorus is easily available because it is found in all meat products, grain products, fruits, and vegetables. Symptoms of low phosphorus levels are weakness, pain, and loss of appetite.

CRITICALLY EXAMINE THE FOLLOWING:

Consider the body's need for vitamins in helping Mrs. Salvador recover from her accident and subsequent surgery. Make a list of the effects that insufficient nutrients could have on her body. Think of her actual problems rather than making a list of each vitamin and listing its symptoms when it is insufficient. Design a day's worth of meals with the foods that would assist her with healing. Include what you have learned from the previous sections on specific foods as well. Be prepared to share your menu plan with the class.

Mrs. Salvador and the Rices should not be deficient in phosphorus unless they have been consuming large quantities of antacids that contain aluminum hydroxide. The aluminum hydroxide reacts chemically with the phosphorus and cancels out its usefulness to the body. Mrs. Rice told you she has been taking more antacids since Mr. Rice had his stroke. You need to encourage Mrs. Rice to tell her physician about her history of antacid use or get her permission to report it to the case manager (Dudek, 2006; Nix, 2005).

Mrs. Rice's history of being thirsty and her report of frequent urination is an indicator of diabetes. Magnesium deficiencies occur with alcohol abuse, renal disease, cardiovascular disease, diabetes, starvation, chronic diarrhea, and vomiting. Magnesium is necessary for energy, maintaining cell membranes, muscle activity, and metabolism. Sources of magnesium are whole grains, green leafy vegetables, dried peas and beans, nuts, and cocoa (Dudek, 2006; Nix, 2005). Ask yourself, "What symptoms should I be aware of that would indicate Mrs. Salvador or the Rices may have low magnesium levels?"

Sodium is responsible for maintaining the body's water balance. Sodium is necessary for glucose activity and nerve and muscle functions. Sodium deficiency is rare unless the older adult has chronic diarrhea, vomiting, excessive sweating, or kidney disease. The body usually excretes excess sodium through the kidneys. Drinking fluids usually dilutes the sodium, but edema and hypertension may result if there is kidney impairment. Ask yourself, "Will Mrs. Rice's sodium level be affected by her frequent urination and her wanting to drink more water? Does Mrs. Rice have symptoms of edema?"

Sodium is found in processed foods and is often added during cooking and at the table. To lower sodium levels, the older adult may be advised to limit salt intake and to reduce processed foods in the diet. Numerous foods contain sodium in various amounts. Mrs. Rice's physician may prescribe a diet to reduce her sodium intake.

Chloride, which is a form of chlorine, is found in the body's tissues and fluids. Despite the fact that the body contains only a small amount of chloride, the mineral is important in digestion and in maintaining water balance. Chloride partners with sodium (sodium chloride) in the diet. A deficiency of chloride is rare. Too much chloride can result in hypertension and perhaps vomiting (Dudek, 2006; Nix, 2005).

Potassium is found in the body's fluids. Potassium is responsible for the nervous and musculoskeletal systems' functions, metabolic activities, blood pressure, insulin release, and the body's water balance. Why should the Rices be interested in potassium-rich foods? The best sources of potassium are unprocessed fruits and vegetables. Potassium is water soluble and can be lost when cooked in water. Some foods may be rich sources of potassium but also contain high levels of sodium. Processed foods are often high in sodium but low in potassium. A dietician is the best health professional to help you with a list of foods that are rich in potassium. An older adult who has a deficit in potassium may have muscle weakness and loss of appetite. Diuretics may cause a loss of potassium through the urine. A resident you were caring for a week ago was on a potassium replacement, and part of your care plan was to monitor for cardiac symptoms, breathing problems, bloating, and overall muscle weakness. You knew you needed to report these signs and symptoms to the RN immediately if they were present (Dudek, 2006; Nix, 2005).

This homeless man has learned where to go for the best meals possible. Some restaurants (for example, fast-food places) discard their uneaten food at specific times of the day. This assures their customers of fresh food. It also provides this man with a good burger that is reasonably fresh. He also goes to the Salvation Army for lunch and the homeless shelter for dinner. Most of his day is spent outdoors, even on cold days like this one.

The human body contains minor minerals, which are called trace minerals. They include iron, zinc, iodine, selenium, copper, manganese, chromium, molybdenum, and fluoride. Iron is responsible for producing hemoglobin and aiding in metabolism. Deficits in iron may reduce the effectiveness of the immune system, affect wound healing, and cause weakness and fatigue. Excess iron may increase risk of infections, organ damage, and joint disease. Foods rich in iron are fortified breads and cereals, red meat, and legumes (Dudek, 2006; Nix, 2005).

Zinc is essential for wound healing and insulin storage, and it aids in metabolic and immune functions. Foods rich in zinc are animal sources, legumes, and whole grains. Deficits in zinc may cause abnormal glucose tolerance, impaired wound healing, weight loss, loss of night vision, and diarrhea. Too much zinc can cause anemia, vomiting, renal failure, malabsorption of calcium, dizziness, and muscle pain (Dudek, 2006; Nix, 2005). Why would zinc be important in Mrs. Salvador's and Mrs. Rice's diets?

Iodine is a component of the thyroid hormone, which regulates metabolism. An iodine deficiency can cause a thyroid goiter, weight gain, and lethargy. Why will it be important for Mrs. Rice's physician to assess her thyroid? Excess iodine may cause an enlarged goiter. Sources of iodine are iodized salt, dairy products, breads, and seafood (Behan, 2006; Dudek, 2006; Nix, 2005).

Selenium aids in healing and in preventing disease, and it is essential to metabolic activities. A deficiency in selenium may cause heart disease. Excess selenium may cause nerve damage, nausea, and vomiting. Food sources of selenium are animal sources, seafood, and whole grains (Behan, 2006; Dudek, 2006; Nix, 2005). What specific foods should Mrs. Salvador and the Rices include in their diets to help in healing?

Copper partners with the body's iron to produce hemoglobin. Sources of copper are organ meats, seafood, nuts, legumes, and seeds. In a report that was being given at Sea Side last week, you heard that one of the residents had a low blood copper level. The gentleman was receiving total parenteral nutritional (TPN) therapy. You wondered if his TPN therapy may be the cause of his low blood copper level (Behan, 2006; Dudek, 2006; Nix, 2005). TPN is a cause for low blood copper levels.

Manganese is associated with metabolic functions and blood clotting. Main sources of manganese are breads, whole grains, legumes, fruits, and vegetables. Deficiencies in manganese are rare (Dudek, 2006; Nix, 2005).

Chromium improves glucose metabolism. Chromium is found in brewer's yeast, grains, and cereal foods. A deficiency in chromium may lead to poor glucose tolerance (Behan, 2006; Dudek, 2006; Nix, 2005). Why would chromium be important in Mrs. Rice's diet?

Molybdenum is essential to many metabolic activities. Molybdenum is found in whole grains, legumes, milk, leafy vegetables, and organ meats. There are few symptoms that indicate lack of or excessive molybdenum in the diet (Behan, 2006; Dudek, 2006).

Fluoride has a role in bone and dental integrity. Fluoride's main source is water, to which it has been added as a supplement. Osteoporosis may result from a lack of fluoride in the diet. Excess fluoride in the diet may cause nausea, vomiting, diarrhea, and chest pain (Behan, 2006; Dudek, 2006).

A point of interest: the quality of foods containing minerals is related to the soil where the foods are grown. Fruits and vegetables that are grown in soils rich in a particular mineral will contain more of that mineral. An example of this is grains grown in soil rich in selenium; they will contain more selenium. The mineral content of foods is hard to determine, because fruits and vegetables are grown in various areas of the world (Dudek, 2006; Nix, 2005).

Water

You always thought it was interesting that fluids were considered an essential component of the older adult's nutrition plan. Water is the most plentiful and easiest dietary means of fluid intake. How much water or fluid the older adult should consume is determined by gender, age, chronic diseases, physical activity, metabolic activity, and heat exposure (Nix, 2005; Dudek, 2006). Older adults are at risk for dehydration because they often neglect drinking adequate fluids during the day. It is important for you to ask the Rices about their fluid intake. Monitoring Mrs. Salvador's fluid intake is part of your nursing assessment.

Water is the main component of the body and has a vital role in maintaining body temperature. It serves as a transport for nutrients and wastes, is a lubricant to body parts, is a solvent for the body's chemical processes, and gives form to the cells and tissues of the body. Water can be found in soft drinks, juices, coffee, tea,

milk, and foods containing high contents of water (Dudek, 2006; Nix, 2005). Part of your assessment of the Rices' daily fluids would be to have them report all drinks they consume during the day. Part of being a good LPN is monitoring your patient's fluids during your shift.

Water helps maintain the body's temperature. Heat may be lost from the body by physical activity or a rise in temperature in the environment. The water lost by sweating during an activity or the rise of environmental temperature serves as a coolant to maintain a normal temperature. When fluid is lost through the cooling process, older adults need to increase the intake of fluids (Nix, 2005).

Blood and other body and tissue secretions are transported or circulate through the body. The circulated fluids carry oxygen, nutrients, and other materials to all body cells. Circulating fluids also carry waste materials from the cells. Fluids provide for smooth joint activity. Fluid also cushions the contact between the organs (Dudek, 2006).

Water is essential for the body's chemical processes. Water is the necessary solvent the body uses for producing the chemical solutions required for health maintenance. It is vital for the body to maintain a water balance. Older adults are at risk for dehydration because of inadequate fluid intake, not feeling thirsty, medications, perspiration, and chronic diseases. Again, you must remember to assess the older adult for oral fluids intake. Water leaves the body through the skin, lungs, kidneys, and stool. Asking the Rices about their urination is one way to assess for dehydration. You also can assess the skin for dryness and loss of turgor.

Body Electrolytes

As mentioned earlier in the chapter, the particles (minerals) in the body's solutions are made up of electrolytes and plasma proteins (Nix, 2005). Remember, the minerals that make up the body's electrolytes are calcium, phosphorus, sodium, magnesium, chloride, and potassium. Each of these minerals carries a chemical charge. Some have a positive charge, and others have a negative charge. You may decide to do a quick review of chemistry to better understand the chemical processes that happen in maintaining an electrolyte balance. For now, you need to be aware that all of the electrolytes must be maintained in a chemical state of neutrality. Any imbalance puts the person at risk for complications. These electrolytes are moved through the body by fluids. Consider fluids and electrolytes lost as a result of vomiting, diarrhea, excessive perspiration, or urination, and then consider the person's potential for electrolyte imbalance.

Plasma proteins consist of protein and globulin. They are the major substance in blood circulation and control the water movement in and out of cells. With this understanding, you should realize that blood volume is strongly influenced by plasma proteins. Both electrolytes and plasma proteins must be kept in balance to maintain healthy body functions (Nix, 2005). Plasma proteins were discussed earlier in this chapter.

LABORATORY TESTS AND OTHER ASSESSMENT INFORMATION

Laboratory tests may be performed on either blood or urine. The blood tests measure serum albumin, hemoglobin, hematocrit, electrolytes, nitrogen levels, other minerals, serum lipids, and glucose. Urine tests measure glucose, ketones, protein, nitrogen, and blood (Nix, 2005; Tabloski, 2006). Refer to Chapter 20 for more information on laboratory tests.

Along with the laboratory reports, the physician will need the person's nutritional assessment and a current list of all medications. Then the physician will write the orders for the older adult's dietary needs. The diet may be modified or changed according to the person's history and laboratory results and your assessment of the person's diet and medication history.

You, the LPN, are in a key position to assess Mrs. Salvador's and the Rices' diets. You will

POINT OF INTEREST

It is best to check skin turgor over the forehead or sternum in older adults. You check the skin turgor by softly pinching the skin and then observing how fast the skin returns to normal. If it is slow to return to normal, the person is dehydrated.

want to assess if they have a variety of fruits and vegetables, meats or other protein-rich foods, and bread and cereals in their daily diets. A poor nutritional intake will put Mrs. Salvador and the Rices at risk for potential health concerns. The physician will order laboratory tests if there is a question about their nutritional status.

DIET PLANS

As the LPN, you need to be aware of the various diet plans that can be used to meet the nutritional needs of the people with whom you work. You are aware that several of the residents at the Sea Side have different diets.

A regular diet is given to the older adult who is healthy, has no special nutritional needs, and is capable of making nutritious food choices. Amounts of foods are dependent on the person's appetite, and selections of foods are made by personal likes and dislikes. Mrs. Salvador is receiving a regular diet.

A modified diet is given to older adults if they have a prolonged illness and have not eaten or if they have difficulty chewing or swallowing food. Foods in the modified diet range in consistency from clear liquids to soft foods.

Clear-liquid diets are foods that are liquid at room temperature and can be seen through. The physician or dietitian needs to write directions about what foods are to be included in this diet. Clear or strained juices, teas, carbonated drinks, clear broths, and gelatins are some of the choices. Most clear-liquid diets do not provide adequate nutritional requirements (Dudek, 2006). People receiving clear-liquid diets are moved to a full-liquid diet as soon as their health condition allows.

Full-liquid diets are composed of the foods included in the clear-liquid diet with the addition of foods that are liquid at room temperature but are not necessarily clear. This includes custards, ice cream, milk, some strained cereals, fruits, and vegetables. The full-liquid diet meets more of the person's dietary requirements but not all nutritional requirements. The dietician will give you instructions on the food to include in a full-liquid diet.

Foods in the soft diet include those from a regular diet that have been modified for people who have difficulty chewing foods. An example is a person like Ms. Taylor who has had problems with her dentures. Her dentures should be repaired soon, but she will probably continue to request a soft diet because of sore gums. Foods in this diet are mashed, chopped, or ground.

A therapeutic diet may be ordered for those people who need tailored nutritional choices. The person may need more calories or fewer calories in the diet. There may be an order to increase or decrease the amounts of carbohydrates, proteins, or fats in the diet. The person may need dietary restriction on foods containing sodium, potassium, iron, or micronutrients. Examples of therapeutic diets are a diabetic diet or a low-sodium diet for a hypertensive person. Fluid restrictions may be necessary for some people with chronic kidney disease. Older adults may have food allergies or may not be able to tolerate some foods. Such foods should not be included in that person's diet.

There are health conditions in which a person's gastrointestinal (GI) system can digest food but the person may be unable to consume food. Enteral, or tube, feedings will be required for these people. Commercial or blended formulas are used to provide nutritional support by using a feeding tube that can be placed in the nose or directly into the GI tract through the abdomen (Dudek, 2006; Nix, 2005). The physician and dietician will determine types and amounts of formulas to be used.

Older adults with more extensive illnesses or injuries may require total parenteral nutrition (TPN) or parenteral nutrition (PN). The TPN is administered through a percutaneous endoscopic gastronomy tube (PEG). The PN nutrition is administered intravenously. A registered nurse is responsible for the maintenance and monitoring of both types of feeding tubes (Dudek, 2006; Nix, 2005). The RN will instruct you on your responsibility in monitoring the person on TPN or PN therapies. Be sure you are very clear on what the RN wants you to do and not do. If you need specific information on these therapies, be sure to ask. Do not pretend you know what you are doing if the opposite is true.

CONCLUSION

Regardless of the type of diet the older adult you are caring for may be eating, you must remember to provide a pleasant atmosphere to encourage eating. You will want to clear the area where the food will be set. Be unhurried and pleasant, and talk to each person. It may be necessary for you to assist the person in eating the meal. If so, be patient and kind as you do this aspect of your

CRITICALLY EXAMINE THE FOLLOWING:

You are assigned to care for Mrs. Pearson, an 81-year-old woman who has had abdominal pain, nausea, and vomiting. Which type of diet most likely will be ordered for her? Explain why.

Mrs. Pearson's symptoms become much worse. Her skin turgor indicates dehydration. What laboratory tests might the doctor order? Which diet is most likely to be ordered by the doctor? Think through Mrs. Pearson's health-care needs and come to class prepared to discuss them.

job. Spending time with the person and sharing a pleasant conversation is a good time for you to educate, support, and assess the older adult's dietary needs.

Not all older adults for whom you will be caring for are in frail health. People are living longer and may have chronic diseases such as arthritis, heart disease, or diabetes. However, many older adults consider themselves to be healthy even with these chronic conditions. Under the supervision of the registered nurse, you will have the opportunity to teach older adults about proper nutrition. You know what nutrients in Mrs. Salvador's diet will aid in healing her fractures and her recent surgery. Nutrition will have an impact on the chronic diseases the Rices are experiencing as well. You know that nutrients affect the immune system, aid in healing, and influence chronic conditions. You must be careful when offering nutritional advice because older adults have issues with food likes and dislikes, economics, and physiological conditions, along with psychosocial issues that they experience.

CASE STUDY

Because you have been thinking about the nutritional needs of Mrs. Salvador and the Rices throughout this chapter, you need to consider them as your case study. Write a one-page summary regarding their health and nutritional needs to submit to the faculty person. Consider each person separately, and then address the following:

1. List their health problems that are related to nutrition.
2. List the nutrients they need and why.
3. List the foods they should eat in order to have the appropriate nutrients.

STUDY QUESTIONS

Select the best answer to each question.

1. All of the following should be assessed when monitoring an older adult's nutrition *except:*

a. Does the older adult eat at least two meals each day?

b. The amount of fluid the older adult drinks each day.

c. Does the older adult eat with others at least two times each week?

d. Does the older adult eat foods rich in vitamins?

2. Consider an older adult with bone and soft tissue injuries from a fall. Which diet would be the most effective for this type of person?

a. High-carbohydrate diet, which will assist in giving the person enough energy for physical therapy.

b. 1000-calorie diet, which will assist in weight reduction and make ambulation easier.

c. High-protein, high-carbohydrate diet, which will assist in both cellular rebuilding and energy.

d. TPN, which will provide all nutrients and save energy for the older person.

3. Which of the following diets would be appropriate for an older adult who has problems with blood clotting?

a. Full-liquid diet

b. Diet low in potassium

c. TPN

d. Diet high in vitamin K

4. All of the following can cause electrolyte imbalances *except:*

a. Vomiting

b. Diuretics

c. Diarrhea

d. Antibiotics

5. You admit a gentleman who is very lethargic. Through your admission interview, you identify that he is a chronic alcoholic. He is thin and has poor skin turgor. You are concerned about his overall nutrition. He states that he NEVER eats green and leafy vegetables. What nutrient do you recognize he needs and is not receiving?

a. Magnesium

b. Chloride

c. Sodium

d. Phosphorus

7

Culturally Specific Care

Jeff Harris
Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Define the differences between culture and ethnicity.
2. Discuss health-care needs of black Americans.
3. Discuss health-care needs of Asian Americans.
4. Discuss health-care needs of Hispanic Americans.
5. Discuss health-care needs of European Americans.
6. Discuss health-care needs of Jewish Americans.
7. Discuss health-care needs of Native Americans.

INTRODUCTION

Hi, I'm Jeff Harris, and I was raised in a state where 75% of the population was white and 75% to 80% was Christian. Utah is a farming state, so I knew many Latinos who traveled through as they worked in the fields, but I didn't see a black person until I was in the third grade. (I saw them on television, but not in person.) Because there are two reservations in Utah, I knew about Native Americans, but I didn't actually know any because they lived and went to school on the reservations. My ancestors were Utah pioneers who sacrificed much to live where they had religious freedom. I feel confident in saying that unless you were born and raised in Utah, our cultures are very different.

The concept of culture is complex, but I have a definition that you should find useful. Culture consists of the nonphysical traits we inherit. I am referring to the stories our parents and grandparents tell us (for me it was the pioneer stories of my ancestors) and the traits we learn from simply being in our family or community groups. Again, for me it was a strong Scandinavian work ethic, family closeness, and a desire to better one's life. You see, my Danish and Swedish emigrant ancestors were very poor, and each generation has worked to provide a higher standard of living for their children. Religion often is considered a significant aspect of one's cultural identity as well.

Culture is related to ethnicity, but it is not the same thing. As culture is our nonphysical inheritance, ethnicity is the physical inheritance. I am blonde and have blue eyes, you guessed it! I got those physical characteristics from the Swedes and Danes on my family tree! When you discuss ethnic and cultural aspects of people, you are talking about transcultural nursing. This is a specialized arena of nursing in which cultural awareness is a priority of care. Nurses can earn a masters degree in transcultural nursing; however, you are not expected to know that body of information on such a high level. I simply want you to recognize that ethnic and cultural aspects of older adults are an important concept of care.

A basic principle of transcultural nursing is simply being aware of the need to focus on it in order to give the best care possible. The other concept reinforced in this chapter is the common sense needed to give transcultural or culturally specific care to others that also addresses ethnic needs. For example, it just doesn't make sense to assist a Christian out of bed five times a day to face east and pray, just as it doesn't make sense to require a Muslim to stay in bed when what he wants is to get out of bed, face east, and pray five times a day. You need to be sensitive to the cultural needs of others in all aspects of their lives.

PRIORITY SETTING 7.1

The priority for this chapter is very clear. It is for you to give culturally specific care. That requires the skills of holism and caring and the ability to use the nursing process. The chapter gives you a basic background for several different cultural and ethnic groups. However, you need to focus on the individual. Talk to the person, take the time, and make a genuine effort to understand the individual's personal needs based on culture and ethnicity as well as the more routine information you need to gather (such as health and medication history). What you discover as personal needs for the person may amaze you. Your responsibility is to meet those needs to promote healing.

One common problem with culturally specific care is the tendency, for each of us, to be ethnocentric. This means that we, as people, think that our "way" is the best way. When one thinks that his or her culture is superior to all others, there is a tendency to dismiss the cultural needs of other people, the thought being that each person should want to be just like you and your culture! This is an act of human nature. For example, when Christian missionaries traveled to the Pacific Islands, they tried to turn the natives into "proper" English men and women. The same thing happened to the Native Americans. Children were taken from their parents during the 9-month school year and were placed in the homes of "proper" white families in an effort to acculturate them. Of course, Hitler and others displayed their ethnocentric behavior by killing the "lesser" culture.

As a soon-to-be professional nurse, you need to be aware of any tendencies you have at ethnocentrism and squash them when you are in the clinical setting. As a professional nurse, your objective, your priority, needs to be cultural sensitivity that results in culturally specific care.

In this chapter, your common sense will be enhanced as we discuss ethnicity and culture in several different ways.

ETHNICITY AND CULTURE AS CARING BEHAVIORS

There are multiple aspects to ethnicity and culture. I would like to tell you the following story from an experienced nurse that addresses both ethnicity and culture.

> *When I was younger and unmarried, I wanted to travel and still use my nursing skills. My ancestors were from Denmark, so that was a place I wanted to spend some time. I finally found a hospital that was eager to take me even though I did not speak Danish. I got my passport and traveled to the land of my ancestors. It all was very exciting. When I reported to work the first day, I realized I had entered a world totally unknown to me as an American citizen. The name of the hospital was exotic and quite beautiful when it was written in Danish. However, the translation to English was something like "The Torture Victims' Hospital." I was confident in my nursing skills before leaving for Denmark. I had worked for 3 years in a high-level intensive care unit (ICU) and knew my way around the system of health care. However, nothing had prepared me for my new job.*
>
> *Torture victims? There was nothing like that in the United States! I was stunned when the nurse orienting me toured me through the building. The lights were turned low, and everyone walked quietly and spoke in semi-whispers. There was not an overhead public address system, nor were there visitors milling around. It was a building filled with men and health-care providers who moved about in the semi-darkness in a quiet and surreal manner.*
>
> *I learned that the men, mostly former soldiers and spies from across Europe, were victims of torture from the Communist regimes of Eastern Europe. These were men who had fought or spied in places with danger that was absolutely unknown to me. My entire life changed because of the 6 months I was there. I learned much more than simply discovering the land of my ancestors. The men there often could not be touched because it brought back memories and/or fears of their torture. It took months for a patient to develop trust with any of the hospital employees. They didn't even trust each other because so many of them had been spies and felt that others were spying on them. It was a place of no laughter. The low lighting and diminished sound were to avoid startling the men, as they had the basic "fight" reaction to being startled. They were, after all, soldiers.*
>
> *Because most of the men had been spies, they spoke English, as do most Danish citizens, so the language was not a problem for me. I spent my 6 months there quietly serving those men in any way I could. In addition, I learned a harsh reality concerning the price of freedom.*

The ethnicity of the patients in this story would indicate that they inherited high IQs, healthy, strong bodies without chronic diseases, and strong will or self-concept that allowed them to survive the torture without mental illness. The cultural aspects of the men indicated that they were patriotic and loyal, self-disciplined, and tenacious (they didn't give up).

The ethnicity (physical changes) of the United States is ever changing. The 2000 Census (2001) indicated that 74% of the U.S. population was white. The prediction is that in 2050 that number will drop to 53%. The prediction also indicates that the Hispanic population will grow from 10.2% to 24.5%; Asian from 3.3% to 8.2%; and black from 12% to13.6%. I realize that 2050 is a long way into the future; however, these numbers relate an ethnic trend. As you work in health care, the number of older people will increase (the Baby Boomers are real!), and the cultural diversity of those older adults will become even more diverse. That is the challenge, you see. It is to be able to give culturally competent care to a greater number of older adults who are more and more diverse. To do so requires learning about different cultures and then paying attention to people and their cultural needs as you give them care. Culturally competent care is a basic concept of administering holistic care to others. It is not possible to do this unless you understand and respect the ethnic and cultural core of each person in your care.

One of my hobbies is learning languages. I have learned five so far and plan on starting my sixth language soon. I love learning languages because it assists me in learning about

the ethnic characteristics of those who speak the language.

I was 20 when I left my small rural community to visit other countries. My first real experience was in Latvia. It is a small country between the Baltic Sea and Russia. I flew into the capital city, Riga, and stayed there for a year. I spoke the native language (I studied it before going to Latvia) and took the time to meet both individuals and families. I was a teacher and spent a great deal of time with people outside of class as well. While in Latvia, I learned about both the cultural and ethnic traits of the society. It was fascinating. The following material is a brief overview of the ethnic and cultural traits of several different groups found in the United States. You may be familiar with many of these groups already, but if you aren't, this is a good time to sit down and be "fascinated" by what you are learning. An example of what I mean is in the following story.

> *I remember one occasion when the daughter of one of the families in Latvia had a bad cold. Her mother called me and asked me to go to the hospital to visit her. I was amazed that her daughter had gone to the hospital and was admitted for a cold. The young lady was in the hospital for 4 days! I also met people (more than one) who took the standard 3 weeks off from work for the flu. I know I wouldn't have a job if I took 3 weeks off for the flu in the United States. The Latvian people look at sickness in a very different way than I do. From my personal experience of having a cold, I can say all I got was cough syrup and my Dad telling me to buck up and get to school. The people of Latvia were responding to their illnesses in the way that was standard for their cultural norm.*

CRITICALLY EXAMINE THE FOLLOWING:

Imagine that you are in a part of the United States where you never have been previously. While there, you encounter the ethnic groups listed in this chapter. Read about the people, and then think about the information. See if you agree with what is written, as I know you have your own experiences with different ethnic and cultural groups. Consider the health-care implications of what you read. Always keep in mind that the information is not designed to stereotype people but to give a general background to different groups of people. Do your best thinking and come to class prepared to discuss your insights and ideas for this chapter.

BLACK AMERICANS

I will be referring to people whose ancestors came from Africa as blacks or black people. This phrase refers to people who have origins in any of the black racial groups of Africa predominately, but it also includes other nationalities who have skin that is black in color. Most members of black communities in this country descend from people who were brought here as slaves from the west coast of Africa. The largest importation of slaves occurred in the 17th and 18th centuries, which means black people have been living in the United States for several generations. In modern times, numerous black people have immigrated to the United States voluntarily and have traveled from Africa, the West Indian Islands, the Dominican Republic, Haiti, and Jamaica.

Blacks live in all regions of the country and are represented in every socioeconomic group. However, they are disproportionately poor, with 22.1% of all black people living in poverty. In addition, over 50% of black people live in urban areas surrounded by the symptoms of poverty—crowded and inadequate housing, poor-quality schools, and high crime rates.

The living conditions and poverty of many older black adults are considered major contributors to the fact that black men and women die significantly younger than white men and women (Table 7.1).

Black people hold older members of their communities in high esteem as they value the wisdom and knowledge that comes with aging. This valuing results in fewer black older adults in nursing homes than white older adults. It is not

TABLE 7.1. Life Expectancy of Older Whites and Blacks in the United States

Group	Life Expectancy
White men	73.8 years
White women	79.6 years
Black men	66.1 years
Black women	74.2 years

Source: Stolberg, S.G. (2002). "U.S. life expectancy hits new high." New York: *New York Times*, Sept. 12.

FOCUSED LEARNING CHART

Poverty is defined as a family of four with an income of $18,000 or less per annum

Government Assistance	Living Conditions	Impact on Health
Public housing	Overcrowded housing	Tuberculosis
Government loans for school	Poor sanitation	Spread of infectious diseases
Medicaid	Homelessness	Diminished personal space
Aid to families with dependent children (AFDC)	Poor nutrition	Diseases of the GI system
Food stamps	Higher crime rates	Emotional detachment from society
Head Start programs	Crowded schools	Nonproductive life
Free school lunch		Malnutrition
		Obesity
		Diabetes mellitus
		Frequent homicide and suicide
		Violence in the streets
		Lack of personal safety
		Poor education with less opportunity for achievement

Note: The 2000 Census notes that people over the age of 65 are at their lowest income level since the census has been taken.

known if difficulty accessing the health-care system also contributes to this fact.

Older black people often embrace the customs and traditions of their ancestors. The core of their health-care beliefs is often based on harmony with nature. They also consider the body, mind, and spirit as interconnected. As you give care to older black adults, you will need to take the time to determine how you can support the person's health beliefs. That can involve a religious practitioner, the need for plants (nature) in the room, or a traditional healer.

Many members of the black community are Muslims. Some are descendents of Muslims who were brought here as slaves, and others have chosen to convert to Islam. Religious beliefs are

an important part of the Muslim lifestyle, and as a health-care provider, you need to be familiar with them. Practicing Muslims eat a Halal diet, which means they do not eat pork or any pork products. You should work with the dietitian to ensure the older black Muslim that his food will not be "contaminated" with pork. There is a potentially serious problem with diabetic Muslims as well. Because most insulin is made from pork pancreas, a practicing Muslim will refuse to take it. Consult with the pharmacy to obtain non-pork insulin, and then assure the person that the insulin is NOT made from parts of a pig so that there will be compliance in taking this critical medication.

Sickle-cell anemia is a disease that exists only in black people. Obviously it is genetically inherited, and scientists have concluded that it originally was an adaptation to fight the disease malaria. Sickle cells result in hemolysis and thrombosis of the red blood cells because the deformed cells do not flow properly through the blood vessels.

The symptoms of sickle-cell anemia include hemolysis, anemia, and severe pain in the areas of the body where the thrombosed red cells are located. Statistics indicate that only 50% of children with sickle cell anemia live to adulthood. Some children develop complications that exist for the duration of their lives. The only way to prevent sickle-cell anemia is to provide genetic testing and counseling to adults before they have children. This often does not happen because of the prohibitive cost of genetic testing.

The leading causes of death are the same for both black and white populations; however, black mortality rates are higher. Blacks die from strokes at almost twice the rate of white populations. Coronary heart disease death rates are higher; black men experience a higher risk of cancer of the prostate; homicide is the most frequent cause of death for black men between the ages of 15 and 34 (realize that these are not gerontological men, but older men do live in the communities with high homicide rates); and the rate of autoimmune deficiency disease (AIDS) is higher for black men than it is for white men (Spector, 2004).

These black older adults have a strong religious background that assists them in the quality of their lives. Would their religion be considered ethnicity or culture?

There are many conclusions you can draw from the information you have just read that will assist you in understanding the needs of older black adults in your care. My purpose is to inform you so you can apply the information to your nursing practice. Your purpose is to learn the information and then determine ways, based on the needs of each individual, to increase your sensitivity to the person's personal health-care needs.

CRITICALLY EXAMINE THE FOLLOWING:

Set a timer for 3 minutes, and during that time write down as many ideas as you are able to regarding why you think the life expectancy figures in Table 7.1 are the way they are. I already have mentioned poverty and living conditions, but you should be able to list detailed problems that occur because of those social conditions. What other ideas come to your mind? Make a list as comprehensive as possible in 10 minutes and be prepared to both discuss it in class and submit it to the faculty person.

NATIVE AMERICANS

Native Americans, American Indians, Alaskan Natives (Eskimos), and Aleuts (who also live predominately in Alaska) are included in this category. Native American will be the inclusive term used in this chapter, as the ethnic groups listed above all were on this continent long before any other people. They were well established before the Europeans came here. In fact, they repulsed the Vikings in AD 1010. The Vikings were here for a decade and then left in frustration. However, as more and more people came to the Eastern shores, the natives of this country were pushed west into the wilderness. They were moved by force; they died because of exposure to disease brought by the Europeans, which their bodies

POINT OF INTEREST

Black American infants have the highest infant mortality rate for mothers 20 years of age and older. The percentage of live births to teenage mothers is double that of other ethnic groups. Consider how these facts affect the lives of older black adults.

did not have antibodies to fight; and they died in war trying to defend their homeland.

As American Indians migrated westward, often under protest, they carried with them fragments of their culture. Their lives were disrupted, their lands were lost, and many of their leaders and teachers were killed. Yet much of their history and culture remain. American Indians predominately live in 26 states, including Alaska, with most of them living in the Western states. Although many American Indians live on reservations, others live in both rural and urban areas.

The Indian Health Service recognizes 560 tribes of Native Americans in this country. Each tribe has its own culture, folklore, and folk medicine. To tell you about one is to leave out the specifics of 559 other tribes. However, all tribes have traditional beliefs in Mother Earth and the necessity of having harmony with nature. If a person is ill, it is thought to hurt Mother Earth, just as when Mother Earth is hurt by disrespectful behavior (such as pollution and litter), it will hurt people. Many traditional Native Americans believe there is a reason for every sickness and pain that relates to their behavior. They often believe that illness is the price to be paid for something they have done in the past or something they are going to do in the future. Often, traditional people who are ill feel that the illness is the best possible price they can pay for what they have done or will do. Native Americans believe in treating illness despite the person's behavior having been the cause.

Traditional tribes have a medicine man or woman. For some tribes, this person is referred to as a Shaman. The Shaman is someone who should be welcomed into the room of the person who is ill. There may be dancing and chanting; family members may gather in the room and perform a healing "sing" with the Shaman; or there could be incense or healing sand paintings. All of these traditional healing methods need to be respected. It is important for you to provide privacy to those who come to participate, treat them and what they are doing with respect, and obtain any items they request. Working with a person in this manner is truly practicing holistic health care.

Native Americans often are caught in limbo in terms of modern health care. They are caught between their traditions and modern treatment, the Shaman and the doctor. Finally, they often are "lost" between the Indian Health Care Services (free access to care for those who live on reservations) and services in the community. At least one-third of all American Indians live in abject poverty. With such destitution comes poor living conditions and the problems that follow such situations. Native Americans suffer from the diseases of the poor, such as malnutrition, tuberculosis, and high maternal and infant death rates. They also have a surprising percentage of diabetes mellitus, with one in five having the disease. This compares to 1 in 10 in other ethnic groups. At the beginning of the 20th century, diabetes was very rare in Native Americans. Why the change in a manageable disease? Some say diet and exercise changes from the traditional lifestyle were the causative factors. I was surprised to learn that the cancer survival rate among Native Americans is the lowest of any group in the country. Scientists do not give an explanation for this occurrence. Now that you know this fact, you have an obligation to take extra time to promote health screening and to do health education related to cancer to assist older Native Americans in reducing their risks and identifying health problems early.

The seven leading causes of death, in order of frequency, among Native Americans are:

1. Alcoholism
2. Tuberculosis (TB)
3. Diabetes mellitus
4. Accidents
5. Suicide
6. Pneumonia and influenza
7. Homicide

Close family bonds are typical in Native American groups, with elderly persons being treated as people with wisdom who are to be respected. It is becoming somewhat common for younger people to feel that the advice of their elders is no longer relevant to their modern lives, and they tend to ignore older adults.

CRITICALLY EXAMINE THE FOLLOWING:

What are the first five causes of death in your cultural or ethnic group? If you don't know, make an intelligent guess and prepare a list. Is suicide, homicide, or alcoholism on the list? What does it mean to a society when deaths of that nature are on the list of the most common causes of death? What does it mean to have so many people dying from TB and diabetes? Do you know any Native Americans? If so, perhaps you could talk with one of the elders in the family and ask them what they think of modern health care. You also should learn about traditional healing methods from them. I am sure you will find it very interesting!

Prepare a paper of no longer than two pages to discuss the questions listed above and any others you would like to have answered about health care for older Native Americans and their culture. Be prepared to submit your paper to the faculty person. If you cannot locate someone to interview, do a thorough discussion on the questions that relate to your cultural group.

Many traditional Native Americans may find the questions usually asked during an assessment or history taking offensive. Asking personal questions can be seen as probing and being disrespectful. You may find it necessary to develop a relationship with the older person before asking the questions you need answered. It would be wise to ask younger family members (adult children) for much of the history, and then you will be seen as less intrusive by the older person. Be sensitive to the nonverbal reactions of the person, and use your common sense based on your knowledge of the culture, communication, and the disease process.

ASIAN AMERICANS

There are nearly 12 million Asian Americans in this country. They constitute the third largest minority group in the United States (Spector, 2004). Asian Americans come from many different countries. The category of Asians includes, for example, people from China, Cambodia, India, Malaysia, Pakistan, and the Philippine Islands. The term *Asian* refers to people with origins in the Far East, Southeast Asia, or the continent of India.

The different groups of Asians came to this country for varied reasons. The Chinese migration began in the mid-1800s because of a severe drought in China. The Chinese workers were hired for cheap wages to assist in the gold rush and to build the Transcontinental railroad. They were victimized and, in general, treated poorly by Americans who were concerned about them taking their jobs. Many Chinese lived in Chinatowns, neighborhoods within larger cities where they went as a place of refuge from the abuse they received from others.

The Japanese immigrants started to arrive at about the same time as the Chinese. Like the Chinese, they took any job offered to them so they could support their families. This resulted in a strong prejudice from men who also were afraid of losing their jobs. Restrictive laws were passed that limited immigration and did not allow a person from Japanese descent to marry native-born Americans. The greatest indignity occurred during World War II (WWII), when 70,000 American-born Japanese were confined to relocation camps. Japanese people also were restricted by law from coming to the United States at that time. The Filipinos began to immigrate in the 1900s and were employed as farm workers. Koreans began to immigrate in the early 1900s to work on plantations, predominately in Hawaii. Another group of Koreans came to the United States with their husbands, American servicemen, after the Korean War. After the Vietnam War, there was an influx of Vietnamese and Cambodians seeking political refuge.

Asian Americans have the highest median income of any foreign-born group; only 13% were poor in 1999; 39% are employed as managers or have professional job specialties; and 53% have employment-based health-care insurance (U.S. Census Bureau, 2002). All of these factors assist them in being healthier people. Yet they are from a variety of cultures, each with definite concepts and opinions.

The following story from an experienced nurse may help you to understand the involvement of traditional elders in many Asian cultures.

> *The nurse was working on the pediatric intensive care unit (PICU) and was the primary nurse for a 6-year-old boy who had been hit by a car. He and his parents were of Japanese descent and were American citizens. He had severe injuries and faced a prolonged treatment and rehabilitation regimen. Every day there were new decisions that needed to be made regarding his treatment plan. It was the nurse's responsibility to talk to the parents and*

explain all options to them for every decision. On the very first day, the nurse became concerned about the parents' inability to make decisions regarding their son's care. The nurse, Roger, needed answers and had concerns that could not wait until the next day as the parents requested. Roger wondered if language was a problem but learned that the parents were born in the United States and had university educations. The nurse shared his experience with the doctor, who also became concerned about the management of the little boy and his multiple problems. Delays were not a good idea based on the criticality of the boy's condition.

It was 2:00 p.m. before the parents came to Roger with a decision. With them were the father's parents. They were immigrants to the United States and were dressed in traditional Japanese clothing. The son was quite formal when he introduced Roger to his father and mother. Something in the way he did the introductions indicated to Roger that it was more than a simple courtesy. Roger invited the four of them to the unit's counseling room for privacy and sat down with them. What he learned in the next few minutes was of priority importance to the care of his young patient. In the traditional culture of this family, the oldest male made all important decisions for family members. If the grandfather was deceased, the grandmother would make the decisions for everyone. This process is based on the traditional Asian respect for the wisdom of older people. The parents wouldn't make decisions that they believed should be made by their parents.

Roger obtained the necessary contact information for the grandfather, introduced the grandparents to the physician and other nursing staff, and felt relief over the management of the care for the little boy. It was clear on the care plan to contact the grandfather for all decision making, and the process worked well. The grandparents always notified the parents about whathad or was going to happen, and the family structure was kept intact. Most important, the little boy received the best care that could be given, and there was no communication frustration or distress.

This little boy's name is Youta. He is dressed in traditional Japanese clothing in honor of his grandfather's birthday.

The previous story indicates how the majority of Asian people feel about their elders. Much like in the black and Native American cultures, there is a great deal of respect for older people and their wisdom. As you give care to people from these cultures, BE SURE you address the older person with his or her formal name, such as Mr. Fudano or Mrs. Begay. Do not assume a casual relationship with any older adult. I feel that older people from all cultures deserve the highest level of respect they can be given. This includes how you speak to them, preserve their modesty, and listen to them, because it is their wisdom that is so highly valued. You should never give a command to an Asian older adult, as it is a definite insult.

In traditional Asian families, the older family members are cared for at home. This decision is based on the value the family members place on someone older. Another story that emphasizes this concept happened to a doctorally prepared nurse who was visiting the People's Republic of China in an official capacity.

One evening she had dinner with Madame Chou, the President of the Chinese Nurses

Association. This is a very powerful position and one that is appointed by the government. Madame Chou was in her early 60s, and the conversation was done through a Chinese interpreter. Madame Chou asked the American nurse what type of nursing she did in the United States. The nurse, who loves old people and her work in nursing homes, explained with excitement where she did her clinical practice, in nursing homes. Madame Chou visibly reacted negatively to what was being said. She even pulled back from the table. The nurse quit talking and apologized for anything she said that had been offensive. Madame Chou responded that she was concerned that the nurse was so happy to be cruel to the older people in her country. The dinner did not end on a pleasant note. The next morning the two women were to have breakfast together and then part as the American nurse was moving on to another part of China. At breakfast, the American nurse apologized again and asked Madame Chou about nursing homes in China. Madame Chou thought for a few seconds and then said there are five. Keep in mind that this is a country with one-fifth of the world's population, and there were five nursing homes! She said they existed for those older people who did not want to be around little children or who had no family with whom they could live when they needed help. Then she made arrangements for the nurse to visit a rural nursing home.

I tell this story to emphasize that you must always be sensitive to the older person in your care; again, this is a time to develop good common sense based on information about older adults.

Asian Americans born in the United States have the same general good health and similar health problems as other citizens. People from most Asian cultures are comfortable with a physician's being in charge of their health management for acute conditions. It is common, however, to use traditional remedies for chronic illnesses. The remedies may include herbs, acupuncture and acupressure, cupping, and spirituality. Once again, allow and support their personal remedies and assist in any way that is appropriate. Always inform the RN about what is taking place.

EUROPEAN AMERICANS

Most European Americans have white skin and are easily mistaken for someone who has lived in the United States throughout his or her life. Many of them speak English, and, depending on how long the European has spoken English, there may or may not be an accent of the person's country of origin. European immigration started with the Pilgrims and has continued since that time.

Each European country, like each Native American tribe, has its own individual culture from its region of the world. European Americans are as diverse as the people of the United States, because all European countries have experienced constant immigration. The following story will make a point about the need for your sensitivity and thoroughness in giving nursing care to Europeans.

I remember being assigned an older white man who was admitted to the surgical preoperative (pre-op) area. The man was there for abdominal surgery that day; his wife accompanied him. The couple was well dressed and knowledgeable about the surgery. All went well until I came back on duty early the next morning and noted that Mr. Swensen had not received any pain medication since his late return from the recovery room. Being a firm believer in the concept that pain must be managed for optimum healing to take place, I went to his room immediately. He was pale; however, his dressing was secure and without drainage, his vital signs were within normal limits, and when asked if he wanted anything for pain, he simply stated, "No, thank you."

I felt concern for this gentleman but also believed in the adage that "what a patient states is his pain level is his pain level." Within an hour, his wife came to visit him and then rushed to the nurse's station screaming with frustration. When I listened to her (I mean really listened without thinking of how to defend myself, just like I was taught in the communication chapter), I learned a valuable lesson. She was very upset because her husband had not received any pain medication since his surgery. According to her, he had severe pain, and she couldn't bear to see him so uncomfortable! I gently took her with me to a quiet place to talk AFTER

I asked another nurse to give Mr. Swensen the appropriate pain medication. Mrs. Swensen, an American citizen, had only recently married Mr. Swensen, a native of Sweden. In the Swedish culture, it is considered rude for a person to accept something the first time it is offered. Mr. Swensen was a very proper gentleman who was waiting for the nurse to make the, to him, mandatory second offer of the pain medication. When she didn't, his upbringing required him to endure the pain unnecessarily. This very unfortunate situation would not have happened if I had known more about his culture, talked with him in more depth about his pain, or talked with his wife. I feel that I missed this critical aspect of Mr. Swensen's health care because I did not use the principles of holistic nursing care.

One of the major differences in health-care delivery between most European countries and the United States is the understanding each has about the responsibility and delivery of health care. Because many European countries have national health-care plans with socialized medicine, there is an expectation that the federal government is responsible for each person's health care. This is in sharp contrast with Americans, who are more individualistic in terms of their health care. Health care in the United States is seen as being reliant on family or extended family groups. This change is often a challenging one for older European adults to accept. It definitely makes working within the health-care system challenging. As the nurse, you need to be aware of this potential problem and refer the person and/or the family to a social worker for more information. Assist the individual by making an appointment with the social worker, if necessary.

HISPANIC AMERICANS

The second largest emerging minority group, soon to be the largest, in the United States is the Latino and Hispanic populations. The terms *Hispanic* and *Latino* are used interchangeably throughout this section, as they are the terms recognized by the U.S. government. These terms refer to people, or their predecessors, who immigrated from Mexico, Puerto Rico, Cuba, Central and South America, Spain, and other Spanish-speaking communities to the United States.

CRITICALLY EXAMINE THE FOLLOWING:

Read the following story and ponder what it means in terms of recognizing individual rights of people regarding their ethnicity and/or culture. What is the Nigerian woman really asking for from the class? Does the same need exist in the culturally diverse people to whom you give care? If so, how can you meet that need? Hint: the need is to be recognized as an individual.

Do your best thinking and come to class prepared to discuss the following incident.

I was in a class where one of the nursing students, a woman from Nigeria, was loudly protesting that she WAS NOT an African American, but she was a Nigerian American. She was very upset because no one in the class commented on something that obviously was very important to her. I finally spoke up and said, "Neta, I will recognize you as a Nigerian American when people start recognizing me as a Danish American." My point was that it just won't happen!

Hispanics are the fastest-growing ethnic group in the United States, and with a mean age of 25.8 years, they are the youngest group as well (Spector, 2004). This young group also has the following characteristics:

1. Hispanics live in family households that are larger than those of non-Hispanic whites.
2. More than two in five Hispanics have not graduated from high school, and there is a variation in educational attainment: 73% of the Cuban population has completed high school, compared with 51% of the Mexican population.
3. Hispanics are much more likely to be unemployed than non-Hispanic whites.
4. Hispanic workers earn less than non-Hispanic workers.
5. Hispanics are more likely than non-Hispanic whites to live in poverty (Therrien & Ramirez, 2001).

The previous facts allow us to make several general assumptions. First, the mean (average) age of 25.8 years for this group indicates that there are not as many older people in the Hispanic population. Many of them live in multigenerational homes, which is a positive thing; and they probably are poor and do not have a high school education. Of course, there are people who are the opposite of this generalized picture. As with all ethnic and cultural groups, you need

CRITICALLY EXAMINE THE FOLLOWING:

A Hispanic couple has brought Mr. Hernanadez, their 73-year-old father, to the emergency room. He is cyanotic and dyspenic, yet he refuses to take oxygen. Neither the children nor the father speak English well, and you know only elementary Spanish. Mr. Hernandez is irritable when you take his vital signs and won't let you finish. He keeps repeating a phrase that you do not understand. It is, "Es mala suerte! Es mi mala suerte!"

1. What do you know about traditional Hispanic people that could assist you in delivering culturally competent care to Mr. Hernandez?
2. What can you do to make this a successful (i.e., the gentleman receives the care he so obviously needs) emergency room visit?

I will give you the priority item for question 2. Find someone who speaks both English and Spanish so you can understand what the man is saying over and over. Does it help you to know he is saying, "It is bad luck. It is my bad luck"?

Answer both questions and prepare to submit them to your faculty person.

to avoid stereotyping people while still meeting their needs. It is a challenge.

Traditional beliefs concerning health, for older Hispanics, do not readily work well with modern health-care treatments. Some traditional Hispanics think that good health is "good luck." When their health is not good, that is simply a mechanism of the "bad luck" they are experiencing. Other traditional Hispanics feel that good health is a gift from God, and as such, it is something not to take for granted. People with this philosophy are expected to maintain their own good health by eating nutritious food, exercising, and getting enough rest. It is the person's responsibility to maintain his or her balance in the universe. Illness is seen as a punishment for wrongdoings. It is combated through prayer and the use of amulets (small figures made of clay or metal), herbs, and spices (Spector, 2004).

Overall, Hispanic cultures assume the responsibility of caring for their elderly persons. There are so few older adults that those who live to be older are treated with respect and love. Hispanic persons generally do not admit an elder to a nursing home, and they try to avoid hospital admissions as well. They keenly feel the responsibility to care for their older adults in the home surrounded with family. As a culturally aware care provider, you need to assume the role of patient advocate and inform the nurse and appropriate others of the desire for the older person to be cared for in the home, if that is true. In many situations, a hospital admission can be avoided with a strong home health-care plan. Of course, this will require effective teaching for the family members who are assuming responsibility for the care. This can be a challenge when English is the second language for the people you are teaching. Read the following story from an experienced nurse, and consider how you will teach people with minimal English skills.

I always have been a coronary care nurse and enjoyed the challenge of family and patient teaching very much. There was one situation where I did not feel successful until I did something drastic. Mr. Lopez, a 73-year-old Hispanic man, was admitted to the unit with a massive coronary (heart attack). He had a charming wife and three adult children. None of them spoke English well, and I did not speak any Spanish. Because of the language problem, I felt I was not being successful with the teaching. This gentleman had a strict medication regimen, was scheduled for cardiac rehabilitation (a supervised rehab program at the hospital) three times a week and for an echocardiogram (ultrasound examination of the heart), and had critical follow-up

POINT OF INTEREST

Envidia, or envy, is considered to be a cause of illness and bad luck. Many traditional Hispanic people think that to succeed actually is a failure. This is based on the idea that people envy a successful person. When friends, family, and neighbors envy a person in the community who has achieved success, that person will blame the envy for any illnesses. There are several social scientists who have determined that the low economic and success rates of some Hispanic groups can be attributed to belief in Envidia.

appointments with the physician. I had pictures of the medications with their time and dosage, a picture of the supervisor for cardiac rehab (I had the supervisor meet Mr. Lopez earlier in the week) with times and dates, and the appointments written down with directions on how to get to them. I went over the information for the last time on the day the man was to be discharged. In his broken English, he kept saying, "You have fixed me." I would respond "No" and would explain again the regimen he needed to follow. He seemed to think that because he was feeling so much better, he was healthy again. I sensed that he would not be following his discharge instructions and was very concerned. This went on for several minutes until I stopped and drew another picture. It was a stick figure of his family. He recognized who they were and was smiling. Then I took a marker and "Xed" out the figure of him and nearly shouted "You will be dead!" He was taken back by what I said. Then he looked at the picture of his family and the teaching pictures and information I had made for him. He turned toward me and said, "I understand." For the first time, I felt that he did. With his new understanding, I went over the teaching plan again, and he really listened. He took out his pocket calendar and wrote things on it in Spanish. He spoke to his wife in his own language and explained things to her. I felt like there was a future for this gentleman and his family.

I don't know if shouting "You will die!" at someone is the best teaching approach. In this situation, it was effective, although unconventional. For you to be good at teaching people who have English as a second language, you need to focus on your skills and awareness. If you don't speak a second language that is useful, you or your facility need to have a list of people with language skills who can be called in such situations.

Another concern to address when caring for older Hispanic people is the weather, especially if this is the first year they are in the United States and your winter climate gets cold. Many of the Spanish-speaking countries have warm climates, and cold weather is nonexistent. These people need to be taught about Pneumovax and the annual flu shot. You also should check to be sure they have or can afford fuel for warming their homes. The Federal government has assistance programs for household heat. You should refer the person in need to a social worker for information.

Another barrier to health care that many Hispanic people encounter is poverty. Like so many others we have discussed in this chapter, Hispanic people tend to be poor. Along with poverty are the diseases of poverty. They include malnutrition, tuberculosis (TB), and homicide. Knowing this should cause you to check each older Hispanic person for TB on a yearly schedule. You also should check the person's laboratory work to determine if malnutrition is a problem. It is important to ask older Hispanic adults if they feel safe in their neighborhood. Do they go out for walks? Visit a local recreation center? Visit with their neighbors? If they do not feel safe

This 63-year-old man is an illegal alien from Mexico. He does not have health-care insurance or a steady job. He stands, sometime for hours, on a specific street corner where people who want day help come to hire him and others like him. His objective for each day is to make enough money to buy food for him and his wife. If there is any left over, it goes toward the money they need each month for rent and utilities. As he ages, how will his lifestyle affect his overall health? Consider that he has no insurance, no guaranteed income, and minimal finances for essentials and that he stands on a cold (or hot) street corner each day hoping for work.

doing these things, they may be staying in the house for prolonged periods of time and should be assessed for depression, muscle disuse, and loneliness. Be creative and use your common sense based on knowledge to assist in resolving such problems. Could a group of elders go for a walk and, perhaps, be safer? Does the senior center have a bus that could pick the older person up routinely? Including the older adult and the extended family in a discussion of such problems may result in very creative solutions.

A serious barrier to receiving modern health care is time orientation. To most Hispanics, time is a relative event, as minimal attention is given to the exact time of day. This becomes a problem when the Hispanic person leaves the folk healer and goes to see a physician because of worsening health. The folk healer comes to the patient's home 24 hours a day, 7 days a week. Yet the physician can be seen only if older adults go to the office and wait a lengthy period of time to be seen. It is ironic to them that they cannot be late (which they often are), but the physician can be very late without criticism. Older Hispanic adults often are slow in coming into the health-care system; I mean that their disease is well developed by the time they get there. This often is because they have gone through all of the folk healers and their suggestions in their local community before coming to a doctor. It is important to understand this behavior rather than criticize it.

Traditional Hispanic people, especially those who are older, have a belief system based on treating "hot" diseases with "cold" remedies or vice versa. An example is that penicillin, a "hot" prescription, may not be taken for diarrhea, constipation, or a rash, as they also are "hot" diseases. The only way you will know what is hot and cold is to ask. Write down the pertinent items and add them to the care plan. You also should verbally tell the nurse or team leader so the information can be shared with the members of other shifts. Another example relates to the use of diuretics. When a diuretic is prescribed, along with encouragement to eat more bananas and raisins for potassium replacement, the bananas and raisins may not be eaten. They are considered "cold" foods and cannot be eaten with a "cold" disease. The resolution to this problem is to determine what the hot and cold diseases are and decide if there is a way to word the current illness so it is a "hot" disease (never lie, however). The purpose of mixing hot and cold diseases and treatments is to find and maintain the individual's personal balance.

JEWISH AMERICANS

It is the strength of the Jewish religion that binds Jewish people together. Jews from many parts of the world have immigrated to the United States. Since it is estimated that 50% of all Jews live in this country, approximately 6 million of them live here. There were several waves of immigration, most of them resulting from the horrors of prejudicial behavior from dominant societies. The most significant example of this behavior is the death of 6 million Jews during Adolf Hitler's "ethnic cleansing" of Germany. I recall doing an evaluative visit to a large Jewish nursing home on the East coast. While there, I met several survivors of the Holocaust. I listened to their stories and touched their tattoos (numbers tattooed on the wrists of all prisoners as a form of identification), and my life was changed forever. I suppose most of them are dead now, but they did live to a wonderful old age.

Once Jewish immigrants arrived, they were forced to work in factories and live in tenement housing, while experiencing prejudice from many people. Yet, they have demonstrated excellent leadership in business, arts, and sciences and have made major contributions to American society. Eighty percent of all Jewish Americans have a college education. This would indicate that when you have an older Jewish adult as a patient, you need to recognize their personal strength and motivation and that they may have more education than you do. Although Yiddish is a traditional language for Jewish people to use with each other, essentially everyone speaks English as well.

Traditional Jews recognize two aspects of health: the spirit and the body. Maintaining good health is an expectation. The use of modern medicine is encouraged; however, a rabbi (religious leader) may be consulted when transplantation or life-and-death issues need to be decided. Prayer is used to ask God for improvement of a condition or healing of one's body. The Torah (the holy book of the Jews) teaches Jewish people to visit and assist the sick. Most elderly Jews have a strong family and community support system.

Traditional Jewish people follow a kosher diet, which means they avoid mixing meat and dairy products; eating shellfish and pork are forbidden. The Jewish culture has many holy days that are observed in a formal manner. You are responsible for assisting older Jewish adults to maintain their healing process as well as meet their need to observe any holy day that may occur while they are in your care.

The following story happened to an experienced nurse who successfully managed what could have been a very negative situation.

One day I was assigned an older woman who was recovering from surgery for a ruptured appendix. She was doing well considering what had happened. I had not been assigned to her before, but I noticed that on the previous day she was bright and pleasant. I was excited to spend time with her. You can imagine my surprise when I went into her room and found her arguing with the certified nursing assistant (CNA). I invited the CNA out of the room and asked her what had happened. After I listened to her identify the problem, I explained to her that she must never argue with the patients and that she should bring all problems that might cause an argument to me, as the licensed nurse. Then I went in the room to talk to the patient, Mrs. Goldstein.

The argument was based on the fact that Mrs. Goldstein would not eat or drink anything. She asked the CNA to remove her water pitcher and her breakfast tray as well as cancel her meals for the rest of the day. Then she asked the CNA to see to it that she not be disturbed throughout the day. You can see the problem with these requests. Mrs. Goldstein was recovering from a very serious peritonitis caused by the ruptured appendix. She should not be NPO (nothing by mouth), and the staff would need to check on her and assist her with ambulation, administer pain medication, and check her vital signs and dressing. Also, when the body is recovering from something serious, it does need nutrients. I had a problem, and it was critical that I resolve it well.

I went into the room and sat down by Mrs. Goldstein. I asked her to tell me what the problem was. I felt it was essential that I get her version of what had happened. I reached out and touched her hand and made sure I was close to the bed so we both could see and hear each other. Mrs. Goldstein simply and clearly told me that she was Jewish and that it was Yom Kippur, the Day of Atonement. She went on to explain that Yom Kippur was the High Holy Day of the Holy Days for her religion. It was sacred to her. Yom Kippur was a day of repentance. No one drives; therefore, her family would not be visiting. And she needed to fast, so she would not be eating or drinking during the day. She felt that this would allow her to be cleansed spiritually and enable her to repent of her sins. I was very concerned.

It was obvious Mrs. Goldstein was a devout Jew and that the sacredness and traditions of Yom Kippur were deeply embedded within her. How could I meet her needs within the framework of respecting her body, mind, and spirit? I talked to her and listened, and then we made a plan.

Mrs. Goldstein agreed that God would understand if she did not observe Yom Kippur in the manner she usually did after I explained the importance of fluids to her healing body. As a result, she agreed to drink water only. Then we talked about nutrition and the work her body cells were doing to heal her. She agreed they needed fuel and said light meals would be satisfactory. I promised her that the staff would come in only for essential activities so she would have time to meditate and ask forgiveness of her sins. She seemed happy with our decisions.

I spent nearly an hour with this wonderful older woman working out a satisfactory solution that would meet her needs holistically. Then it took another 30 minutes to make the necessary arrangements for the day. Fortunately, I work with a team of nurses who "covered" my other patients while I worked with Mrs. Goldstein. I called dietary and organized her meals, including another breakfast. I put a note on her door that said she was not to be disturbed without consulting me. Then I asked the CNA to take the water pitcher back into her room and coached her on a way to apologize for her aggressive behavior and express understanding for the sacredness of the day for Mrs. Goldstein. Fortunately, the CNA was willing to do as I suggested, as she felt badly about her previous interaction.

It was a hectic but satisfying day. Mrs. Goldstein's needs were met on every level without endangering her body. She had a wonderful day and expressed her gratitude to everyone she saw on the following day. I was appreciative to the staff for understanding her needs and assisting me to meet them; it really took a team effort.

CONCLUSION

Giving culturally competent care in a caring and holistic manner requires a great deal of attention, sensitivity, and knowledge. This chapter was written to give you a basic background about the more common minority groups in the United States. Both ethnic and cultural aspects of care were discussed. It is critical that as the number of aging people in this country increases and their diversity expands, you become familiar with the needs of older adults from all backgrounds. When you learn to do this, you will be giving culturally competent care, which is the goal.

Ask questions of older adults and partake of their wisdom as you learn about them and their lives. Advocate for them as they live their culture and religion. Provide them with the items they need to practice their health beliefs. Respect them for the lives they have lived and the reasons they have lived them.

CASE STUDY

During the genetic cleansing that took place in the former Yugoslavia, there were a number of refugees who came to your community to live. Many of them had watched their family members be raped, tortured, and killed. They had nothing of material value and often no family.

You were assigned, as a volunteer, to work with one family. That was amazing in itself, as it was a whole, entire family! You met them at the airport and took them to their roomy and fully furnished apartment. You showed them how the bathroom worked and the shiny new oven and refrigerator and were pleased that there were enough bedrooms for them to sleep comfortably. Supper had been brought in by a local church group, so you left them in their new home and confirmed that you would be back in the morning to assist them in any way you could. It all felt good to you.

The next morning you were at their home bright and early, as you were excited about what you would do with them that day. You let yourself in, after knocking several times, and were shocked by what you found. No one slept in the beds, no one used the new sheets and blankets, and it appeared that no one used the toilet or shower (the new towels were unused on the racks). You found the family in the living room all sleeping together in a big knot of people. Also, there was a stack of small pieces of wood by the oven. You knew by what you saw that you had missed something major when you oriented these people to their new surroundings. After finding the family in the situation described, what were you going to do?

Solution

First, you would control your surprise and that bit of criticism that some people may feel. Then you would think about what you know about the culture of these people, as the problem appears to be one of cultural differences. The following is what I would have done. You may have other ideas that also would work. Remember that my thoughts are not the only answer, or even the best answer. Value your own thinking.

I hope I would have thought to bring breakfast. I would have had the family gather around the table and eat. Because I wouldn't have known their religion or preferences regarding blessing the food, I would have asked them what would be appropriate. While we were eating, I would have listened to what happened after I left them. Remember, they were refugees from a war-torn country where the military government had tried to kill everyone of their ethnic background. They would have told me stories of how they had to live to survive. They were poor and oppressed people to begin with and had been homeless for several months; they were accustomed to living off the streets or stealing in order to eat. They were from a very poor country and did not know what the oven and refrigerator were designed to do. The children had gathered the stack of sticks so they could be put into the oven to cook. The bathroom was another complete mystery to them. (They had gone outside to take care of their elimination needs.) They thought the towels and sheets were too pretty to use! Why were they sleeping on the floor? That was how they slept in order to keep warm and to be together if soldiers came.

By listening to these people, really taking the time to listen, I would have learned where to begin to acculturate them to modern Western society. I would have patiently explained the details of the items in their apartment, and then I would have demonstrated how things worked and let them do what they emotionally could. My only rule would have been that they could not build a fire inside the oven! It might have taken weeks before they could sleep in beds and even longer before they could sleep in separate beds.

With support and respect, this family could make a successful transition to their new lives. It might take more time than I originally planned, but it all would have been very rewarding. I would have continued to work with them until the dad got a job and the mom learned to shop and cook in her new country. English-as-a-second-language classes would have been a priority for everyone, and once the children seemed adjusted to the new culture, I would have assisted the family in getting them into school.

STUDY QUESTIONS

Select the best answer to each question.

1. In comparison with white Americans, black Americans have a life expectancy that:

a. Is longer by 3.2 years

b. Is longer for black women and shorter for white men

c. Is generally equal, as they all are Americans

d. Is shorter for both women and men

2. The leading cause of death for Native Americans is:

a. Homicide

b. Alcoholism

c. Diabetes mellitus

d. Tuberculosis

3. The median income of Asian Americans is:

a. Comparable with that of white Americans

b. One of the lowest of the minority groups

c. The highest of the minority groups

d. At a level that keeps them in abject poverty

4. Among the Hispanic cultures, the Cuban population has:

a. The highest level of illegal aliens

b. The highest level of high school graduates

c. The highest level of tuberculosis

d. The highest level of older people

5. The kosher diet of traditional Jews must strictly follow which basic rule?

a. No pork, shellfish, or white flour products

b. No dairy products served with meat, and no beef or shellfish

c. No white flour products, pork, or dairy products

d. No dairy products served with meat, and no pork or shellfish

8

Activity, Rest, and Sleep as Criteria for Health

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Express an understanding of the importance of activity for all older adults, including the most disabled.
2. Discuss the significance of activity for people with and without chronic diseases.
3. Describe normal rest and sleep patterns for older adults.
4. Identify older adults who are most at risk for developing rest and sleep disturbances.
5. Apply nursing interventions to older adults who are experiencing problems with activity, rest, and/or sleep.

INTRODUCTION

At age 59, I finally got to be a grandma! My darling, whose name is Kedzie, moves constantly. She is only 7 months old, but her arms are flinging, her legs are in constant motion, and her physical flexibility allows her to suck her great toe, if her mother isn't looking! Then when she is tired, she simply goes to sleep. She naps several times a day and sleeps for 8 to 9 hours a night. It is the perfect life.

This chapter will discuss activities similar to Kedzie's in the older adult. Activity, rest, and sleep are not nearly as simple for older adults as they are for children. That is why it is important to discuss them here.

Activity promotes life both physically and psychologically. Even minimal activity will help prevent or manage diabetes mellitus, osteoporosis, heart disease, arthritis, and most pulmonary conditions. The psychological benefits include the sense of well-being that comes with having the freedom to move from one place to the other and to take care of oneself, even if that care is minimal. Rest is a luxury that I assume you do not get to experience a great deal as a student who probably also is working and taking care of a family. The peaceful feeling that comes from an afternoon nap is a wonderful thing. Kedzie and other babies simply fall asleep if they are tired. If you tried that, you would have trouble staying in school or managing your job.

Adults have to work at getting enough rest, which leads us to sleep. I feel confident that there are days, perhaps even right now, when you feel sleep deprived. It is a difficult way to go through your life, isn't it? I am hopeful that this will not be a permanent condition for you. There should be a time, when you are through with school, when you will be able to get more sleep. However, I want you to consider what it would be like to be an older adult whose sleep patterns have changed from what they always have been and whose sleep definitely has diminished in quality and quantity. Sleep deprivation in older persons can be a very serious consideration when planning nursing care. The importance of managing activity, rest, and sleep is critical in giving care to older people.

PRIORITY SETTING 8.1

The priority for this chapter is for you to allow all older adults to do as much for themselves as possible. It is that simple. The challenge is that the person may not want to do all he or she can do. Perhaps the person's family members have pampered and waited on him or her more than is healthy for the older person. Perhaps he or she needs good pain management so that moving is not so painful. Whatever the challenge, you need to use the information in this chapter to determine what is keeping the person from doing everything possible as independently as possible. Be clever, be smart, be caring, and be holistic. But you must get the job done!

ACTIVITY

Activity for people in this country has dramatically changed over the years. As society has moved from an agrarian (farming) society to an industrial one, the natural activities that dominated our society have changed as well. No longer do teens get up at 4:00 a.m. to milk cows, thin sugar beets in the cool of the day, or "buck" (lift and move) bales of hay. Many of those activities are now automated, and there are fewer and fewer farms.

Instead of cutting trees, building houses, and having "barn raisings" along with the farming (I know this is dated, but think of what great exercise it was!), people now go to gyms or join organized community sports groups in order to get enough exercise to be healthy. There are others who participate in sports as a spectator only and spend a high percentage of their free time watching television or sitting with a computer. It is as if exercise is now a luxury instead of a necessity for good health. With the growing obesity problem in this nation, the lack of exercise as a normal part of one's day should be a serious concern for you as a health-care provider.

It is a delight to me to see older persons golfing, mowing their lawns, or walking their dogs. In my mind, I simply say "yea!" What I see are people who are utilizing the health they have and are working to maintain it. I even get excited when I see someone with a cane and oxygen zooming around the grocery store in an electric cart. Even though they are not walking, I appreciate the effort it took for them to get to the store. They had to get up, eat, dress, and manage getting to their car and then the store. They are interacting with an environment different from their home and have to stretch and move in order to get the items they need from the shelves. It is wonderful to see people moving at whatever their physical activity level is. The idea of exercise, for all of us, is if we keep moving, we WILL keep moving!

When Kedzie was learning to walk, she needed assistance from her parents. She would walk and walk and walk until she learned to do it independently. Can you draw an analogy from Kedzie to an older adult who has suffered an injury that limits mobility?

The Advantages and Disadvantages of Exercise

As a nurse giving care to older adults, you have several complex concerns to manage in terms of activity and exercise for them. The number one problem often is managing the older person's chronic disease(s) (Table 8.1). Degenerative arthritis makes it difficult to walk; pulmonary disease makes it challenging to move at all! With the aging of our society, many old-old people use canes, walkers, wheelchairs, and oxygen that add to the need for planning when exercising. Nevertheless, they need to exercise.

When people exercise, they are assisting all of their major systems. Exercise improves the functioning of the heart and lungs, the musculoskeletal system, and the digestive and excretory systems, and it provides feelings of self-satisfaction. Setting goals and having meaningful things to do, all of which require some activity, combats depression, insomnia, and boredom.

When older people do not exercise, they are subject to osteoporosis, joint immobility, indigestion, constipation, pneumonia, weakened cardiac and other muscles, pressure ulcers, and the depression, insomnia, and boredom mentioned before. The aging process is a challenge to maintaining a healthy lifestyle. The instrument for avoiding the pitfalls of inactivity in older adults is the care given by you, as a licensed nurse, and the members of the family, who you are responsible to teach.

TABLE 8.1. Ten Most Common Chronic Diseases in People Over Age 65 in the United States

1. Arthritis
2. Hypertension
3. Hearing impairments
4. Heart conditions
5. Visual impairments, including cataracts
6. Deformities or orthopedic impairments
7. Diabetes mellitus
8. Chronic sinusitis
9. Hay fever, allergic rhinitis/asthma
10. Varicose veins

U.S. National Center for Health Statistics/2003, Vital and Health Statistics. *www.cdc.gov/nchs/data/hus/tables/2002*

How to Keep Older Adults Active

The first and foremost rule when working with older persons and their exercise needs is to allow them to do as much for themselves as possible. This sounds very simple; however, in the real world of your clinical practice, it is not! There is pressure to get everyone to the lunch room in a nursing home in a timely manner, and walking residents to meals is more time consuming than putting them in wheelchairs to transport them. Yet, walking residents to the lunch room is an excellent way to give them some exercise despite the time crunch. This could become problematic for you as you organize your time. It is critical that you and those you manage (the nursing assistants) organize yourselves so everyone can be assisted in walking to their meals, if at all possible. Once there, the residents can use their time to visit with each other, discuss the day's events, and compliment or complain about the food. The difference between getting them to lunch at your convenience and ambulating them to lunch with time for socialization is one of quality of care and caring.

In the hospital, you may need to assist an older adult to a chair so meals can be eaten while sitting upright (better digestion, less acid reflux). Assisting someone to the toileting room, without

FOCUSED LEARNING CHART

Advantages of exercise

Assist to Prevent	Assist to Manage	Can Improve
Osteoporosis	Pressure ulcers	Joint immobility
Diabetes mellitus	Arthritis	Most pulmonary conditions
Heart disease	Depression	Insomnia
Boredom	Obesity	Indigestion
	Psychosocial health	Constipation

the use of a wheelchair, will promote bowel elimination, and the walking is important for muscle strengthening (including the heart) and the avoidance of increased osteoporosis.

The "allowing people to do as much for themselves as possible" rule extends to all of the care you render people in the nursing home, hospital, or home. Allow individuals to brush their own teeth, comb their own hair, and dress themselves as much as possible. All of these actions take time but are excellent for range of motion as well as self-esteem building. Teaching this principle to family and friends will further enhance the quality of life of older adults. Tell them what you are doing and explain the "why." Role model safe and caring ways for assisting the person in your care. During the time you are assisting older persons, talk to them, listen to what they have to say, and value their wisdom and experience. This valuing behavior helps build self-esteem, and it is a caring and wise way to utilize the time you are spending in activity with your clients.

While planning exercise for specific older adults in your care, be aware of their physical ability. It is not helpful to put persons in a situation that makes major demands on their bodies that could be unsafe. For some people, sitting in a circle and throwing a ball from one to another is good use of their upper body and is fun. For other persons, it could be boring and beneath their physical abilities. Begin with a conservative plan, and increase it if it does not physically stress the person.

POINT OF INTEREST

All exercise plans for older adults in your care need to be ordered or approved by the physician. In addition, all reputable nursing homes, hospitals, and home-care agencies have access to physical therapists (PTs). Use the PT to teach you and the family the best approaches and techniques to use with each individual.

You have the knowledge to determine a safe and meaningful activity for each individual. Think of the person holistically, for example, what the individual can do and what he or she enjoys, and then plan accordingly. Washing dishes in warm water is a successful way to exercise arthritic hands and fingers with less discomfort. Encourage arm and ankle exercises while watching television or ankle exercises while working at the computer. A walk outside to the sidewalk and back may not seem like much unless you are the person doing the walking with pain or dyspnea. Suggest a pet if it seems appropriate. The value of pet therapy is well published, and actually taking care of a pet requires physical movement.

POINT OF INTEREST

Much of the current exercise literature states that it requires 30 minutes of exercise a day for the exercise to be effective. Other literature may say that 30 minutes three times a week is required to get positive results. However, you are giving care to a specialized group of people, and those rules designed for 20- to 40-year-olds do not apply to elders. The key to maintaining or improving the health of older people is simply to keep them moving! For example, to walk to the kitchen to get a drink of water is better than having someone getting it for the person. Doing two or three arm extensions while holding a soup can in each hand is better than not doing any. As you plan your care, think of ways you can involve older adults that make movement necessary.

REST

Rest is something most people want to experience more than they generally do. I am sure you would like some time off to do nothing but rest; I do find that to be common among busy students. When dealing with older adults, remember you have a specialized group of people who have specialized rest needs.

Because of the number of chronic diseases older people tend to have, they may be unable to rest because of pain or stress over their diseases. In another scenario, the person may feel that all he or she does is rest! The key to managing the rest needs of older people is to identify what their needs are.

Pain

A common reason people cannot rest is because they have pain that keeps them awake. Pain needs to be identified and managed. It not only interferes with rest and sleep, but it decreases activity as well. It is your responsibility, as the licensed nurse, to identify the pain and share that information with the registered nurse (RN) or physician. It is the RN or doctor's responsibility to do a comprehensive assessment to determine the causative factors related to the pain. Your responsibility, besides reporting the pain and its impact on the resident or patient, is to check for more common possible causes of the pain. Is the individual positioned properly? Are position changes made often enough to prevent pressure ulcers from starting? Have you checked the med-

CRITICALLY EXAMINE THE FOLLOWING:

Look at your own busy life and holistically plan an exercise program for yourself.

What are you currently doing for exercise?

What do you want to do (lose weight, walk further, play ball better)?

How can you do it?

Do you already have an exercise program that works for you?

Write two to three paragraphs explaining an individualized exercise program for you or the one you currently are using that is successful. Bring it to class and be prepared to share it.

Kedzie enjoys just resting. She will lie on her back and talk to her mother or herself or play with her toys. This generally is the time she will demonstrate her flexibility and suck her toe when her mom isn't looking! Older adults also need their rest. Short naps during the day help them to have more energy for their daily activities.

ications to see if there is a drug reaction or interaction? Listen to the person experiencing the pain and carefully describe it when you chart. You also should consider having the older person self-evaluate the pain by using a scale like the 1–10 scale. When using this scale, you ask the person to pick a number that describes the pain on a scale of 1 to 10, with 10 being the worst pain imaginable. When you regularly chart this self-evaluation, it could give the RN or physician valuable information that will assist in pain management.

Stress

Every person has his or her own personal ability to manage stress. This is very important because stress is a normal part of life. Think of the stress in your own life. Without deadlines, you would not be stressed enough to get your school papers or care plans written or prepare for your tests. Every day people manage the stress of weather changes, worldwide events (war, hurricanes, floods), interactions with others, time constraints (like your school assignments), and other physical and emotional stressors. For some people, getting up and dressed in the morning are major stress points. Stress is part of everyone's life, and it will not go away. The key to stress is not elimination; it is management.

Life is a series of stressful events. Much of the stress actually enhances our lives (getting up in the morning and getting dressed). Some assists us in achieving our goals (school assignments), and some simply makes us feel alive and assists us in avoiding boredom. The problem with stress is that there can be too much of it; this is called distress and can be damaging to our lives both physically and emotionally. The potential for the negative effects of distress is why stress management is critical to understand. There is an informative section in the chapter on promoting wellness (Chapter 5) that would be valuable for you to reread. The content supports the principles of achieving rest by managing stress. Refer back to Chapter 5 and apply the information to the concept of appropriate rest for older adults.

"All I Do Is Rest!"

If you hear this or similar comments from your elderly clients, you need to assist them and their family members to understand the information in the activity section of this chapter. All people need to move to the extent of their ability. Their movement will work their muscles, and that encourages the body to rest. One of the main considerations when planning activity and rest is to assist the older person to alternate them throughout the day. Many older people have worked for most of their lives and consider daytime the right time to "do their work" or activities, and they rest in the evening.

As most of us age, we have less stamina for prolonged activities such as working for 8 consecutive hours. It is important to teach older people and their families that the individual really is retired and need not work for so many hours at a time. A combination of activity and then rest, activity and rest again is generally the best way to stay healthy and happy as an aging person. The older one becomes, the more common this tends to be. I personally think that naps are the second greatest thing ever invented! (The first, of course, is being a grandma.) It is not uncommon for older people to take two or three naps a day. Napping is perfectly natural because of the aging body. Encourage naps intermingled with episodes of activity throughout the day. However, you need to be aware of oversleeping because of the possibility of boredom or depression.

Just take a moment to consider if the person is bored. Should the individual be going to the senior citizen center two to three times a week for lunch and socialization? Most senior centers also have classes and crafts that help maintain a person's interest in life and living. Should a craft be brought into the home or nursing home for the individual to do? Do the neighbors need to know that their visits are very welcome, or is there an adopt-a-grandparent program at the local high school? This is a pro-

CRITICALLY EXAMINE THE FOLLOWING:

Look carefully at your life and identify the three major stressors you currently are experiencing. Then, 1) list the stressor; 2) state whether it is "good" stress or "bad" stress; 3) describe how you are managing it; and 4) indicate whether your management of it seems to be successful. If you feel you are not managing the stressors satisfactorily, please indicate a plan that will assist you in more effective management of the stress. Prepare this information to submit to the faculty person. It should not be longer than one page. By submitting this assignment to faculty and receiving feedback, you will have even more ideas for stress management that are specific to your situation. This should be a positive experience for you to identify and evaluate your own stress.

gram where teens volunteer to be with one particular older person. Generally, this results in a very satisfying relationship for both individuals.

Because it is so important, I will once again mention the need for you to take time to actually talk to the older adults to whom you give care. Learn about their lives and the courage and creativity it has taken older people to survive two world wars, the Great Depression, and living in a predominately ageist society. Old people are strong, they are interesting, and they are wise. You need to learn the truth of what I have just said for yourself by talking to them and learning to value them.

SLEEP

Sleep is the most significant activity people can participate in for quality health. Every person, at whatever age, needs sleep in order to function normally. During sleep, the body physically repairs body tissues and emotionally resolves the issues of the day. Some people need only 6 hours of sleep, whereas the tradition is 8 hours a day. Generally when people age they feel less rested, and many need more sleep than they get.

When Kedzie is tired, she falls asleep; it does not matter where she is or what she is doing. I have observed older people who nod off or stay home from a shopping trip because of their fatigue. Everyone needs enough sleep to be at the optimum level of alertness and health. Devise strategies for the people to whom you give care that will allow them the sleep they need.

What Is Sleep?

The central nervous system (CNS) controls the sleep–wake patterns for each of us. There are two types of sleep: rapid eye movement (REM) and non-rapid eye movement (NREM). Every individual, at whatever age, needs to experience both types of sleep every night. The sleep cycle has four stages of NREM and one stage of REM. The NREM stages go from relaxation to deeper and deeper sleep. The REM stage is the deepest sleep and is essential for a good night's rest. People often go through this sleep cycle four times a night, with each cycle allowing for deeper and more restful REM sleep. If the person's sleep is interrupted, the cycle starts over again from the beginning and much of the deep sleep needed for optimum health is lost. This deep sleep is the healing sleep. When you wake up from a night's sleep and feel really great, you have, in all probability, had uninterrupted cycles of sleep.

Another aspect of individual sleep patterns is the person's circadian rhythm. This is the body's response to the day–night cycle of the sun. Within this cycle, people develop personal responses to their sleep needs. A common problem is that as people age, they wake up earlier. As a result, they get tired during the day and need one or more naps. The daytime fatigue comes from normal physiological changes in the person's circadian rhythm. Research indicates that circadian rhythms change over time, resulting in younger people sleeping late in the morning (think of your own teen years) and older people awaking earlier. This normal physiological change causes many older people to want to stay up late so they don't wake up at 4:00 or 5:00 in the morning. Getting up early also reinforces the need for naps throughout the daytime hours.

Sleep Disorders

Sleep disorders come in a variety of diagnoses, but the end result tends to be the same. The older adult often has trouble falling asleep and staying asleep and awakens fatigued, which can last throughout the day. As you probably know from personal experience, people who do not get enough sleep are often irritable, and in older adults, that can lead to confusion. The management of sleep disorders is an important aspect of the care you need to be giving to elders.

A common sleep disorder is insomnia. This occurs when people have difficulty getting to sleep or remaining asleep or simply feel they do not get enough sleep. Insomnia is not a disease, but rather it is the result of some other condition.

CRITICALLY EXAMINE THE FOLLOWING:

Now that you know about normal sleep patterns and changes in circadian rhythms, what have you observed that indicates nursing in general does not consistently address this problem when giving care to older adults? Make a list of three nursing care approaches that could be altered to meet the personal sleep needs of older people. Prepare a one-page summary of the three items you identify and indicate how nursing care approaches can be changed. You may use examples from the nursing home, hospital, or home care settings.

Because I think this is a paradigm-shifting assignment, I am going to give you my three answers. Remember that yours will not necessarily be the same as mine. I am sure that in your experience, you have observed things that I have not. I suggest you ponder the assignment and be thoughtful in your response.

My Answer

1. In nursing homes, residents often are put to bed between 7:00 and 9:00 p.m. I do not remember anyone being able to stay up and watch Jay Leno or read a great mystery until midnight or so. Putting people to bed so early does two things that have negative consequences. The first consequence is that putting adults to bed at the same time one might put children to bed is very paternalistic and power driven. All adults with normal mental capacity should be able to determine their bedtime rather than being put to bed like a child. I feel strongly that this behavior is demeaning to older persons. In addition, it forces the person to lie in bed awake for lengthy periods of time during the night and early morning because they simply cannot sleep that long at one time. Remember that their circadian rhythm has changed as a normal part of aging. I realize that it would be inconvenient for the staff to allow people to go to bed at the time they wish to go to bed. However, I believe something very special is missing when sleep times are regulated. It is quite simply the power for self-governance.
2. In most hospitals, it is noisy at night, and older people, who generally are lighter sleepers, just can't stay asleep once they get to sleep. This disrupts their NREM and REM sleep cycle. It is essential that nursing staff make regular rounds, take vital signs, and do other things, such as checking dressings or intravenous fluids (IVs). However, for most older people, all of that movement and noise interfere with sleep. Modern hospitals generally have single-occupancy rooms, which was not true in the "olden days" of four-bed wards. The positive relationship of a private room and one's sleep, at any age, are obvious. It also is helpful if the activities that need to be done in a patient's room are all done at one time so that there are fewer sleep interruptions. Could the IV/dressing check be done when medication is administered? Staff always should use flashlights rather than turn on the room lights. Noise in the hallways and at the nurses' station should be kept to a whisper level in order to not disturb the patients.
3. If older residents or patients do get up early, is there a place for them to go to read, watch the early morning news, or have a cup of coffee? Since early awakenings are normal physiology, the staff should have a way of managing this occurrence in a positive manner.

Imagine the pain from arthritis without effective pain management. You may be too young to know how devastating arthritic pain can be, but it definitely is enough to keep a person awake. One of my sisters has insomnia every time a storm "blows in." She complains of her lack of sleep until I remind her that the cause is her pain. Then, she takes a long-lasting analgesic before going to bed. It works for her!

Another common cause of insomnia is sleep apnea. This happens when the person's airway is partially obstructed during sleep. The classic symptom is fatigue upon awakening and throughout the day. People with sleep apnea are very tired ALL of the time. They often snore throughout the night, which can result in insomnia for their sleep partner. People with sleep apnea are frequently obese.

This condition is treated with continuous positive airway pressure (CPAP) while sleeping. This is a machine that eliminates the airway obstruction by forcing air into the trachea throughout the sleep period. This is done through a mask that is strapped to the person's nose. Untreated sleep apnea can lead to right-sided heart failure and eventually pulmonary hypertension. Attention needs to be paid to people who complain of constant fatigue. It is your responsibility to report such complaints to the RN or physician rather than dismiss the complaint.

CRITICALLY EXAMINE THE FOLLOWING:

Nursing interventions often bring the needed information and comfort to patients and residents experiencing insomnia. Take the situation of frequent urination as a causative factor for insomnia. There are nursing actions that can, theoretically, improve this situation. Make a list of things you can do and the reasons why. Focus on nursing knowledge and not medical knowledge such as medications. I will write one action and rationale for you as an example; then you need to complete the list. Be prepared to submit your plan to the faculty person.

1. ACTION: If possible, terminate drinking fluids at 6:00 p.m. This is a challenge for anyone accustomed to drinking throughout the evening, but a worthwhile behavior. The nurse will need to give sips of fluids with medications at bedtime. Be pleasant and supportive to the person giving up the fluids. It is hard!
   RATIONALE: It is simple. If the kidneys do not have fluid to process, there is minimal urine. Remember how important it is that any person sleeping has continuous sleep? If not, refer back to the previous section. The action may be all that is necessary to stop nightly urination. However, you should write three more nursing actions that can assist this type of patient/resident.

Other common reasons for insomnia include frequent urination, acid reflux, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). Each of these medical conditions should be treated by the physician. Again, it is your responsibility, as the licensed nurse, to report symptoms related to these diseases and their management to the RN or physician. Then, as the excellent nurse you are, or will become, go a step further by applying nursing interventions where applicable. For example, people with COPD and CHF will sleep better if the heads of their bed are raised. The same is true of someone with acid reflux. This person also should never take medications on an empty stomach.

Nocturnal movement is another physiological condition that will cause insomnia. There are two common types of nocturnal movement. The most common is restless leg syndrome (RLS), which is an irresistible urge to move one's legs. This can happen several times a night, and each episode is capable of awakening the person experiencing the situation. This syndrome can be managed with medication. For some people, heat application also helps the legs to relax. Be sure to report this disruptive complaint to the RN or physician so it can be effectively treated.

Another disruption to sleep is nocturnal myoclonus, which is sudden moving or kicking movements of the lower extremities. This happens without warning and is very disruptive to sleep. Again, report it rather than ignore it as "just another complaint," because there are medications that assist in managing the disorder. These problems are legitimate concerns when considering sleep patterns and, subsequently, the overall health of the people to whom you give care.

Dementia is a deterrent to effective sleep both for the person with dementia and his/her sleep partner. Sleep patterns are altered in someone who is demented, which often results in being awake and wandering at night. This is very disruptive for the caregiver, who most often is the spouse of the demented individual. The result is that there are two people who are sleep deprived and having difficulty because of fatigue. This is one reason many communities have respite programs for caregivers of persons with dementia. The person with dementia is taken to the respite center for constant care, and the caregiver has a few hours or a weekend to rest, visit relatives, or engage in other activities important to a quality of life.

Psychological conditions often are detrimental to effective sleep patterns. People who are depressed often awake early and have hypersomnia, which is sleeping during the time people normally are awake. Anxiety often is related to difficulty falling asleep and frequent awake periods during the night. Psychiatric disorders can be treated with medication and therapy. There are several that interfere with sleep and other life issues. Be diligent in your awareness of what is going on with the people to whom you give care. Talk to family members to gather information and an accurate past history. Share what you learn with the RN and physician so a psychiatric assessment can be made and treatment started. The benefits will be much more than a good night's sleep.

As you evaluate and teach the patient and the family about healthy sleep, keep the following deterrents to good sleep in mind as part of your teaching plan. The following contribute to poor quality sleep: sedentary lifestyle, alcohol, tobacco, caffeine in the evening, disrupted sleep

patterns, noise, and light in the sleeping environment. It is your responsibility to make the environment conducive to sleep, teach the patient/resident and family members about what disrupts sleep, and report any medical conditions appropriately so they can be treated. Please carefully examine and talk to any person in your care who seems fatigued. Fatigue is NOT a normal outcome of aging; it is a problem.

CONCLUSION

The care of older adults requires a special sensitivity to their health needs. Their health is the main factor in determining their quality of life. To have maximum health, all people need activity that fits their physiology, rest that accommodates their lifestyle, and sleep that allows them the ability to function without fatigue. You, the nurse, are the key to these things happening for older adults. The ageist stereotype this country has for older adults leads many people to believe the lack of activity, the taking of several naps in a day, and complaints of fatigue are simply factors that accompany aging. You now know that management of these problems can be done through an interdisciplinary team (IDT) approach (you, the RN, the physician, and the family) once the problems are recognized and documented. Many of the problems can be resolved through good nursing care approaches and family involvement. It is your responsibility to facilitate this type of caring and care.

CASE STUDY

Mrs. McDonald is an 86-year-old woman who lives with her eldest son and his active family of five children. Mr. McDonald died the previous year of heart disease. After his death, Mrs. McDonald became less and less able to care for herself. She cried a great deal and refused to walk to the kitchen to prepare food. She said it was "too much work." She complained of not being able to sleep, yet whenever her son, Sean, came over to see her, she was sleeping in her chair. Being concerned about his mother, Sean moved her into his home with his wife and five children.

Mrs. McDonald had her own room but had to walk a short distance to the bathroom. She often was incontinent because it was "too hard" to get to the toilet. She always was tired and napped four to five times a day. Sean had two teenagers who often had friends over to the house. They were noisy and tended to stay until 9:00 or 10:00 in the evening on the weekends. There also was a 5-month-old baby who woke up crying twice a night. All of the bedrooms were on the same floor, so each noisy incident awakened Mrs. McDonald.

Sean's wife, Mary, began to complain of having to wait on the children (baby, toddler, 5-year-old, and the teens) and Mrs. McDonald. "She won't get out of her chair or do anything for herself. I can't stand the incontinence; my house smells," Mary told Sean one day as she was crying. Sean felt caught between the needs of his mother and the needs of his wife and children. He was committed to not putting his mother in a nursing home, as she was adamant about not going to "live in the county poorhouse." Sean called a local home-care agency to see if they could help him with his problem. You are the nurse assigned to Mrs. McDonald. What are you going to do? This obviously is a holistic problem, as the entire family is involved, so approach your solution with that in mind.

Solution

Gathering Information

You ask the admitting RN if you can accompany him on his first visit. He agrees that you should be there. While the RN does the admission, you ask Mary to show you Mrs. McDonald's room and the bathroom. While you are walking down the hallway, you talk to Mary about the problems she is having. It is obvious the entire family needs help if you are going to assist Mrs. McDonald. The following items need your attention.

Depression

Mrs. McDonald's behavior indicates that she could be depressed and has been since the death of her husband. You use the Beck Depression Scale, as an assessment tool, on Mrs. McDonald; the results indicate that she is clinically depressed. You talk to her and observe her to see if what you hear and see support the results of the test. Your observations lead you to talk to the case manager, who contacts the physician. After talking to Sean, the physician orders a mild antidepressant for Mrs. McDonald. You will observe her closely for the next 3 weeks to determine if there has been a change. If the medication does not relieve the depression symptoms, you may need to suggest some psychological therapy sessions to assist her in managing her feelings regarding the death of her husband. You know that if the depression is managed, Mrs. McDonald will sleep better and be better able to care for herself during the day.

Strengthening

Mrs. McDonald needs more activity in order to be stronger. You arrange your first visit to be when the entire family is at home. Mrs. McDonald also is present at this family meeting. You explain the "first rule" of activity for older adults. Remember that it is for the person to do all activities possible for himself or herself. Mrs. McDonald is not doing that, as she has the 5-year-old and the toddler running errands for her frequently during the day. She refuses to go to the bathroom, hence her incontinence, and she seldom leaves her room "because she is so tired."

Mrs. McDonald likes the idea of being more independent, so she agrees to listen to your plan, which follows. You also explain to everyone that the more activity Mrs. McDonald has, the better she will sleep.

1. She will come to the dining room for all meals. (Mary has been feeding her in her room, which contributes to Mrs. McDonald's depression.) Mary agrees to walk her to the dining room for breakfast and lunch in time to enjoy eating with the family. The teens agree to take turns walking their grandma to the dining room for dinner.

2. The 5-year-old volunteers to "work out" with grandma while she does arm exercises with a soup can in each hand twice a day. You need to evaluate how many lifts she can do with her current muscle strength. You will reevaluate this frequently.
3. The teenagers agree to take turns taking grandma for a walk each day. You demonstrate how to get her out of the chair and how to use a walking belt (you brought one from the agency that will be left at the home) and emphasize that "a walk" initially will be a short trip in the hallway. You will monitor Mrs. McDonald's strength and add to the distance traveled as is appropriate.

Incontinence

This is a major problem that often is the reason families place their older family member in a nursing home. It is unpleasant for both the caregiver and the person experiencing the incontinence. The smell tends to bother the entire family. You see this as an urgent matter. You explain to the family that the exercise will assist Mrs. McDonald in becoming strong enough to eventually ambulate to the bathroom. In the meantime, something must be done to make the situation manageable.

You talk to Mary and Mrs. McDonald privately and suggest adult briefs. Mrs. McDonald is able to change them herself, and their use would diminish the smell in the house as well as stains on the furniture and floor. You suggest a tight-lidded container as the place to dispose of the briefs. This will help control the smell as well. Of course, the container needs to be emptied every day. Mrs. McDonald is excited to have this type of autonomy, and Mary is visibly relieved.

You should advise other methods of bladder control, but since they are not the focus of this case study, they won't be discussed here.

Sleep and Rest

Mrs. McDonald naps four to five times a day and still feels exhausted. You should ask her to keep a log (with Sean's help, if necessary) about her sleep. What time does she go to bed? Wake up? How many times a night does she get up or become fully awake? What causes her to awaken? This information should be shared with the RN or the physician so decisions can be made about sleep apnea tests, medication for RLS, or other medical interventions for Mrs. McDonald's fatigue.

In the meantime, you can get to work on basic nursing interventions. Is the room quiet at night without disruptive lighting? Does Mrs. McDonald avoid alcohol, smoking, and caffeine, as they are things that can disrupt her sleep? Is the room warm enough, and is the bed comfortable for her? Does she need more pillows or a bed that is elevated because of COPD or CHF? Does she need a new nighttime ritual, such as reading a large-print book with a 100-watt lamp? Would she like the family to come into her room and have family prayer at bedtime? There are several interventions you can investigate.

It would be an effective idea for Mrs. McDonald to try to have only two naps a day. She needs to be tired when she goes to bed. Staying awake, if it is reasonable, along with her new strengthening program will help her sleep.

There are other plans you could work out for Mrs. McDonald and her family. Consider at least two more and write them as part of this case study solution. Enjoy the process!

STUDY QUESTIONS

Select the best answer to each question.

1. When considering activity for older adults, the greatest challenge is:

- **a.** Getting them up and about without hurting your back.
- **b.** Keeping their weight within normal limits so that it is easier to move them.
- **c.** Managing their chronic diseases.
- **d.** Doing as much for them as possible as a pain management intervention.

2. The normal sleep cycle for older adults:

- **a.** Has two NREM cycles and an extra REM cycle.
- **b.** Is not affected by the interruption of the NREM/REM cycles.
- **c.** Has a built-in mechanism, which develops as people age, that makes awakening more difficult.
- **d.** Does not change or adapt as people age.

3. The normal circadian rhythm in older adults:

- **a.** Changes as people age.
- **b.** Does NOT change as people age.
- **c.** Protects older adults from sleepless nights.
- **d.** Causes significant disruptions in normal sleep patterns.

4. Older adults who are most at risk for rest/sleep disturbances include all but the following:

- **a.** Those with sleep apnea and obesity
- **b.** Those with depression or dementia
- **c.** Those with RLS or myoclonus
- **d.** Those who are underweight and confused

5. Many sleep/rest problems can be managed with effective nursing interventions. Choose from the list below the activity that is not based on nursing knowledge:

- **a.** Sleep apnea testing
- **b.** Appropriate toileting pattern
- **c.** Strengthening program
- **d.** Administering the Beck Depression Scale

9

End-of-Life Issues in the Older Adult

Emily Ravsten

Learning Objectives

After completing this chapter, the student will be able to:

1. Define the essential characteristics of a hospice organization.
2. Identify the five stages of grief as outlined by Dr. Elisabeth Kubler-Ross.
3. List the qualities necessary for a nurse to give end-of-life care.
4. Express an opinion on assisted suicide.
5. List the eight signs of imminent death.

INTRODUCTION

My only living grandparent is Margrette Romer, an 83-year-old woman who keeps on kicking! She gave birth to six daughters, is the grandmother to 16 children, and is the great-grandmother to nine children, with one on the way. She lived her entire life on a farm in rural northern Utah, until 1998, when she fell and broke her hip and femur. She now lives with one of my aunts, who is her caregiver.

Grandma celebrated her 80th birthday party with her friends and family and was hospitalized that evening for her fractures. The family thought she was going to die. Fortunately, months before, my mom had sat down with Grandma and filled out a "Living Will," a document that expressed my Grandma's desires to live or die if she were in a hospital. This preparation was helpful to my Grandma and to her daughters. At the time of her hospitalization, the family realized that she might not live. However, her health gradually improved. When she was asked why she was fighting to live, she seriously stated that she still had quilts she needed to finish for her grandchildren! Three years later, Grandma is quilting and living a peaceful and pleasant life with her children and grandchildren all around.

I have a deep love for older people. My mom, the author of this book, practically raised me in nursing homes as she traveled from one nursing home to another evaluating the facilities and teaching the staff. Through such experiences, I learned that older adults are very wise and experienced. In addition, as they approach the end of their lives, they have the courage to face the multiple, serious decisions that need to be made. The focus of this chapter is to explore how to assist older adults to die well through the excellent care and support you provide them as they approach the end of their lives. Some terms related to end-of-life care include the following:

This is my Grandma Romer on her 80th birthday. With her is her youngest great-grandson. Grandma had a fractured hip and femur, but she wasn't going to miss her party! The ambulance was on standby, and as soon as the party was through, it took her to the hospital 50 miles away.

- ***End-of-life issues, EOL issues* for short,** are vital issues in health care throughout this country. Americans want to experience a "good death" without being burdened by symptoms or technology. Nurses have an essential role in maximizing EOL care by improving symptom management, communication, and education about choices, referrals, and psychosocial treatments. You, as the care provider, will have the responsibility to explain to older adults and their family members all of the options, referrals, and resources available. It is very important that as you review some of the options in this chapter, you examine your individual attitudes, values, and beliefs. You need to consider what happens if your personal beliefs conflict with the choices and decisions made by the older adult in your care.
- ***Palliative care*** is the term used to describe care no longer aimed at a cure or active treatment of a certain medical condition (Matzo & Sherman, 2001). Instead, the goals of palliation are to provide older adults with comfort and to be able to manage their symptoms. This type of care is the art and science of quality EOL care. It is your opportunity, as a licensed practical nurse (LPN), to take the initiative in providing palliative care that will ensure comprehensive, holistic EOL care for all older adults who are experiencing life-threatening, progressive illness. It is the opportunity to be sensitive and respectful to the older person's values, religious beliefs, family traditions, individual cultures, and beliefs. It is a tremendous amount of responsibility.
- ***Terminal restlessness (TR)*** is another term for agitated delirium. This is a common occurrence for individuals nearing the end of their lives. It may appear as involuntary muscle twitching or jerks, thrashing or agitation, tossing and turning, or yelling and moaning. These symptoms may not appear to be that different from those experienced by residents

in long-term care situations. However, delirium at the end of one's life is usually multifactorial and intensified by the progressive shutdown of numerous body systems.
- ***Hospice*** comes from the term *hospitality* and can be traced back to medieval times, when there was a need to find a place of rest for weary and ill travelers. Today, hospice organizations are located all over this country. A large hospice organization attracts hundreds of people each year with diverse services (Box 9.1). However, more than 50% of all other hospices report being underused. This is poor utilization of a potentially tremendous service.

Often, referrals to a hospice come "too little, too late" in order to be most effective. An example of providing successful care is that of patients with Alzheimer's disease (AD). Providing them with palliative care may be the primary long-term mode of care. However, once death is imminent, generally around the last 6 months of life, a hospice team should be called on to provide their specialized knowledge to the palliation plan of care for the transition from dying to death.

THE MYSTERY OF DEATH

Normally, more than 70% of annual deaths occur in people 65 and older. By the year 2020, 2.5 million individuals older than age 65 will die annually in the United States. Dying is an unpredictable event. People never know the exact moment or situation in which someone will die. Therefore, as the caregiver to older adults, you, as a nurse, need to be prepared to be a positive influence for appropriate EOL issues. First, you need to be educated in EOL issues and learn to communicate them. Then provide the older adults in your care with a high quality of life and a good death. You need skills in working as a team with other caring professionals, families, and the dying person. Finally, you need to maintain a positive work environment. Without skills in these areas, the quality of EOL care for older adults in your care will be diminished.

As all people know, death is an inevitable and natural human experience. However, death has been shrouded in mystery and envisioned as an experience of great suffering and generally is contemplated with fear. The early settlers in this country had a different perception. They had a welcoming relationship with it, one that desired a release from pain as well as recognition of the cycles of nature. For them, there was a time to

BOX 9.1 The Essential Components of Hospice Programs

The following qualities can be found in an excellent hospice program:

- Serves patients, families, and the community with sensitivity to different cultures, values, and beliefs.
- Provides interdisciplinary teams of palliative care experts educated to give competent, compassionate, highly skilled, state-of-the-art care to dying people.
- Has a small patient-to-worker ratio.
- Is responsive 24 hours per day, 7 days per week.
- Elicits and responds to patient and family needs and wants and encourages involvement of patient's own physician.
- Produces accurate, reliable data about care, outcomes, and costs.
- Earns community support.

(Adapted From Christopher, 2001)

PRIORITY SETTING 9.1

This chapter describes the role of an EOL nurse very well. It talks about what you need to learn and explains many things you should work to understand. In my experience, I have found that people cannot apply information regarding EOL in an effective way unless they have come to an understanding within themselves about death. That is your priority for this chapter. Take the content you read and internalize it. Think about people who have died who were important to you. How did you feel, react, grieve? If you are confused or uncomfortable with death experiences, where can you go to get more information? Who can you talk to about the death of someone who was close to you? Do you have religious beliefs that comfort you or friends who can assist you to accept the death?

To give effective EOL care, you need to be at peace with death and its complexities. You should see it as the personal, meaningful, unique experience it is and then be able to share that with the patients, residents, and families with whom you work.

live and a time to die. They were able to accept death as a transition into an afterlife and a reward for a life well lived. Somehow modern society has lost that important concept. What has been the cause of this transition in thinking?

As I watched my Grandmother on the acute unit in the hospital, I saw how different members of my family reacted to the possibility of her death. There were many emotions ranging from acceptance to denial, as well as fear and anger, or joy and confusion. Those emotions were real and will be emotions that you, the nurse, will experience as you encounter family members of a dying person. People need to be allowed to cope with death in their own way, even if it is to deny death's reality until the end.

THE STAGES OF GRIEF

Grief is the normal reaction to a catastrophic loss. What defines the catastrophe? The person experiencing the loss has that responsibility. A catastrophe to one person may not be one to another. Understanding and compassion are essential when relating to people experiencing losses. Dr. Elisabeth Kubler-Ross, a Swiss psychiatrist, spent much of her life defining the stages of grief. Death, the greatest personal loss a person can have, was the focus of her grief work. If you understand the five stages of grief, you can recognize them within yourself, the older adults to whom you give care, and their families. It is important knowledge to acquire.

Death is hard! It is a one-time experience for most people. That makes it a unique and powerful experience. When a person dies, that individual loses everything they ever had. The dying person loses friends and family members, home, pets, beauty, everything! Therefore, the stages of grief demonstrate the reactions, the normal human reactions, people can have when facing a loss. Perhaps the person grieving is a family member of the person dying. Their loss is also great. In addition to death, the stages of grief are valid with the loss of an extremity through amputation or a stroke or divorce; for some sweet, young girl, the loss of a date to the prom can result in a brief grieving process.

Kubler-Ross (1969) identified the five stages as:

Acceptance
Depression
Bargaining
Anger
Denial

CRITICALLY EXAMINE THE FOLLOWING:

Now that we have discussed various aspects of EOL issues, it is time for you to express some of your thoughts on the topic. Please take a few minutes to contemplate and consider *your perfect death*. The purpose of this exercise is to have you apply the information you have just read. Some of the questions you should answer are listed below. Answer them and then add more detail. Consider this a "free write," where anything you say will be respected. You will not have to submit this assignment to the faculty person. However, you will be better able to relate to other people who are dying if you thoughtfully complete this assignment.

How old will you be when you die?
What will be your general health condition?
Who will still be alive and be with you as you die?
How will you die?
Other comments you want to make.

Now consider your ancestors and how and when they died. You have described your perfect death, but few people get to experience such an event. By looking at your parents' and grandparents' health and the death of family members, you will see your genetic predisposition. What do your genes indicate as a possible death?

Do you have any potentially dangerous hobbies like skydiving or car racing? Do you drive an excessive number of miles in a year? Do you have poor health habits? What do these lifestyle behaviors indicate about your eventual death?

You will die. By trying to understand your own death, you will be able to give better care to people who are at the end of their lives.

Think of these terms as steps in the process of resolving grief. The person experiencing the loss can go from one stage (or step) to another and then move back up or down the stages. There is no exact formula or prescription to follow because people are individuals and manage their grief in very personalized ways. Nurses need to allow that type of independent grieving.

Denial

When a catastrophic loss occurs, a person's psyche has difficulty accepting it. Consider a young mother who leaves her aging and confused mom outside for "only a moment" while she goes in the house to get her baby. When the young

mother comes out of the house, her beautiful, loving mother has wandered out into the street, is hit by a car, and eventually dies in the hospital. Some denial behaviors are shock, praying for it to not be true, walking about, or standing and saying, "No, not Mom" over and over again.

Denial is the psyche's way of protecting itself from the harsh, bitter truth. It is as if the mother were wrapped up in a soft, protective cocoon. This psychological protection is there until the person's psyche can deal with the loss. You have heard of people who "were in a daze" during the funeral of a loved one. That is denial. There is no reason to try to force people out of denial. They will move to the next stage when they are able. During this time, people need to be protected from neglect, injury, and financial abuse. Family members need to understand this stage of the grief process and be willing to take care of other children, prepare meals, and protect the grieving person.

Anger

Once the psyche has developed the strength to face the situation, it comes out in a way that tends to keep people away, which saves the person a great deal of energy. What else does it do? This is the one time anger should be encouraged in a person and supported as a healthy behavior when it occurs. Did you think of some of the advantages of the grieving person showing anger?

Anger demonstrates an awareness of the loss and its consequences. This is one step toward adjusting to the loss. It is also an outlet for the outrage the person feels. Assist the grieving person not to hurt himself or herself or others with the anger. Again, the family needs to understand the advantages of the anger so they can accept what is happening and support the behaviors that occur.

CRITICALLY EXAMINE THE FOLLOWING:

List three reasons why anger is a healthy behavior in the person who is experiencing grief:

1.
2.
3.

I will share my answers with you. Perhaps you thought of some reasons that did not occur to me. Compare your list with mine, and come to class prepared to share your thinking.

1. It means the psyche is healthier because the person is no longer in denial.
2. It keeps the people away who say things like: "You'll always have your memories of your Mom" or "She is at peace now." Comments like these disrespect the loss and the grief being experienced. People who make such comments often are not comfortable with anger. Their purpose is to "make everything all right," which is not congruent with angry feelings.
3. It is an outlet for the normal frustration one feels when confronted with a catastrophic loss.

Bargaining

The anger is as if the psyche wants to "scare away" the bad thing that has occurred. However, as we know, that does not work. Once the grieving person realizes that the "bad thing" will not go away, people often turn to God or other supernal powers. This behavior often is demonstrated by bargaining.

Bargaining is seen as something like prayers to God stating that the person will donate a great deal of money to a charitable organization, will never sin again, or will actively do good for others. The thinking is that if one trades something of value, like goodness, with God, then God will perform a miracle. This is very heartbreaking for family and friends. Many say they prefer anger over the wrenching episodes of bargaining. The negotiation with God is the final chance to change the situation. If God cannot "fix things," then no one can. This time in the grieving process requires both patience and gentleness. People are often exhausted in their efforts to support the grieving person. They do not have much more to give. Yet, more is asked of them. When you teach families about the bargaining stage, assure them that this is often near the end. Praise them for staying with the grieving person throughout the entire experience. Try to give them strength and the courage to see the experience to its conclusion.

Not everyone believes in God or a higher power. Work with grieving people in whatever way they are bargaining. The principles are the same for all forms of grief bargaining.

Depression

Depression never is an easy condition. But in the grieving process, it definitely shows progress. When the grieving person is depressed, it means that the individual does not accept the loss but

accepts the fact that nothing can change it. The denial, anger, and bargaining did not work. It makes sense that the grieving person would be depressed.

As with all forms of depression, actively assess for suicidal thinking. If you identify it, keep someone with the grieving person and contact the registered nurse (RN). Suicide is a preventable outcome, so be sensitive to its possibility. Depressed people cry, they sleep a great deal, and they have low energy. Teach this to the family members. Ask them to once again support the grieving person through this last hurtle to acceptance.

Depressed people do not need to be told "everything is all right." For them nothing will ever be all right again. They need quiet love and support while they find a way to continue on with their lives.

Acceptance

Once the grieving person reaches acceptance, there is a sense of relief. The individual still is searching for life structure without the loved one who died. The point is that the grief process is over and living has started again. The grieving person still may call out the name of the deceased person, be found crying after finding a piece of clothing of the loved one, or just sit quietly contemplating the life of the person who died. This is normal.

The grieving process is difficult for the person experiencing the loss and the family members. The management of the experience can be improved when you, the LPN, know the stages of grief and readily share them with appropriate people.

This woman has accepted that she is going to die. As is common with so many people, she does not want to interact with the world anymore. She is done; she has accepted the fact that she is close to death. Notice that she has her call light in hand "just in case." She also must have slowing circulation, as indicated by the afghan, blanket, and oxygen.

QUALITIES FOR A NURSE TO BE A PROVIDER OF END-OF-LIFE CARE

Many nurses have difficulty talking about EOL matters with patients. That makes it necessary for you to learn new skills and acquire new knowledge in order to improve the care of older adults who require palliative care (Box 9.2). Some of the new knowledge you need may be communication skills and knowledge of resources and available services.

BOX 9.2 Qualities to Develop Before Working with Dying People

- Motivation
- Emotional maturity. Death is serious and individualized and happens only once for each person.
- Tolerance and empathy. Nothing goes according to a formula or procedure. This is true of both the dying process and people.
- Communication skills. You need the ability to empathize with all people involved in the death experience.
- Confidentiality. A sense of discretion and respect for patient and family privacy is an essential characteristic.
- Flexibility. Someone who is willing to do what patients and their families need, not necessarily what you think is best.
- Dependability. Dependability turns into trust.
- Good listening skills. Listening is a wonderful gift you can give to someone who may be feeling frightened and alone.
- Sense of humor. Humor in difficult situations can be a plus. It is okay to giggle with patients and families.

You, as a nurse, have a tremendous potential to change the care of dying older adults and the support given to their families. It is critical that you understand human nature as you give care to people who are dying. You need to be able to identify the stages of grief, for example, and translate those stages to family members. Because the stages are expressed individually by different people, you need to be able to comprehend the impact on specific individuals, or understand the nature of the people involved. Another critical aspect of what you need to know in order to be an effective palliative nurse is the ability to identify and meet the holistic needs of individuals, families, and communities.

Tolerance and Empathy

Each individual who you come across in your work is unique and different. This means that you, as the care provider, will need to gain an understanding of people and their differences. This requires that you learn to become tolerant and empathetic to those with whom you associate. Synonyms of tolerance are "compassion," "endurance," "patience," "impartiality," and "open-mindedness." Synonyms of empathy are "understanding," "sympathetic," "identifying with the patient," and "providing insight and feeling in your care."

In order to provide appropriate tolerance and empathy, you must strive to provide an environment that meets the physical, emotional, social, and spiritual needs of each dying person.

Sense of Humor

Having a sense of humor with the dying person is a simple way to assist in relieving, reducing, and soothing the symptoms of a disease. Of course, you must know the personality and mood of the older adult in your care before making jokes about the situation. You must make sure that it is done at the right time and in the right situation. Please think about a time and place when you were suffering and laughter helped with the cure.

Communication

Communication seems to be the key to most situations. When it comes to death and dying, this

FOCUSED LEARNING CHART

Understanding tolerance and empathy

A care provider's goal is to understand the needs of people experiencing an end-of-life situation.

Tolerance	Empathy
Compassion	Understanding
Impartiality	Identify with person
Endurance	Sympathetic
Patience	Be insightful
Open-mindedness	Allow self to feel situation

situation has the possibility of being discussed in a context of hope, meaning, and opportunity. With strong communication skills, uncertainty is replaced with certainty, hopelessness is replaced with faith, and despair is replaced with empowerment.

Good Listening Skills

Being a good listener is the greatest skill any nurse can have. Take time to listen to the older adults' stories about their children and grandchildren, stories about falling in love, and possibly stories about losing their loved ones. Older people enjoy sharing their life experiences. It is important to remember when talking to an older person that you need to speak in a voice that he or she can hear. Move in close to the person, touch his or her shoulder, smile, and really listen to what he or she has to share.

To listen, you must be fully present and attentive to the other person. You are not listening if you:

- Are in a hurry
- Are thinking about yourself
- Interrupt
- Ask the same question twice
- Do not ask any questions
- Assume that you know what the other person is going to say

The good listener is one who does not think about what to say until after the other person has finished speaking.

CULTURAL ACCOUNTABILITY

In addition to the above-mentioned qualities that are needed to care for those nearing the end of their lives, it also is important to be familiar with the cultural diversities of the older adults in your care. A person's culture will influence the decision-making process toward various treatments.

In many cultures, a family's interdependence, harmony, duty, and obligation to a "senior" family member are quite obvious. Some cultures believe that it is inappropriate to tell someone that they are dying because it will create a sense of hopelessness and sadness. Some cultures believe that a sick individual should not be allowed to make any decisions about their EOL care but rather have the family or the eldest son make those decisions. Cultural needs should be addressed immediately on admission to any facility in order for you, as the LPN, to be aware of the family's and the individual's diverse needs.

END-OF-LIFE DECISIONS

As a care provider for those individuals who are nearing the end of their lives, it is critical that you recognize the importance of being aware of the decisions a person has made about his or her current and future medical care and to honor his or her preferences. According to a study report in the *RN* magazine (August, 2000), 25% of nurses have seen other health-care providers deliberately disregard a patient's advance directive, such as a durable power of attorney, a living will, or a health-care proxy document. Therefore, to help protect the patients' right to make his or her own health-care choices and to avoid getting yourself or your facility into legal trouble, you need to understand the various laws, your individual duties to the person dying, and the individual wishes of that person.

Gaining an understanding of all of the issues surrounding EOL care is a daunting task. You will run into challenges about knowledge and skills in assessing and managing pain in cognitively impaired older adults. You will experience frustration about physicians being unwilling to consider a nurse's assessment and recommendations. You will find it difficult to deal with the strong emotional attachments that are formed with older adults at the EOL stage. These are all reasons to learn and study EOL issues.

ADVANCE DIRECTIVES

One of the most difficult situations health-care professionals face when caring for older people is how to assist patients and families trying to make decisions about whether to start, continue, or stop life-sustaining treatments. Elderly people, as a group, comprise 73% of deaths each year, making EOL treatment decisions far more prevalent among them. Documents that assist the health-care team in making such complex decisions are advance directives. There are two types of advance directive documents available: the durable power of attorney for health care (also called health-care proxy) and living wills.

The health-care proxy has the authority to make health-care decisions if the individual loses the ability to make decisions or communicate personal wishes (Box 9.3). The proxy can make decisions as the need arises and is not restricted to a decision that was made previously without knowledge of the current situation.

The other type of advanced directive is known as a living will (see Appendix A). This is

BOX 9.3 Health-Care Proxy

I, ________________, of ________________, this day of ________________, being of sound mind, willingly and voluntarily appoint ________________ as my agent and attorney-in-fact, without substitution. This gives my proxy lawful authority to execute a directive on my behalf under Section 75-2-1105, governing the care and treatment to be administered to or to be withheld from me at any time after I incur an injury, disease, or illness that renders me unable to give current directions to attending physicians and other providers of medical services.

I have carefully selected my above-named agent with confidence in the belief that this person's familiarity with my desires, beliefs, and attitudes will result in directions to attending physicians and providers of medical services that would probably be the same as I would give if able to do so.

This power of attorney will remain in effect from the time my attending physician certifies that I have incurred a physical or mental condition rendering me unable to give current directions to attending physicians and other providers of medical services as to my care and treatment.

Signature of Principal ______________________
State of ____________________________________
County of __________________________________
On the ________________ day of
________________, ________________,
personally appeared before me,
________________, who duly acknowledged to me that he/she has read and fully understands the foregoing power of attorney, executed the same of his/her own volition and for the purposes set forth, and that he/she was acting under no constraint or undue influence whatsoever.

Notary Public _____________________________
My commission expires: ____________________
Residing at: _______________________________

a legal document that allows individuals to share their opinions and wishes regarding their death. The legal statutes that govern the use of advance directives vary from state to state. You, as a licensed nurse, must clearly understand the advance directive laws where you work.

Advance directives came into use when legal cases such as those involving Karen Ann Quinlan and Nancy Cruzan surfaced in the judicial system. Both were situations in which a young woman was kept alive on life-support equipment but had no quality of life at the time and no possibility of improvement in the future. In both cases, the family members decided to remove the life-support equipment and allow their daughters to die. In both cases, the health-care facility refused to remove the equipment, and the parents sued.

In 1989, the U.S. Supreme Court ruled that not even the family should make decisions for an incompetent patient without "clear and convincing evidence" that indicated the person's desire was to die if incompetent. In a five-to-four decision by the U.S. Supreme Court, the following rights were listed for states (*Cruzan v. Director*, 1990):

- The state has a right to assert an unqualified interest in the preservation of human life.
- A choice between life and death is a very personal matter.
- Abuse can occur when incompetent patients do not have loved ones available to serve as surrogate decision makers.

After this court ruling, the majority of state legal systems began requiring an advanced directive on admission to health-care facilities to predetermine the actions that should be taken if a patient became incompetent. As an LPN, you need to determine what the law is in your state regarding advance directives. If they are required on admission, you need to know where they are and what they say regarding your clients. It is the role of the nurse to be an advocate for the people to whom care is given. Knowledge about the advance directive and the state laws that govern its use is very important to you.

When one is working with advance directives, there is more involved than just knowing the law. The law represents legal responsibilities. These are serious responsibilities and should not be ignored; however, as with every issue, there is also an ethical component. It is the ethical responsibility of every nurse to be sure that the person signing the advance directive is not coerced and has full understanding of what is being signed. In most states, the nurse is not allowed to witness this document. It is important that outsiders who would not wield undue influence act as witnesses.

These three friends spent several evenings together to gather information, discuss it, and, as a result, complete their living wills and durable power of attorney forms. None of them are sick, but all three of them feel it is important to have the forms completed and to discuss their wishes with their family members.

Whenever you are giving care to a patient who is in a terminal condition, it is important that you listen as the person talks and give them honest answers to their questions. If someone feels concern over what was written in the advanced directive, you should bring that to the attention of the nurse manager. The instructions for completing a living will are provided in the Appendix of this book. In all situations, it is necessary to keep in mind the primary objective of the advanced directive: to follow the wishes of the person who wrote it.

DURABLE POWER OF ATTORNEY

Durable power of attorney is another legal document about which you need to know. Durable power of attorney is used in cases in which an individual is incompetent. The law allows a competent individual to make all (health-care, financial, disposition of personal items) legal decisions for the incompetent person. The classic example is someone with AD. Before persons with AD become incompetent, they can identify someone they trust and who knows their wishes and assign them durable power of attorney. Then when the dementia increases, the individual's wishes are met.

Not everyone knows that they will eventually become incompetent. When a person becomes incompetent because of, for example, undiagnosed AD or a car accident that causes brain damage, the family may seek a durable power of attorney and the older person will be unaware of what is happening. The forms for durable power of attorney need to come from a qualified attorney to ensure their legality in the state where the older adult resides.

To ensure protection of the older person's rights, you, as the nurse, need to recommend to families and patients that they seek legal council. Once a durable power of attorney has been established, you have a responsibility to identify the type of decision-making authority each person possesses.

CRITICALLY EXAMINE THE FOLLOWING:

Have you considered what you would like written in your living will? Do you want to be pain free? What about antibiotics? A ventilator? Food? Photocopy the living will in this chapter and complete it for yourself. Add the details that are important to you and be prepared to submit your living will to the faculty person or discuss it in class.

IMMINENT SIGNS OF DEATH

It is important for you, as the LPN, to know the imminent signs of death. It is easy to assist someone in their preparation to die if they have been diagnosed as terminally ill. A terminal diagnosis allows individuals to realign their priorities, mend various relationships, and say goodbye to loved ones. In addition, a terminal diagnosis allows staff the opportunity to prioritize their care and assist persons in meeting their goals and achieving a peaceful life closure.

POINT OF INTEREST

Even after a person has gone through the difficult process of writing a living will, that person's family members can change it at any time. This is a point of frustration for many health-care providers, especially nurses. Consider the frustration it causes for the patient and other family members as well.

When death is near, bodily functions will slow and certain signs and symptoms will occur, including the following:

- Rapid, weak pulse
- Decline in blood pressure
- Dyspnea and periods of apnea
- Slower or no pupil response to light
- Profuse perspiration
- Cold extremities
- Bladder and bowel incontinence
- Pallor and mottling of skin
- Loss of hearing

Remember that one of the last senses lost is that of hearing.

One clear sign of imminent death is that of TR. Reports indicate that more than three-fourths of dying patients experience this condition. TR happens in the last hours of life. It is the spiraling down of physiological functions and can be very distressing to the older adult who is dying and family and staff members. At this time so close to EOL, there is a crucial need for careful and thoughtful intervention to provide the dying person with comfort and to be able to control his or her symptoms (Forbes, 2001).

If the dying person in your care has not been diagnosed with a terminal illness, various assessments or interviews can occur at the bedside in order to be prepared to assist the individual. Formal assessments will be done by the assigned RN; however, you, as the LPN, are giving the bedside care and need to be prepared to respond to questions that are asked following an official assessment. The goals of your assessment are to be able to gain a clear understanding of the older persons' experiences with their illnesses. In addition, you need to be able to identify distressing symptoms that need management, convey your concern and empathy to the persons involved, and evaluate any risk that may be expressed due to current distress or feelings. It is important for you to take immediate action when a problem is detected.

To begin an appropriate assessment or interview with the dying person, you should ask various questions about discouragement or distress. For example, "What hurts or distresses you most, and how can I help?" Another good opening question to ask is what the person worries about most when the illness is at its worst and what has been most difficult throughout the process. Your assessment should review the older adult's various abilities to cope with stress and anxiety. For example, "During periods of discouragement, some people wish all this suffering were over. Have you felt this way? Tell me about it." "You seem to feel as if life is not worth living. Are you thinking of doing something to hasten your death? Tell me about it." "No one thinks about ending their life without a reason; tell me how you are feeling" (Engber, 2005).

ASSISTED SUICIDE

Approximately 2% to 5% of terminally ill people choose to hasten their own deaths (Engber, 2005). The reasons for this include poor quality of life and failed requests for treatment withdrawal. People have the right to refuse treat-

CRITICALLY EXAMINE THE FOLLOWING:

Please comment on the questions posed below. They are questions that require you to ponder their significance. Perhaps you do not believe that you have enough experience to make such decisions. Remember that you will soon be part of the nursing workforce, and the need to make some of these decisions will come to you. This exercise is an effort to prepare you for them. Please be prepared to discuss your decisions in class.

How do you feel about assisted suicide?
Would you be a part of such a decision?
Would you work for a facility that supported "slow codes" by not getting to a patient on time or a facility that openly participated in assisted suicide?
These are questions that you will be confronted with as you continue to provide care to patients nearing the end of their lives.

ments, food, or fluids if they wish to do so. The Patient's or Resident's Bill of Rights assures people of that right (see Chapter 4). To make a rational decision about ending life, the older adult needs a clear mind, communication with others, knowledge of alternative treatments, and an understanding of the long-term consequences of actions. The difficulty for most health-care providers is to differentiate between a person's refusal of life-sustaining treatments and providing support to a dying person.

In Oregon, terminally ill people have the right to hasten their deaths by physician-assisted suicide (PAS). By the second year PAS was legal in Oregon, 27 people chose this option. Their median age was 71, 16 were men, 26 were white, and 12 were married (Engber, 2005).

CONCLUSION

Now that you have read this chapter, I hope you will understand the importance of giving meaningful EOL care to all people but especially to older adults. Dying is a unique experience for everyone. The hallmark of a professional nurse is one who can support the dying person and the family in their personal uniqueness of that special event.

I admire your desire and passion for working with older adults. They are at a fragile time in their lives when they are in need of people who care about them. You are one of those individuals, the LPN who will provide older adults who are dying with positive EOL experiences.

CASE STUDY

Please take some time to focus on the following case study situation. Let us say that you have recently moved to the state of Oregon, where assisted suicide has been legalized. You were surprised on your first day when a patient on the unit was going to receive some assistance in her own suicide.

1. Before you moved to Oregon, what resources did you use to learn about the legality, rules, and regulations related to assisted suicide?
2. Every nurse has a right to his or her personal ethical framework of practice. What does your personal framework of practice dictate about what you will do regarding the woman who is assigned to you for assisted suicide?

Solution

1. If I were moving to Oregon and had the potential of working with assisted suicide patients, I would initially contact the state board of nursing for specific Oregon laws. I would also contact the hospital where I would be working and have them send me a packet on their specific protocols regarding assisted suicide. I also may spend some time on the Internet just to see what information is available about the specific topic. You may have additional ideas about gathering information. Please list them and feel free to discuss your ideas with your class.
2. I do not know how you would respond to this situation. The answer to this question is based on individual standards and beliefs. Take some time to ponder thoughtfully giving this kind of nursing care in terms of your personal ethical framework. Consider your knowledge and acceptance of the death and dying process and your personal reaction to assisted suicide as a health-care principle, and explain your responses in writing. Follow through by sharing those ideas in class in a way you feel most comfortable.

STUDY QUESTIONS

Select the best answer to each question.

1. When an elderly client experiences TR, he or she will display symptoms such as:

a. Involuntary muscle twitching or jerks

b. Extreme fatigue

c. A sudden energy for life

d. A calm affect causing the body to have no reactions

2. Palliative care is described as:

a. The type of care aimed at a cure or active treatment of a certain medical condition

b. The type of care that provides comfort and management of symptoms

c. The type of care that allows the family to make all of the decisions

d. The type of care that provides bereavement support to the family for 1 year after death

3. The stages of grief in order are:

a. Denial, anger, bargaining, depression, acceptance

b. Denial, communicate, pain, sadness, joy

c. Denial, affection, bartering, acceptance

d. Denial, anger, acceptance, joy, peace

4. When speaking to an elderly, dying patient, it is important to:

a. Never talk to the patient, but rather communicate all decisions through family members

b. Communicate clearly, possibly with a sense of humor, in a manner that the patient will be able to hear what is being said

c. Explain your frustrations with the patient and his or her care in front of the patient and the family

d. Be sympathetic rather than empathetic with the patient and the family

5. Four of the eight signs of imminent death are:

a. Increased blood pressure, warm extremities, bowel and bladder incontinence, and pallor and mottling of the skin

b. Loss of hearing, dyspnea and periods of apnea, and increased bowel and bladder control

c. Increased sexual drive, slow pupil response to light, increased awareness of surroundings, and more communicative

d. Rapid weak pulse, profuse perspiration, loss of hearing, and decline in blood pressure

10 Environments of Care

Kathleen R. Culliton

Learning Objectives

After completing this chapter, the student will be able to:

1. Discuss the role of the licensed practical nurse (LPN) as an environmental manager.
2. Describe at least two components of the physical environment that nurses need to consider.
3. Discuss the aspects included in a climate of caring.
4. Identify at least four settings in which nursing care for older adults is provided.
5. Describe how nurses, in various care settings, meet the needs of older adults.
6. Discuss relocation stress and ways in which a nurse can help an older person adjust to a new environment.

INTRODUCTION

One of the most important tasks for a nurse is to manage the patient-care environment. Florence Nightingale saved the lives of hundreds of soldiers during the Crimean War simply by cleaning the wards, opening the windows, and providing the soldiers with daily hygiene. Miss Nightingale and her nurses also provided direct, caring, "hands-on" nursing to the soldiers under their care. Before Miss Nightingale's interventions, there were more soldiers dying in the hospitals because of the lack of hygienic conditions than there were dying in the actual battles. Improved health for the men fighting the Crimean War required both environmental management and quality nursing care.

The role of a nurse is not that of a housekeeper but that of an environmental manager. To be effective caregivers, nurses must be aware of the influence of environment on the health and functioning of the patient. Nurses are responsible for the manipulation of environmental conditions to improve patient care. In Miss Nightingale's era, environmental management included such tasks as opening windows to clear the patient's room of stale, potentially illness-producing air; managing raw sewage because plumbing was not available; and controlling the population of mice and rats in the hospital. Modern nurses also must understand the effect that the environment can have in enhancing or impeding the progress and functioning of older adults.

This nursing home resident with dementia and generalized weakness has found herself in a climate of caring. Notice how her clothes match and appear well cared for? Her hair is nicely done, and she is smiling. The LPN kneeling next to her demonstrates the basic symbols of caring. First, she got down to the older woman's wheelchair level so she could be seen and heard. She is reaching out to her, although she comes short of touching her. She looks well groomed, and she also is smiling. They seem to care about each other.

ENVIRONMENTAL MANAGEMENT

Providing care to older adults must include environmental management. Assessment of the environment is the first step. As a licensed practical nurse (LPN), you need to examine the total environment starting with where the older person is living. Remember that there are multiple environments of care where an older adult might live. If the person lives at home, you may want to ask: What is the neighborhood like? Is it a safe neighborhood for an older person? Is there a security system in the home or building?

If the older adult lives in a nursing home or in a hospital, you may want to ask: What is the staffing ratio? Is the environment clean and free of odor? Is there a place where the older adult can socialize with family and friends?

If the older adult lives in an assisted living environment, you may want to ask: How far is it to the dining room? Are there activities that interest the person? Is there a nurse available 24 hours a day?

Assessment of the physical environment includes all aspects of the older adult's living situation that can be seen, heard, touched, or smelled. Each of the physical items in the environment can either contribute to or detract from the optimal functioning of the older person. A room that is too hot may make the older person tired, lethargic, and unwilling to participate in personal-care activities. A room that is too cold may likewise result in lack of activity because the older person is unwilling to get out of bed or to come out from under the cover of an afghan.

A critical question to ask throughout the assessment of the physical environment is how well the older person functions in the living areas. Is the environment as barrier-free as possible? Can the older person walk unencumbered or wheel a wheelchair through the entire setting?

POINT OF INTEREST

People do everything better when they are in a caring environment. Remember Dr. Jean Watson's theory of Human Caring? She has spent her career researching and documenting the significance of caring in our lives. When a nurse and a patient connect in a caring way, Dr. Watson refers to it as "Transpersonal Caring." This happens when you, as the nurse, relate to the older adult in a holistic manner that is based on caring or, in other words, you care about every aspect of the person's life, including his or her environment.

Are there features in the environment to promote physical function? These may include grab bars in the bathroom by the commode, shower, or bathtub seat and handrails by stairs. When assessing how the older person carries out activities of daily living, be aware of possible alterations that may improve function. Lowering a mirror or moving a storage area below shoulder level may improve both safety and convenience. The risk of falling can be decreased with adequate room lighting and the use of night-lights. The room where the older person reads should have high-intensity illumination.

Climate of Caring

Another important part of the environmental assessment is evaluating the climate of caring. The climate of caring involves the people in the environment and the environmental tone and atmosphere. The people in an older person's living environment may include family members, neighbors, friends, and paid caregivers.

The people in an environment are extremely important to the older adult's potential for improvement and optimal function. Families, staff, and visitors can be encouraging and uplifting or depressing and discouraging. A climate of caring includes persons who present a positive but realistic outlook. The older adult's personal space is respected in a caring climate. Such an atmosphere also affords opportunities for privacy, encourages activity and involvement, and facilitates independence.

Safety

In any setting, safety for the older person is a primary concern. Are there any environmental hazards, such as frayed extension cords, malfunctioning equipment, or broken furniture? Falls among elderly people are common, and not all of them can be avoided. However, one thing that can be done is to keep the environment free of fall risks. Such risks include clutter, throw rugs, wheelchair leg rests, and poorly fitting shoes or slippers. Sometimes, a pet can be a fall risk as well.

Stimulation and Personalization

Opinions vary on whether environments for older adults with cognitive impairment should be very stark and nonstimulating or should contain eye-catching and stimulating components. More important, however, is a personalized environment for the older person. Personalized items help older adults relate to the environment and maintain a sense of identity. A special picture can be displayed in the hospital room as well as in the nursing home. In some settings, such as nursing homes and retirement communities, the entire bedroom or apartment can be personalized with cherished furniture and decorations.

A climate of caring facilitates optimal independence and autonomy for each older person living in the setting. There are times when the routines and regulations necessary to operate a large health-care facility, such as a hospital or nursing home, cannot accommodate the individual needs or desires of older adults. The nurse must assess, however, which rules and routines are absolutely necessary and which are the result of a controlling institution or individual staff member. Although a nursing home may need to serve meals at particular times because of regulations and staffing, the rule that all residents must be dressed for breakfast may be unnecessary. This rule does not allow for each resident to take the time to personally do as much of the dressing as possible. Such a rule can force a resident to be dependent on staff for dressing. A climate of caring provides multiple opportunities for individual choice in the environment and encourages the older person to function as independently as possible.

Personal Space and Territoriality

Personal space and territory are important to every human being. Personal space is the area

around a person. Some individuals define their personal space very close to their bodies, whereas others define it as a broader area. It is viewed as an intrusion for someone to invade another person's personal space. In providing nursing care, nurses must frequently invade the personal space of the patient. Nurses must be conscious, however, that they do not do so unnecessarily.

Territory is the space used by a person and seen as owned by the person. Think about a current class. Do you, as students, tend to sit in the same seats during each class session? Technically, you and your classmates do not own the seats, but the tendency exists to define a territory and return to it habitually. The seating arrangement in a dining room in a nursing home or retirement community is frequently consistent for each meal. This tends to occur whether or not seats are assigned. Individuals will defend their territory if an unwanted person intrudes. An older person who has a favorite chair at home or in the nursing home may fiercely defend it from others.

Privacy

All human beings need time to be alone. People need to have opportunities for privacy as well as for human contact. At times, it is difficult for the older person living in a health-care setting to find opportunities for privacy. Many hospitals and nursing homes have multiple-occupancy rooms, so that the patient may never have a chance to be truly alone. As a nurse working with older persons in a congregate setting, you must be aware of the older person's needs for privacy. You should respect that right to privacy by knocking on the door before entering, pulling cubicle curtains during care, and arranging private time for the older adult.

Activity and Involvement

As a person ages, the number of social roles fulfilled tends to diminish. An older woman who was once a daughter, a mother, a wife, a neighbor, an accountant, a Scout leader, and a bridge player may hold none of these social roles at 90 years of age. Because of aging and disability, these roles may no longer be possible. Involvement with others, however, is still a need. A climate of caring affords each individual multiple and diverse opportunities for activity and involvement with others.

As a nurse working with older people in multiple health-care settings, you can help to provide important opportunities for active involvement. It is important to find out the older person's prior social roles, particularly the ones he or she most enjoyed. Activities that include tasks associated with these roles should be encouraged. It also is important to create opportunities for social interaction. By introducing the older person to others in the setting who may share similar interests and, for example, by arranging seating for natural conversation rather than against walls, the nurse can be instrumental in encouraging social exchanges.

This grandma and grandpa are both past 80 years of age and have lived in their current home since they were a young married couple. They have made it clear to their children that they do not want to leave their home if they become ill. They have a large extended family, and they want to be around them until they die. Many older people have a strong aversion to leaving their homes, which is why home care is such a valuable resource to older adults.

RELOCATION TRAUMA

Moving from one environment to another is stressful. Anyone who has ever moved from one house to another or from one city to another can appreciate the stress of relocation. It takes time to adjust to and become familiar with a new setting. During times of crisis or illness, one has less energy available to deal constructively with stress. Older adults are particularly susceptible to being overcome with the stress of relocation. Such stress also is referred to as transitional stress. This refers specifically to the emotional stress that occurs during the time a person is changing from one phase of life to another.

Older people use a considerable amount of energy coping with chronic illness and disabili-

ties. The onset of an acute illness or some other major crisis requires additional coping. If the crisis or illness results in the need to move to another living situation, the older person's coping abilities may be exhausted. A crisis, superimposed on the day-to-day stresses of living with disability and dysfunction, frequently leaves the older person with little coping reserve to deal with the stress of relocation and transition. When the stress is overwhelming and the older person is unable to cope with the situation, there will be signs of decompensation. These may include disorientation, agitation, acting out, and hallucinations. It is not uncommon for an older adult, newly admitted to any of the health-care settings described in this chapter, to exhibit some of these signs. Thus, the movement from one environment to another can be extremely disruptive to the older adult; this disruption has been termed *relocation trauma*.

In addition to identifying and understanding relocation trauma, the nurse can help to relieve relocation stress. It is important to understand that relocation trauma is temporary, and the behavioral signs of decompensation should diminish as the older person becomes familiar with the new environment. You can, however, accelerate the process of adjustment.

Limit stimulation and the introduction of new activities and people on the older person's first day in the setting. Orient the older person to the environment slowly so he or she can incorporate new areas and routines gradually. On the first day, introduce only people and places that are absolutely necessary. For example, placing an older person in the dining room of a nursing home with 20 other residents shortly after admission may be overwhelming.

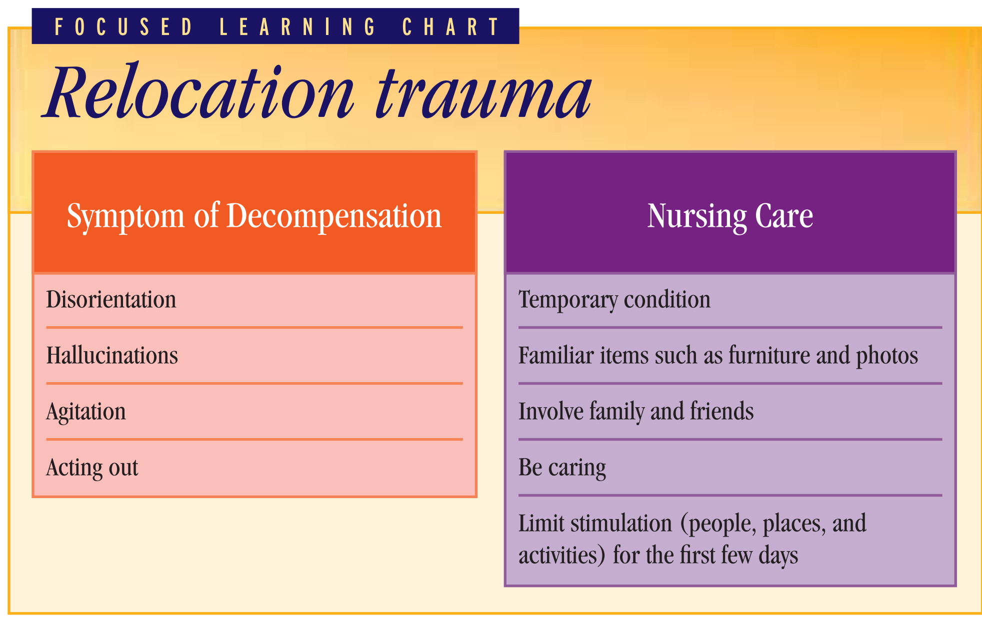
Look for ways to provide links between the old environment and the new one. The more familiar the new environment is to the older person, the easier the transition will be. Bringing favorite furniture and objects, such as pictures, to the new setting will increase its familiarity to the older person. Including the older person in planning for the move is ideal. This is not always possible, however, if the move occurs because of an acute illness. If it can be arranged, involve the older person in selecting the items to take to the new location.

SETTINGS OF CARE

There are a variety of settings in which older persons may receive health-care services. This chapter does not discuss all such settings or services but reviews some of the most commonly used settings of care.

Day Care

A number of communities now have adult day-care centers available to provide supervised activities for older adults. Day treatment centers for older people with psychiatric problems and



FOCUSED LEARNING CHART

Relocation trauma

Symptom of Decompensation	Nursing Care
Disorientation	Temporary condition
Hallucinations	Familiar items such as furniture and photos
Agitation	Involve family and friends
Acting out	Be caring
	Limit stimulation (people, places, and activities) for the first few days

CRITICALLY EXAMINE THE FOLLOWING:

Review the following situation and devise a plan that would have minimized Mrs. G's relocation trauma. Be prepared to share your ideas in class.

Mrs. G. was moving from her home of 40 years to a retirement community. She had some short-term memory problems and walked with a slow gait. To expedite the move, Mrs. G's son packed for her and sorted through all of her belongings to identify what items to take and what to give away. Because many of her things were very old and worn, her son decided to purchase all new furniture and decorations for her new apartment. The new apartment looked beautiful. After moving, Mrs. G. became extremely disoriented and paranoid, and she accused everyone of stealing her belongings. As the nurse in the retirement community, what would you have taught Mrs. G's son about preparing his mother for relocation?

day hospitals for older persons with considerable physical disability are available in many localities. Day treatment centers and day hospitals focus on a particular type of older person and provide specific services to meet their physical and psychiatric needs. Many day-care centers provide transportation for the older person to and from the center. Fees for day care may be charged on a sliding scale, according to the ability of the older adult to pay. Few insurance policies, including Medicare and Medicaid, cover the cost of day care. Generally, the older person or the family must pay for these services personally.

A typical day in this care setting includes planned activities such as group discussion, current events, exercise, snacks, and lunch. Volunteers often visit a center to speak on community affairs or health-promotion topics or to present entertainment programs that encourage group participation. Many centers have activity directors who plan and schedule events that are appealing, offer a variety of choices for the older adult, and promote group interaction.

Nurses working in a day-care setting provide a number of services, according to the needs of the individual. Assessment of the older person's physical, psychological, and emotional functioning is a critical component of the nurse's role in the day-care center. Health teaching to older persons and their families and ways to administer medication also may be included in the nurse's role.

Some older people may need assistance with mobility, toileting, or eating. Other older adults may need help in taking medications, whereas still others simply need encouragement to participate in center activities. Nurses in day-care centers need a solid foundation in gerontological nursing to help them in their daily interactions with older people. Such a foundation ensures that subtle physical or emotional changes are not disregarded or blamed simply on "old age."

Acute illnesses in older adults can present themselves in atypical fashion. The nurse who knows and appreciates normal aging is better prepared to assess subtle changes in older persons and to be alert to the possible implications of these changes. Because so many older adults have chronic illnesses, medication administration often becomes a major responsibility for the nurse in a day-care center. The nurse needs to be skillful at administering medications and needs to know their expected effects and possible side effects. The nurse also can use knowledge of medications to teach the older person and family members the importance of safe and accurate medication use. Do the older adult and the family know which medications are being taken and why they are prescribed? Are the older adult and the family aware of possible side effects, potential drug interactions, and the necessary steps to take if problems are suspected? The nurse, as teacher, has an important role in this setting.

Ongoing assessments of the day-care participants are especially important. Frequent contact with the older person allows nurses to see subtle changes in function that may signal serious underlying physiological problems. The nurse's powers of observation and knowledge of the aging process are critically important in detecting actual or impending illness. Is an older person experiencing mobility changes? Are you seeing decreased participation in formerly active participants? Has an older person had changes in weight or affect? If you are making these types of observations, the next questions becomes, "Why are you seeing these changes?" Good communication skills may uncover a change in family living conditions, changes in medication, or exacerbation of the effects of a chronic illness.

Day-care centers provide opportunities for socializing and staying involved in the world. Many families use day care to give respite to the main caregiver for the older adult. The stresses of caregiving can have a strong effect on the older person, caregiver, and family. Respite allows caregivers some time to attend to their own needs. Grocery shopping, housekeeping,

CRITICALLY EXAMINE THE FOLLOWING:

Read the patient care situation below before reading the author's comments. Ponder what you would do and make some notes. Compare your thinking with that of the author. Be prepared to discuss your thinking in class.

You are the licensed nurse at the Golden Ages Adult Day Care Center. Mrs. Y. attends the center every Monday, Tuesday, and Wednesday until after lunch, when her husband picks her up. This Tuesday you notice, for the second day in a row, that Mrs. Y. has been unsteady when she walks. She stops to rest frequently when moving around the center and has been falling asleep during group activities. These behaviors are unusual because Mrs. Y. normally ambulates well, participates enthusiastically in center activities, and often encourages others to "join the fun." What further assessment do you now want to make?

Author's comments:

Certainly, vital signs will provide some basic information. It also would help to ask Mrs. Y. if she has noticed any changes in the way she feels or functions. When you speak with Mr. Y., you ask him about changes in Mrs. Y.'s routine and medications. He tells you, "She was so upset and restless last weekend, I had to give her one of my sleeping pills to help her calm down and get some rest Sunday night." By using your powers of observation and problem solving, you are able to uncover the need for medication administration teaching for Mr. Y.

socializing with friends, and participating in enjoyable activities for the caregivers can often mean the difference between continued home care versus institutionalization for an older adult. Nurses in day-care centers are able to use their assessment skills to identify the older person's strengths and weaknesses, help elders to continue to participate in daily living activities, and provide information for older persons and their families about community resources.

Although day-care nurses may perform few technical nursing procedures, they use a variety of different nursing skills. Day-care nurses must have particularly strong physical and psychological assessment skills. They also must be adept in communication and teaching. The day-care nurse also must have a thorough knowledge of community resources and be able to refer older persons and their families to appropriate services in the area.

With the increasing awareness and concern about care for people with dementia, there are some programs now available to provide day care specifically for older persons with cognitive impairments. These day programs are designed to give care that takes into account the abilities and safety needs of individuals with Alzheimer's disease or other dementias.

Home Care

Home health-care agencies provide a number of services for older adults in the home. Such agencies provide nursing services, given by licensed nurses and nursing assistants, and therapy services, such as physical, occupational, and speech therapy. Many agencies also provide medical supplies and equipment. Most agencies are licensed and, therefore, eligible for state or federal reimbursement for services. Medicare, Medicaid, and community funding may pay for limited home health-care services if the older person qualifies for such reimbursement.

Home care may be provided on a daily basis or intermittently, according to the needs of the patient. Nursing care provided in the home has become more complex in the past two decades. It is not unusual for people who need help during their recovery to be discharged from the hospital "quicker and sicker." Chronically ill older adults may be receiving home care to avoid frequent hospitalizations.

The LPN in home care works under the instructions of the registered nurse case manager. In the home-health role, the LPN will be assigned basic nursing care, medications administration and teaching, and dressings and wound care and may be asked to spend 4 to 24 hours in the home to provide respite care to the primary caregivers. The LPN often is asked to work with the certified nurse assistant (CNA) in coordinating care for the patient.

A certain amount of creativity is needed in home-care nursing owing to limitations in the type of equipment and supplies that are available. As in other settings, it is helpful for the nurse to be aware of resources available to the older adult and of ways to gain use of those resources. Nurses who choose home-nursing care can expect a variety of older persons and conditions. Caring for older adults in the home can be very rewarding and challenging. Because the home-health nurse generally visits the older person on a less-than-daily basis, patient and family teaching is very important. Teaching may be needed to help the family ensure a safe environment for the older

CRITICALLY EXAMINE THE FOLLOWING:

Read the patient care situation below before reading the author's comments. Ponder what you would do and make some notes. Compare your thinking with that of the author. Be prepared to discuss your thinking in class.

As an LPN for a visiting nurse group, you are assigned Mrs. E. Mrs. E. is 75 years old and lives with her husband in their home. Mrs. E. was just discharged from the hospital following surgery to pin her broken right hip. She is not capable of weight bearing, and the physical therapist is scheduled to visit her at home twice a week. Mrs. E. has mild dementia and frequently forgets that she is not permitted to walk. Her husband, Mr. E., wants to keep her in bed to remind her not to walk. What care do you need to teach Mr. E.?

Author's Comments:

It would be appropriate to talk with Mr. and Mrs. E. about the hazards of immobility and the need for Mrs. E. to be out of bed. Together with the physical therapist, you should teach Mr. E. how to safely transfer his wife in and out of bed and on and off the toilet. With Mr. E., you work out a system to remind Mrs. E. that she cannot walk alone. This may include posted notes and frequent verbal reminders. You also suggest that Mr. E. try to keep his wife in the same room with him as much as possible. Finally, you teach Mr. E. how to do skin checks and observe his wife's bony prominences for signs of redness or breakdown.

adult. Educating older persons and families about fall prevention, medication safety, positioning, and transferring techniques may be needed. A family also may need to learn more complex procedures, such as how to change dressings or give injected medications.

The amount of time spent with older persons is often limited by the nurse's workload and the reimbursement for care given. The nurse is responsible for assessing and documenting care needs and providing prescribed treatments. Good communication skills are important to ensure that all members of the health-care team are aware of the older person's needs and progress.

Community-Based Care

Nursing opportunities are available in a variety of settings not linked to formal institutions such as hospitals or nursing homes. LPNs may provide care for older adults in a community clinic, dialysis center, or physician's office. In these noninstitutional settings, the nurse may practice under the direct supervision of a physician rather than a registered nurse. Practice in these settings often includes assisting with physical examination and treatments, and nurses in these settings are frequently an important source of information and clarification for patients. The nurse uses assessment skills and provides information on resources available in the community to meet the older person's needs. Contact with older adults in these settings may be more infrequent than in other care settings.

Hospice

Hospice care is designed to provide care for the dying patient and the family. A team approach is central to the hospice concept. Team mem-bers include physicians, nurses, social workers, and nursing assistants, as well as other ancillary workers. The goal of hospice is to help dying persons remain at home, if possible, with all the support needed to ensure a "good death." In this case, "good" means that the older person is kept

CRITICALLY EXAMINE THE FOLLOWING:

Read the patient care situation below before reading the author's comments. Ponder what you would do and make some notes. Compare your thinking with that of the author. Be prepared to discuss your thinking in class.

You are the office nurse for Dr. Agnew, a geriatrician. Mr. M., a patient of Dr. Agnew's, is 74 years old and recently retired. On this day, Mr. M. has an appointment with the doctor for a complaint of stomach upset. You notice that Mr. M. is quieter and more withdrawn than usual. What additional assessment would you make?

Author's Comments:

While you are waiting for Dr. Agnew, you ask Mr. M. if he has had any changes in routine lately. In reviewing his sleeping, eating, and activity patterns, you note that he said he is getting up early in the morning and not eating well. In the course of the conversation, Mr. M. tells you that he is tired all of the time and does not feel like living. You suspect depression and share your observations with Dr. Agnew before he examines the patient. Dr. Agnew assesses Mr. M. further and identifies a clinical depression with suicidal thoughts and prescribes an antidepressant. When he is leaving, you ask Mr. M. if he would mind if you call him in a few days to see how he is feeling.

comfortable and able to receive the support of family and loved ones in a famil-iar setting.

Hospice work allows nurses to give direct patient care and develop a close relationship with the patient and family. As in the care settings previously discussed, the nurse's role as a teacher is especially helpful. Most families are not prepared to meet the needs of a dying family member. The hospice nurse can teach family members how to provide for the comfort of their loved one. The nurse also can identify hospice resources available to help families and older persons cope during this extremely demanding time. Nurses who have not worked in a hospice setting may be reluctant to try this type of nursing because all of the clients are terminally ill. Talking with nurses who work in a hospice, however, often shows that the team support and the closeness to patients and families provides a high degree of job satisfaction.

Assisted Living Environments

As people age, there is a tendency to simplify lifestyles and living space. The size of the home needed to provide adequate living space for a family can become more of a burden than an asset to older adults. Assisted living communities are an increasingly popular way for the elderly person to have a home without homeowner responsibilities. Not having yard work and other maintenance tasks associated with a large home relieves a number of burdens. The communities generally offer apartments with community dining and activity areas. They have a nurse, an activity director, CNAs, and housekeepers as well. The goal for these retirement communities is to appeal to a broad range of older adults by offering security and a variety of conveniences and services. Although communities for retirees have been popular for quite a while, assisted living facilities that also provide services for older adults with physical care needs are now increasingly common. Many assisted living complexes have a satellite branch of a home health agency on site.

The goal of assisted living units is to provide older persons with help in performing activities of daily living. Frail older persons who do not require continuous care are able to have help in such activities as meal preparation, grooming and bathing, laundry, and housekeeping. Most assisted living programs require that the older person be ambulatory and fairly independent. Much of the care provided is done by nursing assistants rather than LPNs. The practical nurse in an assisted living program often provides supervision for nursing assistants, medication administration, basic documentation of care given, and assessment of the older person's ability to function.

The assisted living nurse also must use creative talents to ensure that the environment is as homelike as possible. This means the nurse must be flexible in tailoring care to the individual needs of each older adult. The nursing assistant in assisted living may be called a resident assistant and perform many functions that do not relate directly to activities of daily living. Assisted living nurses and nursing assistants often are very involved in activities and social planning for residents.

Some assisted living facilities provide a continuum of care for older adults. They can be admitted to their own apartment, but if their health changes, they can also be admitted to the nursing home for care.

For many older adults, the appeal of a continuing-care retirement center lies in the fact that clients are able to stay in a familiar environment regardless of their health status. Nursing in a continuing-care retirement center offers many opportunities. Home visits, health promotion or screening activities (such as blood pressure mon-

CRITICALLY EXAMINE THE FOLLOWING:

Read the patient care situation below before reading the author's comments. Ponder what you would do and make some notes. Compare your thinking with that of the author. Be prepared to discuss your thinking in class.

You are the staff nurse on a medical unit at Hoover Medical Center. One of your patients is Mrs. O., a 69-year-old, married woman with chronic lung disease. Mrs. O. has been on your unit many times. This time, she and her husband realize that her lungs cannot last much longer, and she expresses that she does not want to be put on a ventilator. Mrs. O. wishes to die at home and tells you that she does not believe she will return to the hospital. She seems to have accepted the idea of death but tells you that she is worried about how her husband will deal with her passing. What suggestions can you offer Mrs. O.?

Author's comments:

Hospice services are available to individuals with terminal illnesses. They are not exclusively for cancer patients. You could talk with Mrs. O. about the services available through the hospice, including grief counseling for her husband before and after she dies. She is very receptive to the idea, and you initiate the appropriate referrals.

itoring clinics), health teaching, and direct bedside care to nursing home patients are a few of the opportunities available to nurses in continuing-care communities. As in assisted living situations, supervisory ability is a valuable asset for the licensed nurse. Retirement community nursing allows nurses to work with older adults who have a variety of needs and abilities. The ability to apply your knowledge of the aging process in this setting helps you enhance the quality of life for the older persons there.

Nursing Homes

The nursing home is an area of practice that has been available to practical nurses for a number of years. With the growing number of frail elders as well as the old-old (85 and older), the need for nursing home care remains high. Some nursing home residents need a full range of nursing care; others may be independent physically but have cognitive changes that require a high degree of supervision to maintain their personal safety. In discussing nursing home care, there are two categories of care defined by federal regulation. The first category is the skilled nursing facility (SNF) and the second is the nursing facility (NF). The nursing facility level was previously referred to as intermediate care.

All nursing homes must be licensed by the state in which they operate. If they wish to receive reimbursement from Medicare or Medicaid for the services provided to residents, they also must meet additional federal requirements and be certified by the federal government. A nursing home may choose not to accept Medicare and Medicaid funding and admit only private-pay residents. Medicare, the federal health insurance program for older and disabled individuals, has two parts that can pay for some services in the nursing home. Most persons over 65 years of age have Medicare Part A. This will pay for up to 100 days of care in an SNF if the older person is being discharged from the hospital after a stay of at least 3 days and requires skilled nursing or therapy services. The requirements for skilled services are very specific; do not assume Medicare will pay for nursing home care after a hospital stay. Medicare Part B is a voluntary insurance program that many older persons purchase. It will pay for some physician and therapy services and some medical equipment, but it does not pay the daily fee for the nursing home.

Medicaid is a welfare program that pays for more than 50% of the nursing home care in this country. Older people must have a very low income to qualify for Medicaid. Many older persons pay for nursing home care privately at the beginning of their stay until they have spent all of their savings. They then can apply for Medicaid. The Medicaid program pays for all medical services in the nursing home.

In an SNF, care is provided by licensed nurses around the clock, and a registered nurse is present at least 8 hours a day, 7 days a week. An SNF unit also offers the services of allied health professionals, such as speech, physical, or occupational therapists, at least 5 days a week. An NF generally does not have the same level of staffing by registered nurses or therapists as an SNF.

Regardless of category, long-term care facilities offer a team approach to meeting the older person's needs over time. Facilities that receive

CRITICALLY EXAMINE THE FOLLOWING:

Read the patient care situation below before reading the author's comments. Ponder what you would do and make some notes. Compare your thinking with that of the author. Be prepared to discuss your thinking in class.

As a center staff nurse, you have been invited to the Evergreen Retirement Center's Monday Morning Coffee Club. The center's activity director has asked you to talk with club members about home safety. Make a list of at least four safety concerns for older adults. What suggestions would you give regarding these concerns in speaking to the Coffee Club Group?

Author's comments:

Your talk might focus on the following areas:

Problem	Solution
1. Unable to read dials and gauges on thermostats	Bright, nonglare lighting to enhance visual ability
2. Potential for falls when walking into the home, while using the toilet, and while getting in and out of the shower	Handrails and hand guards
3. Potential for falls through tripping over items or slipping on unsecured scatter rugs	Uncluttered environment
4. Hazard of living alone and falling or losing consciousness	Daily networking with family or friends

These older women are healthy and able to volunteer at their community's local nursing home. They assist others with making the transition to a new environment and provide many services that otherwise would be unavailable.

CRITICALLY EXAMINE THE FOLLOWING:

Read the patient care situation below before reading the author's comments. Ponder what you would do and make some notes. Compare your thinking with that of the author. Be prepared to discuss your thinking in class.

Mrs. H., an 85-year-old widow, was recently admitted to Sunny Acres Nursing Home after falling in her apartment and breaking a hip. She had surgery for a hip replacement and can walk short distances, but she is unsteady and tires easily. She is underweight, eats poorly, and does not want to be in the nursing home. Her family lives out of town and is not sure she can live on her own any longer. You are the nurse in charge at Sunny Acres. What are some of the most important areas you would want to assess for Mrs. H.?

Author's comments:

Because Mrs. H. was functioning independently before her fall and she does not want to be in the nursing home, the first area you assess is her potential for discharge. What is the prognosis for improvement in function? With what does she need help? Could she return to her own apartment with additional services in the home? Will she fit appropriately into an assisted living program? In addition to discharge planning, your assessment includes mobility function, eating patterns and ability, and evaluation for signs and symptoms of depression.

federal funds are required to offer the services of a social worker as well as an activity director and dietetic consultant. Licensed nurses can gain input from a variety of sources in planning and delivering care by being actively involved with the interdisciplinary health-care team.

The practical nurse, in long-term care, has traditionally been responsible for supervising the nursing assistants who give hands-on care to residents. In many facilities, practical nurses mainly give medications or do treatments.

The nurse interested in long-term care has the opportunity to get to know residents well over a long period of time. Because of the changing needs and physical condition of residents, the long-term care nurse needs very good assessment skills. Skills such as monitoring resident responses to treatments, observing for signs of decreasing function, and assessing subtle changes in condition are used by long-term care nurses on a daily basis. Accurate documentation, skillful use of the nursing process, and good interpersonal skills in working with residents, staff, and family members are valuable tools in long-term care.

Care in a nursing home differs from hospital care in many ways. The skills required of the nursing home nurse are no less challenging and the tasks no less difficult than those of the hospital nurse. The goal for the hospital patient is to cure illness in a brief period of time. For the nursing home resident with multiple chronic conditions, cure is not possible. In the nursing home, care rather than cure is the primary focus. When you make the care given to residents transpersonal caring, the quality of care will improve remarkably.

Acute Care

The final clinical site for working with older adults is the acute care setting. Most admissions to hospitals comprise people aged 65 years and older. In fact, depending on the source used, it is estimated that 40% to 65% of hospital admissions

include older adults. Nursing practice in a hospital setting presents a number of opportunities and challenges. Usually, practical nurses are given responsibility for a set number of patients, and depending on policy, they may perform a variety of procedures. Most patients are hospitalized only briefly. The emphasis on cost containment and federal mandates means that reimbursement for care is often limited to a set period of time. The concept of diagnosis-related groups (DRGs) has allowed reimbursement for hospital treatment to be based on a specific number of hospital days for specific conditions. Hospital-based practice requires all of the basic skills the practical nurse possesses. Acute care also involves brief contact with a large number of patients.

There are several challenges in giving nursing care to older adults in the hospital setting. They include establishing a trusting relationship over a short period of time, dealing with problems secondary to relocation stress or medications, and resisting the tendency to stereotype patients because of their age. In addition, a major challenge for the nurse working with older people in the hospital setting is to create a safe and caring environment that facilitates independence. This must be done while the tasks required for the cure and treatment of the patient are accomplished. Environmental management, as discussed earlier in this chapter, is the most difficult task to accomplish in the hospital setting. The short time frame and the urgency for treatment in many situations do not readily accommodate the slowed responses and abilities of older persons. It is your challenge to slow things down so the older adult can manage them.

As a gerontological nurse, it is important to understand the special needs of older adults. They have difficulty seeing and hearing. They move much slower, and they need clear explanations as to what is happening. Now that you recognize these needs, you have a responsibility. That responsibility is simple; it is to meet the needs of older adults and assist others to slow down and focus on their needs as well.

PRIORITY SETTING 10.1

As with the other chapters, everything mentioned in this chapter is important. The question is what is the priority.

As a novice nurse, your priority should be to gain knowledge and experience in as many care environments as possible. You don't want to work 3 months, then change jobs, work 3 months, and then change jobs. That is not what I mean. But you need to know about the different environments of care in order to:

1. Recognize the best place for you to be employed. It is important to have a satisfying job that allows you to be the most effective caregiver possible.
2. Function most effectively as a member of the health-care team. By knowing about different environments of care, you have more information to share with the team where you are working. This is an important aspect of being a valuable member of the health-care team.

One of the positive things about being a nurse are the many opportunities there are for different types of work.

CRITICALLY EXAMINE THE FOLLOWING:

Read the patient care situation below before reading the author's comments. Ponder what you would do and make some notes. Compare your thinking with that of the author. Be prepared to discuss your thinking in class.

Mr. W. is a 90-year-old resident of a nursing home who was admitted to your floor at Hoover Medical Center for treatment of congestive heart failure. He has a significant dementia, is incontinent of bowel and bladder, and is very unsteady on his feet. As his primary nurse, what can you do to make his hospital environment more like home?

Author's comments:

You call the nursing home nurse and talk with her about Mr. W.'s habits at the nursing home. You also ask her to send to the hospital any familiar items Mr. W. may appreciate having in the hospital. The nurse tells you that Mr. W. likes to stay up late and is accustomed to remaining in bed until after breakfast. You write this routine into the care plan and pass the information on to the night shift.

CONCLUSION

This chapter has provided a brief overview of the nurse's role in environmental management and the various settings where older adults receive health care. Of special significance for the older adult is the opportunity to receive care from a nurse who is familiar with the aging process and uses that knowledge when giving nursing care in any setting.

CASE STUDY

Your neighbor, Sally, asks your advice about finding good care for her 80-year-old grandmother. The grandmother, Mrs. G., lives at home alone in an isolated section outside the city limits. She recently was discharged from the hospital after injuring her right arm in a fall at home. The arm is in a cast, which makes it difficult for Mrs. G. to cook and perform other self-care activities. Your neighbor is unable to visit her grandmother daily because of work and child-care commitments and is worried about her grandmother's ability to remain at home. She wants her grandmother to move in with her for at least a month. However, Mrs. G. insists on staying in her own home. Sally asks for your advice. She ends the conversation with the statement, "I just don't know what else we can do to make sure Grandma is safe and taken care of in her home."

Discussion

Based on the above situation and your readings from this chapter, what advice would you offer Sally?

Solution

Considering Mrs. G.'s location and her desire for independence, Sally could look into home-care services. The assistance with bathing, grooming, and food preparation could be addressed by the home-health agency team, and a plan for home care could be developed. There are no indications that Mrs. G. needs the type of care offered by the other agencies or facilities mentioned in the chapter.

STUDY QUESTIONS

Select the best answer to each question.

1. Mr. D., 75 years old, is discharged from the hospital after a right-sided cerebrovascular accident. He requires at least 6 weeks of further nursing care and physical therapy. The facility most likely to meet these needs is:

a. A continuing-care retirement center

b. Hospice care

c. An intermediate-care facility

d. A skilled nursing facility

2. Hospice care provides a multidisciplinary approach to caring for people with:

a. A chronic illness

b. An acute exacerbation of a chronic illness

c. A terminal illness

d. A contagious illness

3. The major benefit of living in a continuing-care retirement community is:

a. Low household maintenance requirements

b. Services available for a continuum of health-care needs

c. A safe environment for older adults

d. The presence of a hospital in the complex

4. Mr. J., 83 years old, has Alzheimer's disease and has wandered from home on several occasions. Mrs. J. is concerned for her husband's safety and desires some respite services. You recommend that she investigate:

a. A local nursing home

b. The local senior center

c. A home health-care agency

d. An adult day-care center

5. In the home health-care setting, the licensed nurse can expect:

a. A limited amount of equipment and supplies to be available

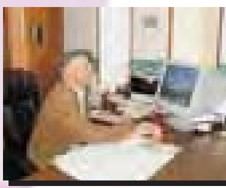
b. Intermittent contact with clients

c. To care for clients discharged from the hospital with a number of physical care needs

d. All of the above

11 The Management Role of the Licensed Practical/Vocational Nurse

Mary Ann Anderson
Tamara Chase



Learning Objectives

After completing this chapter, the student will be able to:

1. Identify three management styles commonly used and determine the style that is most effective in gerontological settings.
2. Express an overall understanding of communication techniques and their use.
3. Describe two methods for managing stressful communications.
4. Describe the planning hoop and its use in setting priorities.
5. Identify three common errors made in doing employee evaluations.
6. Define Total Quality Management and explain its importance.

INTRODUCTION

Administering excellent care to frail and ill individuals through the mechanism of an interdisciplinary team and, frequently, a mass of bureaucratic paperwork requires management skills of the highest level. This is the challenge of today's licensed practical nurse (LPN): successful administration of managed care to older adults in all settings. Certain skills are critical for LPNs to master in order to function successfully in the management arena of health-care delivery. This chapter is designed to introduce such skills as they are used within the realm of gerontological nursing.

Some people believe that LPNs are not qualified to be managers, yet many are placed on units as charge nurses. I have worked with LPNs over my 40+ years of nursing and have found your colleagues to be excellent. I remember working night shift as a new graduate when an astute LPN saved the life of a surgical patient. He would have died without her critical observation and intervention. The very fact that you manage patient or resident care makes you a nurse manager. I am proud of you and what you can and will do in this wonderful profession of nursing.

MANAGEMENT ROLES

The management role of the LPN is one that changes constantly to keep pace with changes in the health-care delivery scene. It is challenging to be an LPN prepared to assume the responsibility of management. You need to recognize that the work of a licensed nurse always involves leadership skills, and the scope of responsibility frequently changes.

In some nursing homes, LPNs are directors of nursing, whereas in some hospitals, they are not allowed to administer medications. This diversity in scope of responsibility is important to understand. If a registered nurse (RN) is on the health-care team, the LPN is responsible to the RN. This is always true because of the dictates of licensure. It is possible for an RN and an LPN to have the same job description in an organization, just as it is possible for an LPN to be the director of nursing or shift supervisor. Always keep in mind that even if you and an RN have the same job description, you have different licensure; the licensure and its scope of practice are critical for you always to follow.

The LPN should clarify, at the time of employment, the scope of responsibility and role expected to be fulfilled. Determining that the duties assigned are not in conflict with the State Nurse Practice Act also is important. As licensed nurses, all LPNs are responsible for knowing the law governing their practice. This responsibility should not be delegated to a supervisor or another nurse.

MANAGEMENT STYLES

Every individual has a personal management style. This comes from the lessons learned while maturing as a person and as a nurse. Nevertheless, to be a successful nurse manager, it is important to understand various management styles and master those that are most effective for you.

Three basic styles of leadership need to be understood. In addition, other leadership styles exist, and many leadership theories have been proposed. The LPN nurse manager needs to understand the basic styles and be flexible enough to incorporate other information as it becomes pertinent. The overall objective for understanding the basic styles of leadership is for the LPN to determine an effective but flexible leadership style for professional use.

Authoritarian

In the strictest sense, authoritarianism functions with a high concern for tasks done and low concern for the people who perform those tasks (Anderson, 2005). People with this leadership style work well as assembly line managers in a setting where the employees are not in a job that requires individuality and the machinery is critical to the production of the workload. Does this description cause you to have a feeling of concern when considering an authoritarian management style for a gerontological care environment?

The authoritarian or autocratic leader tends to make all decisions in the work environment and then simply order the employees to follow the decisions that have been made. The manager is one who has worked hard to create a power base and does not relinquish it to employees. Generally, this type of manager sees employees as irresponsible and lazy. That opinion of employees is the manager's personal justification for the control placed over them.

An authoritarian manager does not allow for creative thinking or new ideas. No opportunities are presented to try new concepts on a

patient/resident care plan unless the idea is the manager's own. This type of manager is more interested in seeing that the work is done rather than that the patients are being lovingly cared for and their individual needs met. As an example of this type of management, the workload plan would require baths to be completed by 11:00 a.m. instead of treating the patients as individuals and allowing them autonomy in planning their morning care.

Situations do exist in which this type of management style is critical for success, for instance, during an emergency! If a visitor or older adult fell to the floor in cardiac arrest, this type of manager would take over, give orders, and, in all likelihood, save the life of the person. However, the problem with this management style is that life is not a constant series of emergencies. This style does not allow for the creative and caring approaches that are necessary for effective gerontological nursing. Often, older persons miss out on the best possible care, and the employees miss out on opportunities to learn and grow as they implement new care practices. The managers, generally not respected or esteemed by employees, feel frustrated when their work is not valued by others.

Permissive or Laissez-Faire

The laissez-faire style of leadership is the exact opposite of the authoritarian style. Essentially, this style consists of an absence of leadership (Anderson, 2005). The manager wants everyone, including himself or herself, to feel good and works hard toward that end. The basic strategy is to allow the employees to make the decisions, do the planning, set the goals, and essentially manage the organization. This manager sees employees as ambitious, responsible, intelligent, and creative. The laissez-faire manager does not require accountability from employees for their time or for the quality of work done. Initially, this may sound like an ideal management style.

It is important to examine this type of management style in relationship to organizations involved in gerontological health care. Most care given to the elderly population depends on federal approval and on complex payment systems that go through both state and federal government organizations. It is difficult to envision the federal guidelines for safety (Occupational Safety and Health Administration [OSHA]) or for nursing home licensure carried out in a permissive or laissez-faire manner. The same is true for quality-assurance programs in health-care environments. Most elder-care facilities require specific attention to the paperwork that keeps an organization's doors open. It also is necessary to have layers of responsibility that ensure every person in the facility the best possible care with, again, attention to detail.

In other environments, however, laissez-faire management is very successful. A good example is a group of highly motivated, professional people, such as a group of researchers, for whom independent thinking is rewarded. Conversely, it is difficult to imagine an effective nursing home or hospital unit being managed with this style of leadership.

Democratic or Participative

This management style has a strong valuing of the people on the team. The manager gathers information from the other team members and then presents it to the group. All suggestions from the group are considered before decisions are made by the group (Anderson, 2005). This is a very open system of management, yet it identifies the individuals who are responsible for the various projects being managed.

The disadvantage presented by this type of management style is that it takes a great deal of time and energy. Generally the results are positive, and the employees are very satisfied. This is

A participative manager always involves others in decisions unless they have to be made in an emergency.

a style that works well in gerontological environments because it is focused on people and includes the employee, the older adult, and the older adult's family. It is a system that considers change and improvement continuously and assigns responsibility for such ventures.

As an LPN nurse manager, you need to evaluate yourself and determine which general management style is yours. Then consider whether it is a style that is best used in the care of older people. If it is not, you need to learn more about other management styles and with that knowledge consider making changes in yourself. You may need to find a mentor who has a management style you would like to learn more about and ask that person to assist you. This mentor could teach you, become a role model for you, and assist you in applying the management techniques you want in the real-world setting. Being a manager is a challenging facet of your professional life. Take the time to learn the skills and patterns of thought that you will need to function at your most effective level.

COMMUNICATION

The most important skill for a manager, in any situation, involves communication. Nurses in gerontological care spend 85% of their time communicating with a wide variety of people who are involved in the care of older adults. This makes mastering the skills of communication essential for the successful LPN. Communication involves delivering messages that will be understood, listening to messages that may or may not be confusing, and properly interpreting messages that have been misdirected or are delivered with intense emotion, such as anger.

For the LPN, the art of communication involves various groups of people. The LPN needs to be able to communicate successfully with the older adult, the family or other members of the person's support group, and the numerous members of the interdisciplinary health-care team. Expertise in communication is demanded every day from those who manage, direct, or administer care to older people.

Verbal Communication

Verbal communication is the exchange of ideas and understanding that occurs through the use of spoken words and phrases. For the message to be received, the sender must use words and phrases that are appropriate for the listener. The success of all communication is measured by the question: Was the message properly received?

It should be easy to remember sitting in a class and "listening" to a lecture or presentation when you did not "receive" the message. Perhaps you were too tired to concentrate, or the instructor was boring or had inappropriate content to share. For communication to occur, being present is not enough. The critical measure is whether the listener actually understood or "received" the message.

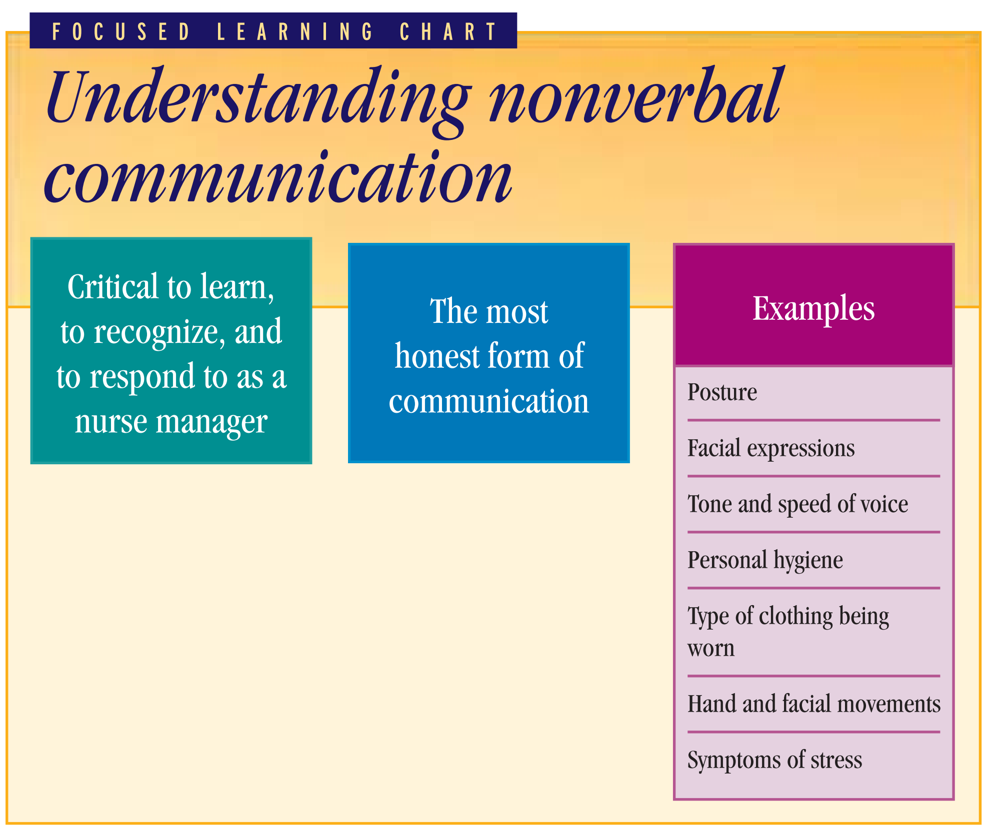
Nonverbal Communication

Nonverbal communication is the ability to share messages without using words. It refers, among other things, to a person's body posture (is the person tired and slouched over, or excited and alert?), the tone and speed of the voice, the kind of clothes a person wears, and hand and facial movements. Nonverbal communication is considered to be the most honest communication a person can receive. For example, someone may say, "I'm having a great day. How are things for you?" in a cheerful-sounding way, but an examination of his appearance may indicate something different. The face is not smiling, and the posture is one of fatigue. The person's hands may be clenching and unclenching as a symptom of stress. Or take another classic example: A resident in a nursing home is asked each morning, "How are you?" and each day responds verbally, "I'm fine." The person asking the question is busy with the breakfast tray or the linen and does not look at the sad and worried face of the resident who answers with the reply that is expected, rather than with the truth.

The ability to recognize honest communication and respond to it is critical for a successful nurse manager. The nurse manager must learn to develop the refined skill of understanding nonverbal communication because it will convey valuable information about patients and employees. Nonverbal communication is an honest method of communication and will allow the LPN to follow through on problems and concerns that otherwise might not have been recognized.

Communicating with Clients

The decision to work with the elderly population is a commitment to accept the normal physiological losses that accompany the aging process. That commitment requires knowledge of the normal changes that occur in elderly people (see Chapter 2) and the skill to work with them suc-



cessfully. A tendency exists in our ageist society to negatively judge older citizens because of the normal aging processes they exhibit. Normal aging changes that might affect communication are slower speech, presbycusis (difficulty in discriminating sounds), presbyopia (difficulty seeing near objects), and overall slower movements or responses to what is being communicated. The knowledgeable LPN recognizes these as normal occurrences and responds to them with skill and compassion.

Some people are impatient and negative about the aging process. It is as if they were punishing people who had simply neglected to die young! As you know, this is ageist behavior and is unacceptable in any setting. The skills necessary for successful communication with older adults must be firmly based on respect for them as people. If that ingredient is missing, communication is unsuccessful. Consider the following strategies (not every older adult will need every strategy):

- Do not approach the person from the side because you may not be seen and the person could be frightened by your sudden appearance. Approach only from the front. This factor is important because of the gradual loss of peripheral vision that often accompanies aging.
- Place yourself on eye level with the older person so a comfortable presence occurs during the communication process.
- Reach out and touch the person if it seems appropriate; this is often the bridge to a trusting relationship.

POINT OF INTEREST

Presbyopia and *presbycusis* are commonly used words when talking about older adults. It will complement your educational process to take the time to memorize those words and use them as you speak. Work with them and make them a natural part of your vocabulary. Make it fun!

- It is important to speak at a normal rate and not to shout, even if the older person is having trouble hearing. Shouting does not overcome the problems of presbycusis. Speak in a normal tone and speak slower than usual, but not so slow as to insult the person.
- If the patient is having trouble hearing you, move closer and speak in a normal tone. Moving closer often allows for lip reading or the reading of facial expressions.
- Pleasantly repeat what is being said, if necessary.
- Do not be impatient or judgmental.
- Place yourself and the older adult in a setting where there is a bright light but no glaring of light.
- Use a setting without disturbing or distracting noises.
- If the older adult gets confused while speaking or responding to a question, give the person time to collect personal thoughts. Do not rush the individual.
- Repeat questions or comments in a different sentence structure if the older person is having trouble understanding what is said. Do not keep repeating the same information in the same way.
- Reflect on what the older person has said by repeating it back in a different way; for example, "Do you mean that you are lonely because your wife is in the hospital and not able to visit you here in the nursing home?"
- Listen carefully to the words used and verify what they mean.
- "Listen" carefully to the body movements and other nonverbal communication and verify what they mean.

It is critical to keep in mind that your goal is to have the message successfully received. The use of these basic, caring strategies enhances your achievement of that goal, as well as your relationship with the older adults in your care.

Communicating with the Families of Older Adults

Often, the family members of older patients or residents are worried, exhausted (if there has been extensive care given at home), and experiencing feelings of guilt over the condition of their family member or the necessity of admitting their loved one to a health-care facility. Successful communication with this varied group of people is challenging because of their emotional status. The issues involved often go beyond concern over an admission to a hospital or nursing home to such highly charged questions as the right to die, the decision whether to do an amputation, or dealing with a diagnosis such as Alzheimer's disease.

It is critical for the LPN to recognize the emotional environment of the family members before entering into any communication with them. The goal is still the same. You want the message to be received by the listener. Some communication strategies for families are:

- Listen to them before you attempt to impart information. It is essential that you evaluate the emotional environment to determine if they are able to listen to you. Often, just listening allows for you to learn critical information that you otherwise would not learn.
- Plan to spend time with the family members. They will have questions and concerns, and they deserve to have them addressed.
- Family members often feel guilty over some issue with their loved one and need to have that clarified. Families need not feel guilty unless evidence of elder abuse is found.
- Find a quiet place to speak to the family. It should be a place where they can sit comfortably and be together as a group. The nurses' station is never an appropriate place for meaningful communication other than the simple sharing of facts.
- As nurse manager, the LPN needs to facilitate the sharing of information with the family. This could mean arranging an appointment with the social worker or assisting a family member to reach the physician.
- The older adult's family is as important as the older person. Generally, strong personal relationships that are interdependent exist. Always treat the family members with the high level of respect and concern that you use with the older adult.

Interdisciplinary Team Communication

It is unrealistic to give quality care to older adults without the support of an interdisciplinary team (IDT). Generally, the care given to older people in all settings is based on the interdisciplinary approach. It is critical that the nurse manager be an active and contributing part of this team. Generally, nurses are with the patients 24 hours a day, or if the older person is a home patient, the nurse generally sees the individual more frequently than other members of the team. This

When working with a colleague on patient/resident care or other projects, be sure that your message is received. It pays to check and double check.

constant attendance of the nurse to the patient provides a vast amount of personal and pertinent information. Therefore, it is essential that the nurse manager be active in contributing to the knowledge base and planning of the IDT.

Again, concern arises over how to share information the nurse has gathered about the older person. It needs to be shared with skill so that the message is received. This process is different in a group setting than it is with an individual patient or family members. The group consists of professionals who have specialized knowledge regarding the older person. Unfortunately, rarely is there sufficient time to discuss the patients in a thorough and relaxed manner. Often, a time crunch exists in IDT planning that establishes a unique atmosphere for communication. The following are strategies for communicating with an IDT:

- Come prepared! There is no time to waste in these meetings, whether in groups or one on one.
- Plan ahead and have priority concerns in your mind or on a piece of paper.
- Remember that this is not a team of nurses, and they may not understand a nursing concept that is very familiar to you. Because nursing is its own specialty, you may be asked to justify your requests or concerns or to teach the team about a nursing concept.

In most situations, the nurse has the role of patient/resident advocate. This occurs naturally because of the amount of time nursing personnel spend with patients compared with that spent by other disciplines. This time allows for personal information and concerns to be communicated. It is critical that the patient advocacy role be accepted by the nurse so that the patient is protected from the system and its potentially depersonalizing effects.

ADDITIONAL COMMUNICATION SKILLS

Very specific skills are necessary for successful communication, and each of these skills can be used appropriately in all settings. Such skills are necessary to clarify communication errors, or potential errors, and are commonly necessary in difficult situations. They are important for every LPN to add to the communication skills checklist, and their importance can be compared with that of being expert at cardiopulmonary resuscitation (CPR). You may not use the skills very often, but when they are necessary, you need to know how to use them.

Assertive Communication Skills

The normal physiological reaction to being attacked physically or verbally is "fight or flight." This reaction occurs without thinking about it; it is normal physiology. When a situation occurs in which you are being attacked verbally or feel threatened by what is being said or done, the normal response is to fight back (an argument) or to take flight (avoidance). In the framework of assertive communication, these two normal responses are more formally identified as *aggressive*—fight or *passive*—flight. The third concept that belongs on a continuum between these two is *assertive*—dealing with the problem.

Ideally you will use assertive behavior when someone has violated the rights of an individual either verbally or physically. Assertive behavior is the most effective response to that violation. The major rule regarding the concept of assertive communication is simply that the assertive response *must not* violate the rights of the person who just infringed on your rights. What does that look like? An argument is the best example. Someone comes to the nurses' station and criticizes you in an angry, loud manner. Of course, there are residents or patients, visitors, and coworkers in the area listening to this *aggressive* communication. It is embarrassing and humiliating to be the victim of a communication delivered in such an inappropriate way. The normal physiological response is to either run away, perhaps crying *(passive),* or to scream back *(aggressive).* Screaming back or starting an argument is a violation of the other person's rights. It does not matter if he or she deserves it, it is still wrong.

The *passive* behavior or running away does not violate the other person's rights, but it does prevent a resolution of the problem.

Assertive communication requires that the person being violated not respond in a normal physiological fashion to the situation. Instead, it is necessary to resist the normal response and use the skills of communication to promote problem solving. This is done most effectively in a private area. Assertive communication often follows this response format:

"I feel"— Tell the other person how the aggressive attack made you feel. Perhaps you feel frustrated, devalued, angry, or frightened. Many other options are available for you to describe how you feel about what has been said.

"When you"— Describe for the person the behavior that has caused you to feel the way you do. It could be when you raise your voice at me, talk about private concerns in public, demand things from me that I cannot do, or criticize me in front of others. Again, many other statements could be used here. The statements used must not be personal statements that attack the other person.

"We should"— Together determine a solution to the problem. This is difficult to do because it is not one of the two normal and usual responses. Use it anyway. Take a deep breath and simply ask what the two of you can do to prevent this from happening again. Be open minded and expect that there will be more hostility because of the discomfort that comes to the aggressive person with your unusual approach. It is hoped that the two of you can resolve the problem. If not, you still have done a good thing. Another skill that may help you in this type of situation is active listening.

CRITICALLY EXAMINE THE FOLLOWING:

Think back to the last "failed communication" you either observed or took part in. Would it have helped to make the conversation successful if the skills of assertive communication had been used? Briefly describe the failed communication and then reword it using the assertive communication pattern.

Assertive Communication Pattern:
"I feel…."
"When you…."
"We should…."

Active Listening

Another communication skill that complements assertive behavior is that of *active listening*. Most people respond to aggressive and negative remarks with defensive communication. While the aggressor is making comments, the person being attacked generally is mentally preparing the defense to the aggressor's attack. These are the defensive comments that often provoke an argument. They follow the script of "It is not my fault; now let me tell you why!"

Active listening requires that the person being verbally attacked listen to what is being said. Because of the natural inclination to prepare a defense, this is a challenging thing to do. Just listen and, while listening, try to determine the cause of the problem beyond the apparent anger.

The person who is out of control must be removed to a private setting, such as an office or the clean holding area. This prevents that individual from self-embarrassment in front of others, and it places you in an environment with fewer distractions.

After the angry person has finished saying all the aggressive things there are to say, he or she will take a deep breath and stop talking. This is where the person uneducated in communication skills presents his or her defense. But you, the nurse manager, need skills beyond the ordinary person. Active listening is one of those skills. The deep breath is the signal to use the information you learned, while listening, to clarify the problem and negotiate a solution.

Comments like "You seem so frustrated with…," "It is unlike you to be so upset," or "How can I help?" are effective ones to use. They are not what the aggressive person expects to hear and generally prevent the person from losing control again. They are helpful comments that show caring and problem-solving skills. These are hallmark behaviors for nurse managers. The next move is for the two people involved to sit down and rationally look at the problem and work on a solution. The whole process begins with the nurse being able to stop "self-defending" and focus on listening.

The format for active listening is:

- Remove the conversation to a private setting.
- Listen.
- Do not prepare a defense.
- Listen for the deep breath that means the person has finished speaking.

CRITICALLY EXAMINE THE FOLLOWING:

It is not enough to read about assertive communication and active listening and think you have learned them as skills. You need to work at incorporating them into your professional repertoire. During the next week, carefully observe yourself or others as they communicate in professional settings. Determine whether you observe the following actions. If so, record your thoughts and make comments regarding each communication technique.

1. Passive Communication:
2. Aggressive Communication:
3. Assertive Communication:
4. Active Listening:
5. Inactive Listening:

- Show support for the other person's feelings.
- Negotiate how to resolve the problem.

Some LPNs reading this text may feel concern over being responsible for assertive communication and active listening skills. They are two of many possible communication skills that could have been discussed in this book. They are listed for a very specific purpose. LPNs, in management roles, have very challenging positions that may place them in serious situations that must be managed rather than ignored. Some people will say, "But I am just an LPN!" and feel that their role does not involve managing and solving problems of this nature. However, it is important to recognize that if you are a nurse manager, you have an obligation to develop the skills necessary for managing these acute and potentially destructive problems.

THE PLANNING HOOP

Every day, decisions must be made regarding the workload of the LPN and others that affect the scope of LPN practice. These are decisions that should be made with careful thought and planning rather than casually and without attention to detail. The decision that may be required of you could be as simple as who will get the first bath as you give morning care; but even this decision may have serious implications for the patients or residents who are receiving your care. Other decisions that will be required of the LPN nurse manager could be counseling an employee whose behavior is unacceptable, making care assignments, confronting a doctor or therapist with an alternate plan of care for a resident, or managing daily staffing. None of these tasks, and the many others that are required of a nurse manager, are easy or simple. They require the highest level of skill and attention to manage the process of making such decisions effectively.

To set priorities and make excellent decisions, the LPN nurse manager must understand the importance of planning, which is an intelligent process of thinking based on facts and information, rather than on emotion and wishes. An example is the holiday schedule. Staff members want Christmas Day off to be with their families. You, the manager, want everyone on your staff to be happy, but you have a clear picture as to what would happen if you granted everyone's wishes for Christmas Day! Instead, you need to intelligently make a rotation plan for the holidays, or perhaps draw names out of a hat, assign requests according to seniority, or determine some other way for the Christmas Day shift to be adequately staffed.

Planning is a process that never ends. It can be thought of as a hoop with notches where you stop and enter another phase of the planning process; then you continue going around the hoop over and over again. It is unrealistic to develop a plan and think that it will never change. It may be perfect for the moment, a week, or even an entire year; but the complexity of health care and the individuality of clients and staff require that your excellent plan be continuously re-evaluated. The planning hoop (Fig. 11-1) begins with an assessment.

Assessment

What is the problem or potential problem that concerns you? You know how to do a physical assessment. This is a similar process. Look at the problem from "head to toe" and assess what really is wrong. If it is a staffing problem in a nursing home, look at the mix of licensed and unlicensed personnel. Is it right for the needs of the residents?

Is the problem a lack of knowledge? If it is, you need to assess where the lack is, who needs to know the information, and how to most effectively teach it. Do not be distracted by other issues as you do your assessment. Keep focused on the problem you are trying to resolve and learn all you can about it. Otherwise, it would be similar to trying to assess two residents at the same time. One does not get a clear picture of the problem unless a very focused effort is

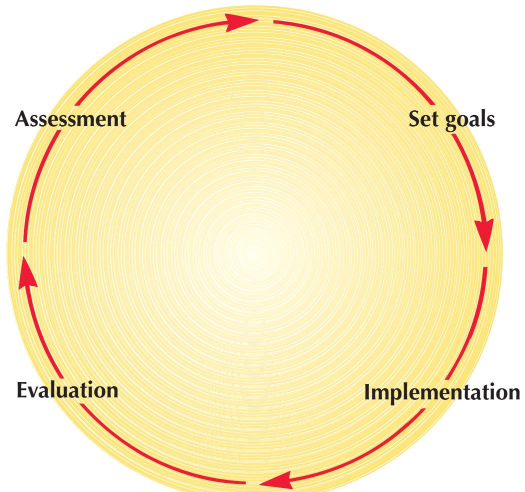


FIGURE 11.1. The planning hoop. The effective nurse manager must learn that planning is critical to getting the total workload done effectively.

made. The next step in the planning hoop is to set goals.

Goal Setting

Now that you have a complete set of data regarding the problem, you have enough information to set goals. This, again, is very similar to the nursing process. Instead of writing a care plan, you are preparing a plan to resolve a management problem. Make the goals reasonable and achievable. As we saw, not everyone can have Christmas Day off. If the problem is an unbalanced mix of licensed and unlicensed personnel, your goal could be to correct the mix through attrition and selective hiring within the next 6 months. If the problem is knowledge, your goal would be to have 100% of your staff attend a class on the information needed by a specific date. The goals should be meaningful and demonstrate your most careful and organized thinking.

Implementation

This is the test of good planning. Was your assessment done accurately, and are your goals realistic? Perhaps the actual implementation requires you to not hire an RN or LPN when they apply because your staff has too great a proportion of licensed personnel. Or, implementation may mean that you need to find the budget money to pay the staff to attend the education program you determined they needed. In addition, you need a plan for getting everyone to attend. This could involve bonus money or other rewards, and in all likelihood, it would mean presenting the education program several times. Implementation is the actual performance of your plan.

Evaluation

Did your plan work? Was Christmas Day successfully staffed, and did the staff feel that the staffing decisions were made with fairness? Within 6 months, was your staff mix at the level at which you needed it to be? How effective was your education program? Did it bring about the change you wanted? Such questions initiate the process of evaluation. A nurse manager cannot just do something and consider the problem solved. Instead, a careful evaluation must be performed so the cycle of the planning hoop can begin again. That is right; once you have evaluated your plan, you need to do another assessment and begin the circle again!

Many people do not spend a great deal of time planning solutions to the unit's problems. The profession of nursing is filled with "doing types" of people. One of the critical skills of being a manager is to learn to quit "just doing" and begin planning "to do." It is a challenge to take the time necessary to plan because planning does not enter into the conventional description of a "good nurse."

When a person is planning, that person is sitting somewhere quietly thinking. The profession of nursing generally does not see that as productive because beds need to be made, and there are baths and treatments to be given. With those unfinished care issues, how can a real nurse take the time to just sit and think? A real nurse manager soon learns that doing the thinking or planning is critical to getting the total workload done effectively. So, fight the urge to be busy when planning is needed. Teach the staff that the time you spend planning is critical to the overall picture of care for patients and job satisfaction for them. Be courageous enough to use the planning hoop to resolve problems and prevent new ones. Because if you do not, you will become a victim of crisis management!

Crisis Management

A crisis manager is a person who does not take the time to plan. This manager waits until the week before Christmas to resolve the problem of the staffing crisis. A great deal of hysteria, excess

energy, and distress are involved in solving problems when they occur rather than foreseeing them and taking the time to plan a solution for the problem. The phrase, "All I do is run around and put out fires!" is indicative of the crisis manager. It is not effective management and can be prevented by the implementation of the planning hoop into your management style. Look to the future and anticipate problems. Then devise a plan for solving them before a crisis happens.

Some situations still will become a crisis for even the best manager. Accept this, solve the problem, design a plan so it will not be a crisis the next time, and move on to the next situation.

PRIORITY SETTING

Every LPN has learned how to prioritize the work of giving patient or resident care. Traditionally, the sickest patient receives the nurse's attention first and the least seriously ill person waits until last. This concept assumes that each patient is assessed and observed frequently, rather than being ignored until her or his turn comes to receive care.

Priority setting in management situations has a similar format. The priority of each management problem is determined after the assessment of the situation has been completed. The method for determining priority problems generally is based on determining what is essential for the organization or the person at the time. Staffing for Christmas Day is essential, as is giving pain medications in a timely manner.

The nurse manager needs to think of the entire organization when determining priorities. They often are divided into two categories: (1) concerns that relate to patient or resident care, and (2) concerns that relate to the process of running the business of the institution.

Each category should be considered separately, although a great deal of overlap of concerns occurs in implementing problem solutions. Each concern needs to be listed as a *need* or a *want*. Obviously, needs should be met before wants. It is helpful to use this method for categorizing your management concerns before prioritizing them.

MANAGING PERSONNEL

As a nurse manager, you will be involved in, if not responsible for, the hiring and evaluating of employees. This is a critical aspect of your job and one that requires the highest level of professional skill and performance. This work cannot be done by intuition or "best guess." All personnel decisions directly affect the lives of the employees of the institution. These people deserve as much care and attention as the patients.

The hiring process is where the employee begins a career with your organization or, if not employed, will leave with an impression that will be taken out to the community. It should be your desire to have that impression be a good one. Many legal issues are involved in the hiring process. Be sure to clarify them with your personnel manager or administrator. Laws exist that involve the advertisement of a job and how the interview is conducted, and federal rules identify questions that cannot be asked in an interview because of concern over discrimination. Be alert to these rules and follow them.

The philosophy of interviewing someone for employment is to find someone who fits with the philosophy and image of your institution. The applicant needs the licensure or certification that the job description demands and the experience to perform the job at a satisfactory level. The interview also allows the nurse manager to determine the shift availability and whether the potential employee is available for part-time or full-time work. Moreover, an effort should be made to learn the specific interests of the applicant so plans can be made to use any special skills and knowledge the person possesses. The screening process of the personnel department presumably will eliminate anyone unqualified for the job. It is not necessary for unqualified people to be interviewed.

Interview

The purpose of the interview is to exchange information. Be prepared to give positive information about your facility to all applicants whether they are to be employed or not. Remember, you want applicants to say favorable things about your organization even if they are not selected for the job. During the interview, the nurse manager is expected to determine the applicant's:

- Dependability
- Skill level
- Willingness to assume the responsibilities of the job
- Willingness and ability to work with others
- Interest in the job
- Adaptability

When interviewing someone for a position, establish a friendly and positive atmosphere. Be consistent in the interview process with all applicants, and be honest in your assessment of qualifications.

- Consistency of goals with available opportunities
- Conformity of manner and appearance to job requirements

The interview has definite purposes and should be carried out in a professional manner. It is not the place for social chit-chat; however, some warm and friendly comments at the beginning of the interview should put the applicant at ease so the interview can be emotionally comfortable.

The greatest predictor of the applicant's future success is past performance. Is this someone who has worked with older adults previously and enjoyed it? Has applicant sought additional educational experiences that will enhance work in your type of setting? Was this person a desirable employee at the last place of employment or, if a new graduate, a good student? These critical pieces of information should be noted on the application and verified in the interview.

It is your responsibility, as the nurse manager, to set the tone for honesty in the interview. Be specific and direct in your comments. It is helpful to have an interview guide available to use for every interview. This guide is a written document that contains questions, directions, and pertinent information to be shared with the applicant. The presence of an interview guide ensures you, the applicant, and the institution that the same process is being used in every interview. It avoids the gathering of prejudicial information and provides consistency in the interview process.

Questions on the interview guide should cover subjects such as which shifts the applicant is willing to work, whether part-time or full-time work is desired, and feelings about working with older people. It also could contain a brief case study or scenario about a gerontologically focused situation that requires a response from the applicant. The presence of two or three such questions gives you additional information about the potential employee. All applicants must be asked the same questions to avoid discrimination or the appearance of discrimination in choosing future employees. You also need to carefully review the Title VII Civil Rights Act before conducting any interviewing. This federal law prohibits discrimination in any personnel decision on the basis of race, color, sex, age, religion, or national origin. A comfortable format for an interview is presented below:

- Use an opening to establish rapport, and put the applicant at ease.
- Share the interview procedure with the applicant.
- Discuss the applicant's interests in being employed at your facility.
- Obtain an educational history.
- Discuss future plans of the applicant, for example, upward mobility and future education.
- Share case studies and situations and discuss them.
- Inform the applicant about the organization.
- Allow time for the applicant to ask questions and get answers.
- Close by clarifying how to reach the applicant after the interview, informing the person when the decision will be made, and thanking the applicant for considering your organization for employment.

Employee Evaluation

After the nurse manager has made a decision to hire an applicant, a very focused effort must be made to give that person a thorough and extensive orientation to the job, its standards, and its expectations. The quality of personnel hired and retained in the organization determines the success of the organization. The quality of the orientation directly determines the overall success for both the organization and the employee.

After the employee has had the opportunity to work with other qualified employees and to establish an effective working routine, a new employee can be allowed to work independently. A resource person should always be available, in some way, to the new employee for the first 3 months of employment. This provision

POINT OF INTEREST

One of the most effective habits you can develop as a manager who does performance evaluations is that of gathering evaluation information on a daily basis. With the use of computers it is much easier than it used to be to get this organized. Simply have a disk for evaluation. Each employee's name or section should be on the disk. When something happens, you simply record it. It could be a compliment from a family member or a display of poor judgment. Making notes on your performance disk is something like doing your patient charting: it needs to be done every day. You won't make a note on every employee every day. But it is important to record the significant things that have happened for the day. This technique for organizing data will make your evaluation process a "breeze"!

indicates that a sincere effort is being made to ensure success for both the organization and the employee.

Each organization has an established process for evaluating employees. The first evaluation may come at 3, 6, or 12 months. Earlier and more frequent evaluations take more of the manager's time but also provide regular feedback for the employee. Overall, it is generally time well spent. Your organization also should have an established written form for evaluating employees. Again, this process should be consistent for all employees to avoid discrimination.

For all employing organizations, a performance appraisal may be based on the five basic realistic assumptions outlined below:

1. The appraisal will help an employee improve the management of the workload.
2. Employee appraisal is a difficult process but a skill that can be mastered with hard work.
3. Few people like the current form (a perfect one simply does not exist!).
4. The appraisal will be made by the employee's supervisor.
5. Information must be gathered on a day-to-day basis.

The challenge to the nurse manager is that the performance appraisal must accurately reflect the person's actual job performance. It cannot contain prejudicial information, hearsay, or undocumented information. It is designed to be helpful to the employee, and, by assisting the employee to improve, it will be helpful to the organization.

Traditionally, potential evaluation problems can contribute to a less than accurate evaluation. The first one is *leniency error*. This occurs when a supervisor wants everyone to be buddies or be the manager's best friend. It results when the manager "looks the other way" or gives an employee the "benefit of the doubt" rather than finding out what really happened.

A competent nurse manager cannot afford to be "best friends" with employees. The manager needs to be the manager. It is critical to success for the manager to be an honest and fair person who does not lose the ability to be objective. The leniency error does not help an employee improve, and it does not contribute to the overall functioning of the organization.

The *recency error* is an indication of a manager who has forgotten the basic assumptions of evaluation and who has not kept records of employee performance over the year. Because of the lack of written record, the manager then evaluates only on what is remembered most recently. All employees know when their annual review is scheduled and often find it easy to "look good" during the time just before their evaluation. Again, this type of evaluation process enhances neither the performance of the employee nor that of the organization.

The *halo error* is allowing one trait to influence the entire evaluation. It could be either a strongly positive trait or a strongly negative one. Either way, it clouds the objective evaluation of an employee if only the halo behavior is remembered. Evaluations need to be fair and comprehensive regarding the employee's behavior and skills.

The evaluation process is critical to the growth and stability of the organization. Evaluation standards cannot be successful if they are ambiguous. The process of rewarding a strong employee and counseling a poor employee must be valid. This happens only if the manager maintains a professional and consistent attitude toward the evaluation process.

Negative or probationary evaluations are very difficult for all managers to give. Use the same process you would use for a positive evaluation. Make it fair and comprehensive, and share the information you have in a professional manner. For all terminations, the process of counseling the employee must be carefully doc-

umented over time. This is an act of fairness toward the employee and a protection against litigation for the institution.

Making Care Assignments for Older Adults

One of the day-to-day management skills used by LPNs is that of making care assignments for older adults. The skill of making effective assignments is critical to any clinical area. The goal of making successful care assignments is to match the worker with the older person in a manner that allows for the best nursing care to be administered and received. As the manager, you also need to focus on an assignment that affords the highest level of employee satisfaction. This requires sensitivity, awareness of the skills and attitudes of others, and the ability to form a plan and to follow through on it. Several aspects of making care assignments should be examined.

When making care assignments, you must consider the personal skills of each person you are managing. You have learned how to assess older adults; now your question might be, "How do I accurately assess a nursing assistant's skills?" Dr. Patricia Benner, who developed the nursing theory *From Novice to Expert*, describes a specific way to identify clinical skills. Benner's theory focuses on intensive care, registered nurses, and their clinical expertise along the five points of:

- Novice
- Advanced Beginner
- Competent
- Proficient
- Expert

Dr. Benner's theory was designed for RNs. However, national research is currently being done to determine if the five points of clinical expertise will identify the clinical skills of certified nursing assistant (CNAs).

As a nurse manager, it is important for you to understand the five points of clinical expertise and how you can use them to identify skill levels for CNAs and other personnel who work under your direction. The five points are:

1. *Novice*—CNAs performing at this level have no prior experience with certain situations. They will not understand the detailed information regarding what is happening. They simply do not have the experience to understand what is going on in the situation. For example, a CNA may have several years of employment as a CNA but may not have any experience working on an Alzheimer's unit. As a nurse manager, you should be aware of such a lack of skill and may want to assign a novice CNA to work several shifts with a CNA who is experienced caring for people with Alzheimer's disease.

It is worth your time to consider the level of expertise the CNAs who work with you have achieved. This will influence your scheduling, educational programs, and, most importantly, the quality of care provided to older adults. It is your responsibility to identify and assist those who need more education and/or experience.

2. *Advanced Beginner*—CNAs functioning at this level can demonstrate limited acceptable performance. Advanced beginners generally have had multiple clinical experiences, independently or with a mentor, so they have a general understanding of the clinical situation. Advanced beginners perform tasks using behavior that follows instructions only rather than appropriate behavior for a specific situation.

   You, as the nurse manager, may ask a CNA to assist a resident into the shower. When the CNA enters the room, the resident is found confused and combative. Rather than gauging the situation and deciding that this may not

be the best time to give this resident a shower, the CNA does everything possible to complete the task of giving the shower. The focus is on the task, not the aspects of the specific situation or the needs of the older person.

3. *Competent*—The competent CNA has an increased level of skill and ability. The knowledge is based on following the positive role-modeling of other CNAs as well as dealing with a variety of situations where clinical skills were learned. However, the competent CNA still focuses on organizing the assigned tasks. The competent CNA makes sure the time is managed well in an effort to complete the tasks on the list, instead of basing work decisions on the older person's needs.
   As a nurse manager, it is critical that you make sure that the resident's needs are actually being met by the CNA in a timely manner. Otherwise, those you manage may give care based on a schedule and a list rather on than the needs of older adults.
4. *Proficient*—The proficient CNA is much more comfortable with clinical skills and has the ability to deal with different situations as they arise. The proficient CNA engages more with the older adult and family instead of focusing on required tasks. The focus of the CNA's nursing care is on the needs of the older person rather than on a list. An advantage to working with proficient CNAs is their ability to reprioritize the workload based on resident/patient needs. As a nurse manager, you may delegate several things to the proficient CNA, who will then decide in what order they should be completed.
5. *Expert*—The expert CNA has experienced many different situations and has learned from the experiences. These experiences assist the CNA in making decisions based more on intuition (referred to by Benner as intuitive knowing) than on timetables and rules. The expert CNA knows the older adult's patterns of behavior and is able to anticipate the unexpected. This complexity of skill and thinking assists the CNA in making decisions based on the "big picture" or the holistic needs of the person receiving care.
   As an example, the expert CNA walks into a room where an older adult is behaving differently and spends time with the person trying to identify the problem. The expert CNA will take vital signs and ask questions so there are data to report to the licensed nurse. The expert CNA will know what to do for this patient.

Are you able to identify where your CNAs fit in Benner's five points of clinical expertise? Do you have a new CNA who is still working at the novice level? If so, that person should be assigned to older adults who only require basic skills that were learned in the CNA class. The novice CNA also should be assigned to an expert CNA who can assist with care when needed, as well as serve as a positive role model. Novice CNAs should not be assigned to give care to challenging clients. They could be assigned to work with another CNA who has the challenging resident and, in that way, have experiences that eventually will lead the CNA to the level of expert without hurting an older person in the learning process.

Do you also have a CNA who has worked at the facility for several years, is very familiar with the residents, and has excellent clinical skills? That is the CNA who should be assigned to the most challenging older adults so they, the older adults, can benefit from the CNA's skills and knowledge. This may not always be the sickest person on the unit. The assignment could be to the latest admission, in which the older person and the family are having a difficult time adjusting to the transitional stress of the admission.

It is important when developing staffing patterns that a team should not consist of a novice CNA and a novice-licensed nurse. A better staffing pattern would be an expert CNA with a novice nurse or expert nurse with a novice CNA. The mix of novice and the levels of expertise that lead to expert are important to acknowledge and use as you manage care.

Once you, as the nurse manager, have identified the "expertise" levels of each nursing assistant, you should praise each one for their special skills and allow them to use them. Assist employees to develop skills related to their interests and abilities, and recognize them for the skills they develop. Assign staff older adults who will benefit from their skill and knowledge. This enhances both quality of care and employee self-esteem. This, in turn, enhances the entire organization.

When working with older adults, it is generally more effective to assign the same employee to an older person for several days in succession. This allows the caregiver to learn the personal needs and nuances of the persons receiving care and address them successfully. When a "new" person is assigned to an older person each day, it puts a demand on the older adult to need to explain again that he cannot hear out of his right ear, that he wants two cups of coffee on his breakfast tray, or that it is his right knee that does

not work very well. Generally, a comfortable camaraderie and sense of teamwork develop between the caregiver and the care receiver that enhances the work of healing when they are allowed to work together over time.

Sometimes a difficult or demanding older person requires more energy and patience than most employees can provide day after day. When this occurs, the nurse manager should rotate the assignment in a direct effort to avoid burnout of the employees.

Another consideration for making assignments is that of physical demands. Often when caring for older adults or chronically ill persons, a heavy physical demand is made in turning, positioning, and assisting the older person to ambulate. When the nurse manager makes the assignment, the physical, muscular work of the care should be considered in order not to overwork a particular employee. Another consideration is the geographic placement of the rooms. It is unnecessary to make assignments that require an employee to travel to both ends of the hall or in other diverse patterns. Make a strong effort to group the room numbers assigned to avoid unnecessary walking. Most workdays are tiring enough.

Delegation

As the LPN manager, you need to know what is involved in delegating to CNAs. The goal is to delegate tasks while maintaining quality patient and resident care. Your first step is to familiarize yourself with the Nurse Practice Act for the state where you work. This document defines the roles and responsibilities of a licensed nurse. You need to determine if your Nurse Practice Act allows for delegation and, if so, whether there are any limitations as to what you can delegate to a CNA or Unlicensed Assistive Person (UAP). Your next step is to become familiar with the policy and procedures for your facility as well as the written job descriptions. Any job you assign must be within the employee's job description. Once you have identified a task that can be delegated, you want to use sound delegation approaches. You also will want to keep in mind how delegating this task will affect the safety of the older adult. Has the older person been accurately assessed, and are there any safety issues that need to be addressed? The National Council of State Boards of Nursing (NCSBN) has developed guidelines to help nurses ensure safe and proper delegation. The NCSBN has developed the "Five Rights of Delegation," which provides a checklist nurses can use when making delegation decisions. The Five Rights of Delegation are:

1. The right task
2. The right circumstances
3. The right person
4. The right direction
5. The right supervision

In general, CNAs can do tasks that assist older adults with basic needs and activities of daily living. They cannot assess, plan, or evaluate any aspects of patient care. If an older person is taking Lanoxin for his heart, the nurse can delegate to the CNA the task of taking an apical pulse and notifying the nurse what the heart rate is once the pulse is taken. The CNA cannot decide if the older adult can have medication based on the pulse the CNA took. In addition, the nurse will make the decision as to when the pulse should be checked again. It is very important, when working with CNAs, that the nurse give clear instructions as to what time the task should be completed and whether they need to report back to you directly once they have completed the task. It is wise to encourage CNAs to take notes as you are giving them the information regarding the delegated assignment. When delegating a task to a CNA, you must remember that you still are responsible for the older adult's care. If you delegate a task to a novice CNA and the task should have been delegated to an expert CNA, or if you do not give proper supervision, you may be held responsible for the outcome of the care. If, however, you delegate to the appropriate person and provide appropriate supervision, the CNA may be liable for his or her own actions.

As a manager, you should always be willing to delegate certain projects. As organizational needs arise, you may be assigned a project that will not allow you to complete your regular workload. This is a good time to delegate routine work that can be done by someone else.

In your role as an LPN, you will find it necessary to do effective delegation. Does that mean that you delegate the projects that you do not want to do? Does delegating make you a lazy person? The answer to both of these questions is "No." Delegation of routine tasks to someone else frees the manager to work on more complicated unit needs. Because delegation is critical to effective management, you want to make sure you are doing it as efficiently as possible. When delegating to anyone, your responsibility as the manager is to identify if they have the basic skills or education necessary to complete the assignment. You also should make sure they have the

time to complete the assignment by the deadline without requiring them to put aside their regular job responsibilities. Delegating to someone who is interested in the assignment is a good choice.

Once the individual is identified, you should give the person clear and direct instructions on what is to be done, including why they are doing the assignment. How the person completes the assignment should be an individual choice. This is the really hard part. Once you delegate a responsibility in the manner described earlier, just leave it and allow the person to do the work. You can "check in," determine whether the person needs something, or just observe so you can step in if there is a critical situation. Giving the employee autonomy in deciding how to complete the assignment is a positive factor for the employee and the key to successful delegation. It also is important that you do not oversupervise the employee. If you are going to watch and participate in every step of the project, then you may want to ask yourself why you chose to delegate it.

Definite time lines for completion of any delegated project should be discussed, and the manager should check in periodically to ensure that the deadline will be met. Monitoring the assignment periodically allows for questions and discussion regarding the project as the work is being done. Being available for interaction is an important concept. You always should be available to assist the employee if he or she is having difficulty. Taking the delegated project back would be a last-resort behavior because it makes the employee feel like a failure and "demotivates" rather than motivates. When the project is complete, you must evaluate the performance, giving both praise and additional information to the employee. This lets the person know what was done well and what may be done differently next time he or she is given a similar assignment. Delegation is an effective way to assist someone to move from novice to expert because of the opportunity to develop new skills and have new experiences.

Providing Education for Your Employees

This chapter has discussed management concepts needed to supervise employees. Now the question is, "What is the nurse manager's role in providing continuing education to the staff?" What can the nurse manager do to move CNAs from novice care providers to expert care providers? Health care changes on a regular basis, and we, as licensed professionals, are all trying to keep up with the changes. It is important for unlicensed health-care providers to keep up with health-care changes as well. As a nurse manager, you need to assist with this endeavor. There are several areas of education that need to be addressed. The first is the orientation process for new employees. It is suggested that orientation programs for new CNAs should extend to at least 3 months. An orientation program should match, one on one, a new or novice CNA with a veteran or expert CNA. The program should provide the new CNA the information needed to function as an effective member of the nursing team at the end of the orientation period. The orientation information should include the policies and procedures for the facility, information about the daily operation and schedules for the facility, and, most important, detailed information about the older adults and the specific skills needed to give excellent nursing care.

The expert CNA who is willing to be a role-model and mentor for the new employee should be a valued employee who consistently demonstrates expert clinical skills and care behaviors. This is a CNA who demonstrates willingness to orient the new employees as well. It is appropriate to demonstrate valuing of employees who participate in the orientation program through some type of a reward.

The novice CNAs must have continuity of instruction throughout the orientation. If the facility has five units, the CNA should spend equal amounts of time on each unit. The time spent should be consecutive days so the CNA can become acquainted with the staff and procedures on one unit before moving to the next. This also provides consistency of care for the older adults who are getting to know the new employee.

At the end of the orientation period, the new employee should be evaluated. It is at this time the nurse manager must decide if the employee is acceptable for the facility. If you are not satisfied with the employee's performance, a plan of action should be developed to assist the employee in meeting the requirements necessary for successful employment. This also may be the time when the nurse manager may make the difficult decision to release the employee.

Once a nurse manager hires an employee, an effort should be made to increase and maintain the skills of the employee. There are various ways to accomplish this goal. Mentorship programs match individuals together when one person has the required skills and the other needs to learn them. These programs generally last for a

longer period of time than orientation, and, in most cases, are less formal. A CNA who is interested in becoming an LPN may be matched with an LPN who is interested in helping the CNA be prepared for nursing school. Or, you may have an employee who works well with people with Alzheimer's disease and their families. This individual could work as a mentor for other employees who would like to possess the same skills.

Some facilities use clinical ladder models to increase employee skills. Different levels of knowledge are identified as well as ways to obtain and document the skills. When an employee meets the requirements of one level or "rung" of the ladder, there often is a promotion. When employees have met the requirements for an advanced level, they often are recognized with a ceremony and a monetary award, an increase in pay, or a set one-time dollar amount. Facilities have found that clinical ladders can assist with employee retention as well as improve employee morale. The benefit to the facility is better patient care. The improvement in care is a result of the facility seeking to prepare its own expert CNAs, LPNs, and RNs.

MANAGING THE QUALITY OF CARE

The process of managing and evaluating the quality of health care is not new. Florence Nightingale (1859) urged that all nursing care be carefully evaluated. Because of her innovative nursing-care practices and her ability to measure and evaluate nursing care, she was able to measure changes in the health of patients. At one hospital during the Crimean War, she measured a decrease in patient mortality of 50% down to 20% after her nursing-care ideas were instituted. Different outside organizations measure the quality of care given in hospitals and nursing homes. The Joint Commission on Accreditation of Hospitals (JCAH) was founded in 1952 to evaluate health-care services. Two nursing organizations followed this trend in the late 1950s. The American Nurses Association developed and published standards of care for the various nursing specialties, and the National League of Nursing published standards that the public could expect from nursing education. Quality health care is the right of persons who enter the health-care system. The organizations just listed provide outside evaluation of the organization. Other methods for making self-evaluation that involve the LPN also exist.

Total Quality Management

Total quality management (TQM) is a management philosophy that emphasizes a commitment of excellence throughout the entire health-care organization. The principles are widely used throughout many business organizations in addition to health care. The overall purpose of TQM is to improve quality of service and ensure customer satisfaction.

The four major characteristics of TQM are (1) customer/client focus, (2) total organizational involvement, (3) use of quality tools and statistics for measurement, and (4) identification of key processes for improvement. The LPN is involved in all four aspects of the TQM process.

Most nurses naturally believe that their focus is the customer or client. This is the overall theme of TQM and calls for all personnel in each department to focus on the needs of the client. An example would be a smoother admission process, given that that process is often an area that provokes customer complaints. Another example is the housekeeper responding to the patient. This could be simply friendly visiting or putting aside the housekeeper's usual work to go get a nurse for a patient.

The customer focus of TQM is most effective when all employees in a hospital or nursing home respond to the challenge to focus on the needs of the patient. This philosophy eliminates the idea of "That is not my job!" Instead, everyone works toward the overall goal of satisfied customers. This may make it necessary for a nurse to assist the housekeeper in making beds because of the large number of admissions and discharges done in one shift. Or a physician may need to transport a patient from the emergency room to the unit; respiratory therapists may assist patients to the toilet; the unit secretary may need to transport patients who are being discharged to their car. The point is that everyone is committed to the idea of customer satisfaction and is willing to fulfill whatever role might be necessary and safe to meet that commitment.

The use of high-quality tools and statistics to measure the level of care that is being given is an important consideration. An organization cannot determine whether the quality of care is being improved unless accurate measurement takes place. This generally is not the responsibility of the LPN but an upper-management or administrative assignment. The LPN may need to complete forms or make reports that contribute to overall measurement of the work being done, but such an assignment will be

made by someone else in the system to you, as the LPN.

The fourth component of TQM is identification of key processes for improvement. All activities in an organization can be described in terms of people working together. The term *identification of key processes* refers to the efficiency or effectiveness of the work people or teams do together. One example is the PDCA cycle. This is the *P*lan, *D*o, *C*heck, and *A*ct cycle. It very simply defines the processes a group or team should be following as they do their work.

CONCLUSION

Many skills are needed by the nurse manager, but this is just a chapter, not a management textbook. The case study at the end of the chapter will give you practice in considering management issues. Finally, it is important for you to find a mentor to assist you with the real world of management.

PRIORITY SETTING 11.1

I want to list every concept in this chapter as a priority! That is how important I think it is for you to master the skills of management. This is the challenge of setting priorities. When several things are important, how do you choose the priority order? I finally narrowed this chapter down to two items that are both very important for you and then had to make the hard decision as to which one I should highlight here. The two items were understanding leadership styles and communication. You will have those same challenges as you do more and more nursing. The decisions are made based on your knowledge, life experience, and thoughtful consideration of the situation.

The priority for this chapter is communication. As it says in the chapter, as you practice your profession, you will spend 85% of your time communicating. The really challenging communication skills directly relate to the management role. You need to learn them and incorporate them into yourself to the point that they come automatically. I am referring to assertive communication and active listening. These are the "upper division" communication skills that every effective manager must have. Let me repeat, every *effective* manager *must* have them.

Please reread the sections in the chapter referring to these skills. Then consider how you can become great at using them. You may want to read more about them in management books in the library. Talk to your faculty person about them. Discuss them with nurses (both RN and LPN) where you work or during your clinical experiences. Observe people in all settings to see if and how the skills are used. I think you will find that many people don't use them, and then there are problems.

To be really good at active listening and assertive communication, you need to do what **does not** come naturally. You need to overcome your natural tendencies as a person. With attention to yourself and others, you can develop these skills, and they will be strengths to you throughout your career.

CASE STUDY

It is 7:35 a.m. and you are the nurse in charge of a 25-bed skilled nursing facility (SNF) unit at the nursing home where you work. The night nurse went home early because she was ill, and you have just discovered that only half of the 6:00 a.m. medications have been distributed. You have a new LPN orienting with you, but she is a recent graduate, and you are not yet sure of her skill level.

You have an 8:00 a.m. meeting with the social worker and a family who is struggling with the decision of whether to allow their mother to die or to place her on stronger life-support mechanisms. The final concern you have is making up the payroll. It is your responsibility to have the paperwork completed on the payroll by 9:00 a.m. If the payroll forms are not in the personnel office, a 3-day delay will occur in paying the employees on your unit. It is the week before Christmas.

As you are struggling to set priorities for the morning, Dr. N. comes onto the unit in a rage and begins talking to you in a raised voice and with an angry nonverbal appearance. This is a physician who is known as a bully with both nurses and families, yet you have learned by working with him that he really does care for his residents. You stop everything you are doing to listen to him degrade you with his unprofessional manner. The halls are full of residents and employees who are watching this situation. As the charge nurse, you are responsible for all activities on the unit.

Please make a priority list with an explanation for the ranking of each item. Then, in narrative form, describe how you would implement the priority list you have made. Good luck!

Discussion

PRIORITY LIST

1.

EXPLANATION:

2.

EXPLANATION:

3.

EXPLANATION:

4.

EXPLANATION:

Solution

1. The medications must be distributed.

EXPLANATION: The medications are already an hour and a half late. This could have very serious physiological consequences for the frail elderly residents on the unit. This is a critical need.

2. The physician must be managed.

EXPLANATION: He is preventing me from resolving the other problems on the unit, and some of them are critical. In addition, he is very disruptive to the people (including residents) on the unit.

3. The meeting with the social worker and the resident's family must be held.

EXPLANATION: This is a very emotional situation for this family, and it is unethical and unkind to ask them to wait or come back at a more convenient time. An issue of this importance cannot be delayed once people are ready to deal with it. It is listed third because the meeting could go ahead without me since the social worker will be there.

4. The payroll forms need to be completed.

EXPLANATION: It is unfair not to have the employees paid in a timely manner. Yet people are always more important than paperwork. This could wait because paperwork does not bleed, die, or have feelings.

Narrative Explanation of This List

I would ignore the physician and his screaming; in the meantime I would call an experienced nurse on another unit. I would quickly explain to her the medication errors and the availability of only my newly hired LPN for assistance. My request would be for her to come to my floor and work with the new LPN to pass the medications that were missed. I am asking her for 30 minutes of her time in an emergency situation. I would not turn this assignment over to the new LPN because I am unsure of her skill level. This is a critical situation that demands immediate correction by someone with a very high skill level.

CASE STUDY *(continued)*

Because I know the physician really cares about his residents, I would resist the desire to humor him; instead, I would let him know that I had a resident emergency and could see him about his problem after 10:30 a.m. This is not a good example of problem solving with him, but it is an excellent example of setting priorities. He might still be angry with me, but I would be keeping my residents in the best health possible with my decisive action. My hope would be that his natural caring for residents would prevail, and he would cooperate in this situation.

I would notify the social worker that I would be at the meeting but that I might be late. And, finally, I would call the personnel office and explain to them that a crisis involving the residents occurred and that the paperwork would be delivered to them by noon. If that did not allow for the employees on the unit to be paid in a timely manner, I would request that an employee from their office come to the floor and do the necessary paperwork.

I would not give lengthy explanations to any of these people. Instead, I would count on my professional reputation to underlie the urgency of the situation. After the day was under control and all of the problems resolved, I would very conscientiously go to each person involved and thank him or her for their cooperation and give the explanation each person deserves. I would call the night nurse and let him or her know of the situation and ask the nurse to come in within 24 hours to complete the medication error forms. I already would have made the necessary phone calls to the physicians informing them of the medication errors.

STUDY QUESTIONS

Select the best answer to each question.

1. Every LPN must practice within the definition of the State Nurse Practice Act. The best way for an LPN to determine whether the current job description is within the current Nurse Practice Act is to:

a. Ask the supervisor.

b. Discuss it with the personnel office during the hiring interview.

c. Read the Nurse Practice Act.

d. Ask another LPN.

2. The authoritarian style of leadership is the most effective to use in gerontological settings because:

a. The work gets done in a timely manner.

b. Geriatric settings have many emergencies to manage.

c. Authoritarian leaders are very person focused.

d. Authoritarian leadership is not strongly compatible with elder-care settings.

3. The most honest form of communication is:

a. Nonverbal communication

b. Verbal communications with facial movements

c. Sitting quietly and listening

d. The written word

4. Assertive communication is:

a. Inappropriate for an LPN to use

b. A meaningful way to share angry feelings

c. A learned behavior that allows for effective communication

d. A normal physiological response to stressful communication

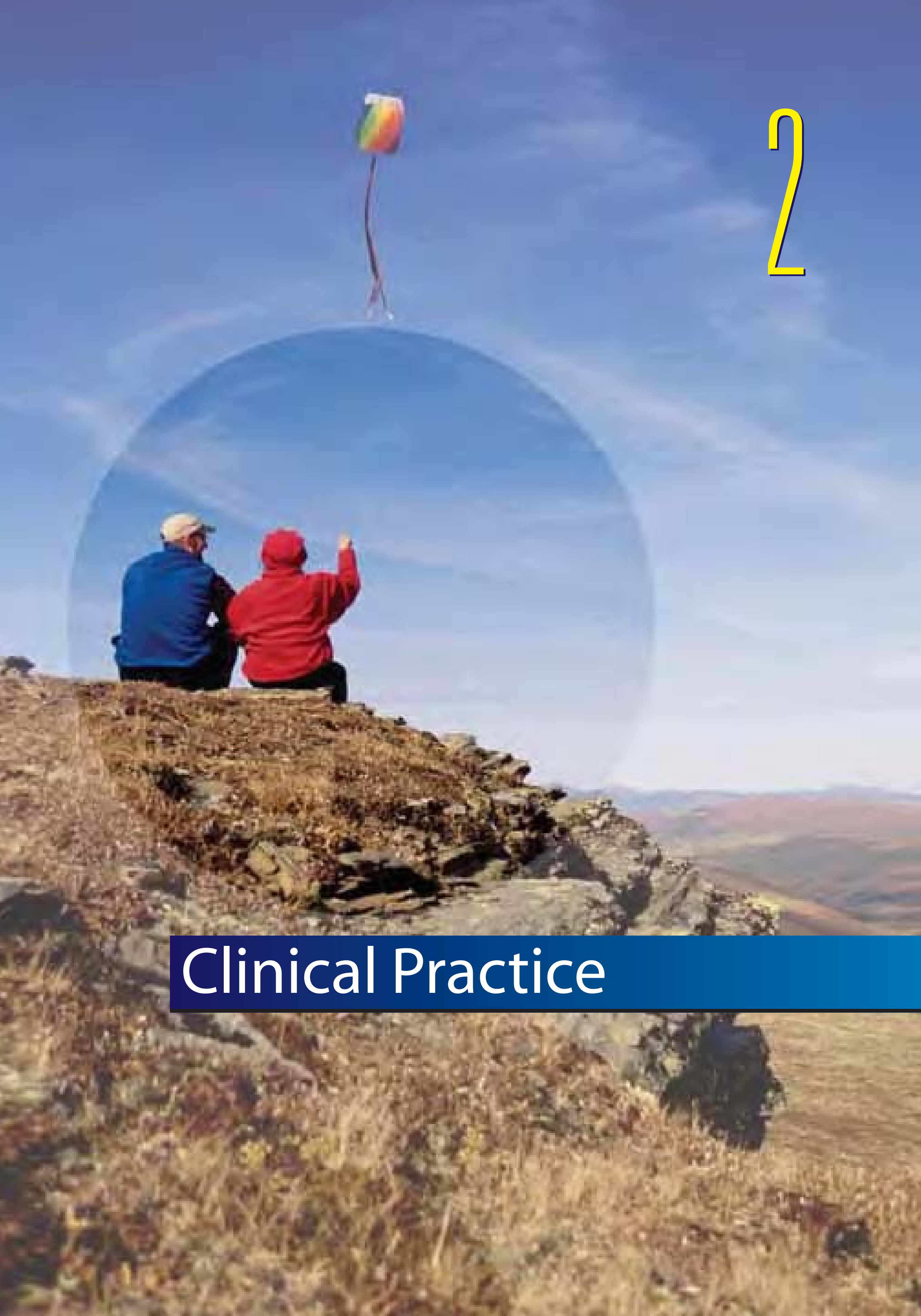
5. The purpose of an employee interview is to:

a. Learn the prejudices of the applicant before employment

b. Exchange information

c. Fill the employment quota of minorities

d. Make new friends


2
Clinical Practice

12 Common Infectious Diseases

Judith Pratt
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Learning Objectives

After completing this chapter, the student will be able to:

1. Identify causes of common infectious diseases in older adults.
2. Use appropriate environmental and hygienic measures that will reduce infectious diseases.
3. Identify measures that will assist older adults in maintaining a healthy immune system.
4. Identify appropriate immunization protocols.
5. Identify infections that can be precipitated by chronic medical conditions and by the aging process.
6. Discuss the role of the licensed practical nurse (LPN) in the management of infections in older adults.

INTRODUCTION

Everyone wants to be healthy. Even the simple head cold is an irritating and inconvenient event in our lives. As a nurse, you know that there are many more serious infectious diseases than a head cold. When these infections attack older adults, the problems can be grave. This chapter is a challenge to you, the bedside nurse, to knowledgeably protect older adults from the harsh reality of infectious diseases.

Natural immunity toward infectious diseases may not be affected by aging in healthy older adults (Tadloski, 2006). Yet some infections tend to increase with the process of aging and are major health problems in the older population. Older patients' physiological responses during an infectious illness differ from those of younger or middle-aged adults. In addition, the course of illnesses leading to recovery or death is different.

This chapter provides information on the prevention of infectious diseases and the treatment of infections when they occur. Items to be discussed are as follows:

- Maintaining a healthy immune system by participating in health-promoting activities.
- Preventing infections with scheduled immunizations, keeping a clean environment, and following good hygiene.
- Common infections caused by food or water, other people, animals, or insects.

Infections can affect all the systems of the body and may be precipitated by chronic medical conditions such as diabetes. In this chapter, respiratory, genital and urinary, intra-abdominal, and integumentary infections are addressed.

The nursing role in the management of infection in older adults includes recognizing, reporting, and documenting signs and symptoms of infection; complying with medical direction for care; and preventing the spread of infection.

This picture portrays a sharp contrast between the health of the immune system. This grandmother is saying goodbye to her great-grandson, who is leaving for 2 years in the Peace Corps. The great-grandson is 19 and in perfect health. Grandma is 84 and cannot be around anyone with an infectious disease because of her compromised immune system.

PRIORITY SETTING 12.1

This chapter discusses so many serious diseases that, in my mind, there is only one overriding priority. It is described well in the chapter. I can summarize it by saying, "Wash your hands!" But the chapter does a better job.

There are many new viruses that are being discovered and can cause an outbreak of illnesses such as the SARS outbreak a few years ago. As the nurse caring for older adults, you need to be aware of your own personal hygiene and become vigilant about washing your hands and taking proper care of soiled materials. Masks, gloves, and gowns should be worn when there is a question about the spread of an infection. Remember to protect yourself, as well as others, from a potential infection. There is a possibility that infections can be carried from patient to patient on the hands of a nurse. As a dedicated caregiver, you do not want to make the people you care for ill.

POINT OF INTEREST

Infectious disease and hand hygiene are words often used at the same time. It is important to note that hand hygiene, washing your hands with soap, water, and friction for a minimum of 15 seconds, is the Centers for Disease Control and Prevention's recommendation. Teaching older adults this principle may save them many illnesses. As a health-care provider, it is important to remember to do appropriate hand hygiene between patient-care activities. In home health, extended care, or hospitals there may be alcohol hand rubs. These products are safe to use and helpful in decreasing the spread of infections.

To make this point even more vivid, I thought you might like to know about an exciting celebration at one of the hospitals where I work as an infectious disease nurse. It was a registered nurse's birthday. She was working part time in the operating room, and she was 80 years old! In speaking with her about her ability to work while being 80, she stated that the basics make a difference. "I try to eat healthy food, drink enough water, and golf. I also take the recommended influenza shot each fall, and I have had my pneumococcal vaccine. I always try to remember what my mother taught me, to wash my hands when I need to and always clean up after myself."

This nurse is a living ad for good infectious control techniques.

MAINTAINING A HEALTHY IMMUNE SYSTEM

One of the purposes of the immune system is to protect the body from the invasion of harmful bacteria, fungi, viruses, parasites, and other microorganisms. As the body ages, lymphocyte function and antibody immune responses become delayed or inadequate and put the older adult at risk for infections. The following are ways to support the health of the immune system.

Nutrition

The LPN is responsible for assessing and monitoring the older person's nutritional status. This is an important aspect of maintaining a healthy immune system. (Review nutrition and the reasons for poor nutrition in Chapter 6.) It is important to identify nutritional deficits and potential reasons for these deficits. The LPN must determine, through questioning and observing the person's nutritional patterns, why there may be deficits in eating. There often are problems with older adults and the food they eat. Food may be too expensive, or it may not taste good because of the decreased sensitivity of the taste buds. Perhaps there is no desire to prepare food, or the older person may be unable to chew or digest food properly. These are just a few reasons for poor nutritional patterns. You, the LPN, are an important team player when reporting nutritional concerns and potential solutions to members of the interdisciplinary health-care team (IDT) for management.

Fluid Intake

Another nutritional challenge is for older adults to maintain adequate fluid balance for wellness. Dehydration following outside activities, an illness, or not drinking enough fluid during the day can lead to potential problems. It is common for older adults to not drink sufficient fluids during the day. Fluid intake should be assessed, along with nutritional intake and deficits.

Lifestyle

The need for exercise, rest, stress management, avoidance of cigarette smoke, and alcohol usage are discussed in Chapter 5. Compliance with these activities heightens the abilities of the immune system. As an LPN, you need to assess compliance or noncompliance with these activities frequently and educate the person as necessary. Knowing the older adults' lifestyles, living conditions, and economic situations are important when endeavoring to assist them in maintaining a healthy immune system.

Chronic Medical Conditions

Chronic medical conditions have an effect on the older adult's immune system. Chapter 13 discusses chronic medical conditions and the potential for infections. A classic example is the person with diabetes. You need to educate the diabetic person to take precautions to prevent infections by wearing appropriate shoes, observing for lesions that do not heal, and caring for skin cuts and abrasions.

Urinary Tract Infections

Preventing urinary tract infections is an important aspect of preventive nursing. Older adults should be encouraged to drink adequate fluids and to empty their bladders frequently. If incontinence occurs, older persons should have their skin cleansed and soiled clothes replaced. Older adults' skin is sensitive and can break down, which invites infection. Catheters often are a source of infection; the LPN needs to follow agency protocols in an effort to prevent them.

Respiratory Infections

Respiratory infections may have a significant effect on the older adult. Older people need to be encouraged to receive influenza and pneumococcal vaccines to prevent severe respiratory infections. Increased fluids will keep the secretions thin and allow the pathogens to be coughed out of the respiratory tract.

The pneumococcal vaccine builds antibodies to fight against 23 pneumonia organisms. I know an older active adult who enjoyed the many busy things she was doing in the areas of service as a volunteer at the local hospital. She was around patients and welcomed them to the hospital at the front entrance desk. Each winter she would miss several months of volunteer service because she had pneumonia. After receiving strong encouragement from her physician and several older friends, she decided to receive the pneumococcal vaccine. She has not had pneumonia since! Often, it simply is education that individuals need to make the decision to improve their health. You, as the LPN, are in a perfect position to provide the necessary teaching.

Intra-Abdominal Infections

Intra-abdominal infections are common in older adults. Signs and symptoms of infections may be difficult to differentiate from other chronic diseases in the older person. Laboratory results and uncharacteristic complaints may confuse the findings. Older adults may have coexisting conditions or be mentally confused, making history and physical examination difficult or misleading. Cholecystitis, diverticulitis, and appendicitis are examples of intra-abdominal infections that may be difficult to diagnosis in older people. The LPN is able to help gather verbal information, note signs and symptoms, and evaluate vital signs to assist in diagnosing the condition.

Integumentary System

With age comes changes in the integumentary system. Many factors influence changes in the course of aging. Exposure to the sun, diet, heredity, and general health affect the skin. Pressure ulcers and their potential for infection are discussed in Chapter 15. The LPN needs to be aware of other skin infections. Redness, swelling, pain, lesions, and discoloration are among the signs and symptoms of skin infections. As an LPN, you will report all signs and symptoms of a skin infection to the registered nurse (RN). If requested, you will obtain a specimen for culture. Culture and sensitivity tests may be necessary to identify the organism causing the infection and to treat it appropriately.

The following microorganisms are listed to give an overview of skin pathogens:

- Staphylococcal bacterial infections are impetigo, boils, carbuncles, and cellulitis.
- Streptococcal bacterial infections are impetigo and erysipelas.
- Fungal infections are the cause of "athlete's foot" and thickened nails on the fingers and toes.
- Viral infections are herpes zoster and herpes simplex.
- Scabies and lice are examples of parasitic infections.

It is impossible to protect people from the invasion of harmful microorganisms, but an older adult with a healthy immune system will have a better recovery if an infection occurs. Adherence to wellness activities plus additional measures to prevent infections should be used for a positive outcome.

PREVENTING INFECTIONS

Immunizations

Immunization recommendations change as people age, and health conditions affect immune responses. Unfortunately, the need for the older adult to be immunized is not always recognized. Immunization histories may not be part of the person's medical record or the information simply may not be noted. The older adult's immune system may need to be "boosted" for the body to continue to have the ability to resist certain infections. The LPN must consider the need for the older adult to have continued protection from preventable disease.

Diphtheria-Tetanus

Diphtheria-tetanus (DT) vaccine is probably the most overlooked immunization. Once the initial DT series has taken place, a booster is required every 10 years for life. The LPN should evaluate the DT status for all older adults and determine the need for a booster. Often, it is discovered that some older adults have never had a DT series. All the men going into the military during World War II were given DT immunizations, but during this time period, women were not routinely immunized. Not all adults who lived during the 1940s were immunized. The LPN should report the need for the DT series if a person is identified who has never had it.

Influenza Vaccine

The influenza or "flu" vaccine should be given each year to all adults older than 65 years, unless contraindicated. Older adults who have lung disease, diabetes, kidney disease, or other diseases that affect the immune system should be particularly encouraged to get the vaccine. The flu virus changes each year, so the formulation of the vaccine changes each year. Vaccines should be given starting around mid-October. The vaccine is generally available in physician offices, senior centers, home-health agencies, public health departments, and certain places of business.

Pneumococcal Vaccine

Pneumococcal vaccine provides protection against 23 pneumonia organisms. Only one dose is needed if it is given after the age of 65, but there needs to be a booster every 5 years following the initial dose. When chronic health conditions such as lung disease, heart disease, diabetes, kidney disease, alcoholism, liver disease, cerebrospinal fluid leak, or cancer are present, the vaccine should be considered at age 50 (CDC Guidelines, 2005). If pneumococcal vaccine is given before age 65, a second dose would be required after age 65. The second dose would need to be given at least 5 years after the first dose. The physician or primary care provider will make the determination as to when the vaccine should be given. The vaccine is available from a physician's office, hospital, or public health department.

Hepatitis A

Hepatitis A vaccine arrived on the market during the past several years. Hepatitis A is recommended for people traveling to global areas where hepatitis A prevalence is high. In the past, people traveling to some countries would request immune globulin or the "gamma shot." Now, getting the first dose of a two-dose series of hepatitis A 2 weeks before traveling will provide significant protection against this disease. For the best protection, the older adult should receive both doses. Immune globulin "gamma" will not be necessary after the hepatitis A vaccination series has been completed. The vaccine will provide protection for many years.

Hepatitis A is prevalent in some areas of the United States as well, and a hepatitis A vaccination may be warranted. Local health departments should be consulted as needed. The vaccine is available at public health departments.

Hepatitis B

Hepatitis B continues to be problematic throughout the world. Older adults traveling to areas of the world where hepatitis B is present should

POINT OF INTEREST

It is important to note that a DPT (diphtheria-pertussis-tetanus) should not be given to adults. The pertussis (whooping cough) vaccine in the standard DPT can make adults very ill. DT (diphtheria-tetanus) vaccines, however, are safe for adults and are available at physician offices, hospitals, and public health departments.

However, older adults can still get whooping cough, and they may give the infection to young children who visit them. Older people become ill with whooping cough, but their bodies are able to fight the infection in most cases. However, young children with pertussis can become critically ill and even die.

Older adults who have young children visit them may want to be immunized with a new vaccine specifically for older people. It does not make older people ill, and it offers another layer of protection for young children. The vaccine is available at some doctors' offices.

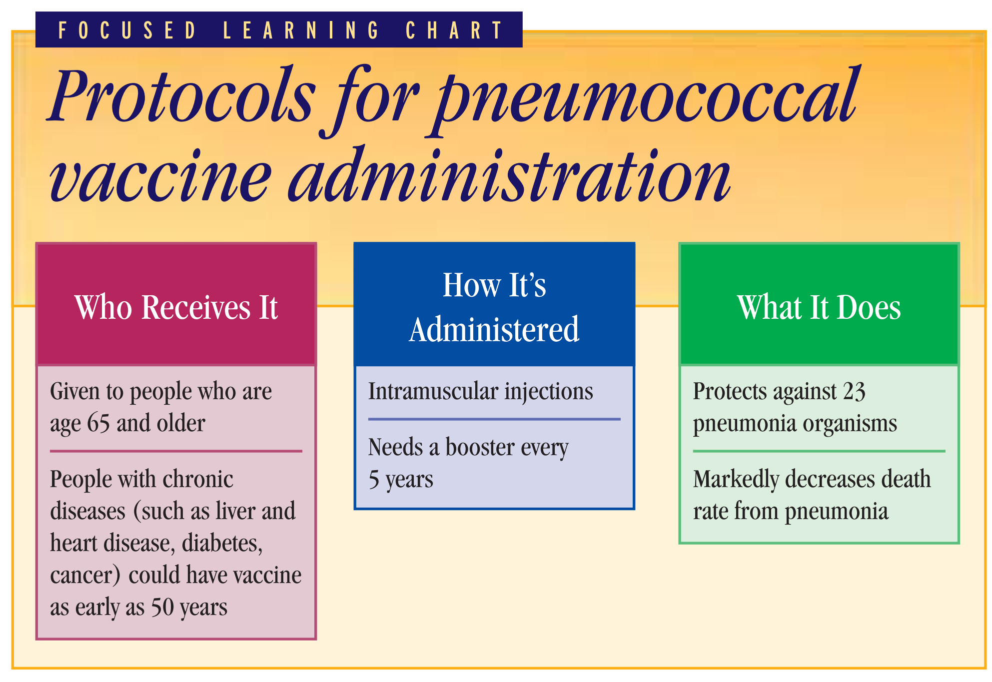
POINT OF INTEREST

The pneumococcal vaccine builds antibody to fight against 23 pneumonia organisms. I know an older active adult who enjoyed the many things she was doing for service as a volunteer in the hospital. She was around patients and welcomed them to the hospital at the front entrance desk. Each winter she would miss several months of volunteer service because she had pneumonia. After receiving the pneumococcal vaccine, though, her pneumonia days were over. She now enjoys working each winter at her favorite spot, the front desk, welcoming people who come to the hospital. The pneumococcal vaccine is recommended for people with chronic diseases such as diabetes or heart disease and for people who are over 65 years of age. The vaccine needs to be renewed every 10 years.

consider being vaccinated. If the person is planning on staying in the country longer than 6 months, hepatitis B immunization should be strongly encouraged. The vaccination is given in a three-part series over a 6-month period. Patients on kidney dialysis or requiring transfusions for clotting problems are candidates for hepatitis B vaccine. Older adults who provide services to developmentally delayed persons, health-care workers, or safety workers should consider being vaccinated. Hepatitis B has not been specifically categorized as a sexually transmitted disease, but it is a blood-borne pathogen. The LPN may be asked to evaluate the patient's sexual history to help the primary health-care provider decide whether or not to vaccinate against hepatitis B. The vaccine may be available at hospitals, the physician's office, or the public health department.

Measles-Mumps-Rubella

Measles-mumps-rubella (MMR) is thought of as a childhood immunization. The vaccine may be recommended for persons who travel internationally. Health-care workers and older adults who are actively working with or volunteering to help "high-risk groups" should be considered for MMR immunization. Even if MMR has been given during the person's lifetime, a second dose of MMR is recommend for people in the above-mentioned groups. The LPN will assess the immunization status and report the findings to the primary care provider, who will determine



FOCUSED LEARNING CHART

Protocols for pneumococcal vaccine administration

Who Receives It	How It's Administered	What It Does
Given to people who are age 65 and older	Intramuscular injections	Protects against 23 pneumonia organisms
People with chronic diseases (such as liver and heart disease, diabetes, cancer) could have vaccine as early as 50 years	Needs a booster every 5 years	Markedly decreases death rate from pneumonia

immunization needs. The vaccine is available at hospitals, the physician's office, or the public health department.

Meningococcal Vaccine and Haemophilus Influenzae Type B

Older patients with compromised immune systems, organ transplants, cancer treatments, or splenectomy should be considered for meningococcal and *Haemophilus influenzae* type B (HIB) immunizations. The immunizations also are recommended for older adults who travel to areas of the world where these diseases are prevalent. The LPN will assess the immunizations and report the findings. The primary health-care provider will determine if the immunization is needed. The vaccines are available from the public health department.

Immunizations should be continued throughout life for vaccine-preventable diseases. A report from the United States Centers for Disease Control and Prevention (2005) claimed that approximately 50,000 American adults die from diseases that could have been prevented by vaccines or complications as a result of not being immunized. Immunization histories are an important part of the assessment you, as the nurse, will perform. New vaccines are being developed, and when completed, they will be added to the list of available treatment options.

SAFE FOOD AND WATER

Food-borne diseases are very common in the United States. Each year millions of people become ill due to contaminated food, and thousands die. Microorganisms find food a great place to live and breed. The signs and symptoms of food-borne diseases may resemble a bad case of "stomach flu," and the older adult may delay seeking medical care. Most food-borne diseases have common signs and symptoms, which are sudden onset, abdominal pain, fever, and vomiting and diarrhea. Laboratory testing (stool culture) is required to identify the infecting organism. The LPN will need to instruct the person on collecting a stool specimen.

Campylobacteriosis

Campylobacter infections are the most common food-borne diseases. Foods most commonly associated with *Campylobacter* infections are undercooked poultry, unpasteurized milk, and contaminated water (campylobacteriosis is also known as travelers' diarrhea). Inadequate cleaning of food preparation areas and poor hand washing before food preparation can lead to infection. Symptoms of *Campylobacter* infection are diarrhea, abdominal pain, fever, nausea, and vomiting. These symptoms occur within 2 to 7 days after exposure. A stool specimen will be required for an accurate diagnosis. The older adult is at risk for dehydration complications due to the diarrhea. The LPN needs to encourage the elderly person to drink more fluids. *Campylobacter* infections may resolve without medical treatment, but those with dehydration and delayed recovery need to be referred to a health-care provider. The LPN will need to educate all household members about hand washing to prevent the spread of the infection to others.

Cholera

There are sporadic outbreaks of cholera in the United States that are related to eating raw or undercooked seafood from contaminated waters. In addition, cholera can be spread by the people preparing foods and by foods that have been washed with contaminated water. The main symptom of cholera is diarrhea, and it may appear in a few hours or up to 5 days after exposure. Stool specimens are required for diagnosis and treatment. Increased fluid intake needs to be stressed because diarrhea will put the older adult at risk for dehydration. Medical intervention may be required. Travel information is available for people who plan to visit global areas where cholera is present. The travelers should be particularly aware of food preparation, water, and certain foods being served (cdc.gov, 2006).

Salmonella

Salmonella bacteria can be found in many foods, such as custards, milk, eggs, salad dressing, and shellfish. Contaminated water and food handlers are the causes of many salmonella infections. Symptoms of infection are diarrhea, fever, and abdominal cramps that usually occur within 12 to 72 hours after exposure (cdc.gov, 2006). A stool specimen is required for the diagnosis of salmonella. The concern of salmonella infection in the older adult is dehydration from the diarrhea. Again, the LPN needs to educate the person to increase fluid intake. As in all cases of food-borne illnesses, the LPN needs to educate household members to practice good hand washing and to keep food preparation places clean.

Shigella

Shigella infections are found in many foods and are usually due to contaminated water or poor hygiene practiced by food handlers. Symptoms of infection are vomiting, nausea, cramps, and diarrhea, with blood and/or mucus in the stool. Symptoms may occur from 12 to 96 hours after exposure. Shigella may require medical intervention in the frail elderly person and other older adults. Increased fluid intake is important, and the LPN needs to give instructions to family members on hand washing and sanitary food preparation.

There are other food-borne infections that are not mentioned in this chapter. Signs and symptoms of food-borne infections are similar, and diagnosis can be made only by a laboratory test. You, in your role as the nurse, will want to note the following in a suspected food-borne illness: the time that signs and symptoms occurred, what the person ate in the last few days, where the food was served, and whether other people became ill. This information should be reported to the local health department. The health department investigates all potential food-borne diseases, and they will take appropriate actions.

Food-borne infections can be prevented by good hand washing, using safe foods, and keeping food preparation areas sanitary. You need to instruct those preparing food to:

- Store food correctly
- Protect food from insects, rodents, and animals
- Cook food thoroughly
- Eat cooked food immediately
- Refrigerate uneaten food immediately
- Reheat cooked foods thoroughly
- Wash hands frequently
- Keep food preparation areas clean

CRITICALLY EXAMINE THE FOLLOWING:

You are working at the local health department and have been asked to answer the phone while the secretary goes to lunch. You are the only nurse in the department when you receive a call from Mr. Harold Gee. Mr. Gee reports to you that he and his wife began vomiting and having diarrhea a few hours after eating a shrimp salad at a local restaurant. Mr. Gee mentions his wife has a history of heart problems since her heart attack at age 60.

What information will you want from Mr. Gee?

Why will you report this information to your supervisor as soon as possible?

Note: Health departments have information report forms that are used by the public health nurse when conducting a potential food-borne infection investigation. This form may not be immediately available to you when the call comes. Nevertheless, it is a form you need to know exists.

ENVIRONMENTAL CLEANLINESS

Household Pets

Household pets are a source of friendship and companionship for older adults. However, older people need to be aware that pets also can become a source of infection. Pets may become infected and transfer their disease to household members. Animal waste can become a source of infection if it is not properly handled. Pets need health and medical consideration to protect the older adult from a disease carried by a pet. An

POINT OF INTEREST

While I was consulting for an extended care facility, a call came that three health-care workers had diarrhea as did two residents. Any more than two cases of diarrhea at one time in a nursing home is an alert for close observation to see if others come down with the same symptoms. Stool cultures were sent to the laboratory, and while we waited for the results, four more resident and two more health-care providers became ill with diarrhea. It was important to stop the spread of this organism. The recommendation was to have everyone eat in his or her own room, stopping all dining room privileges. All outside activities with large groups were stopped, and an extra person worked with environmental services to clean all parts of the facility. Staff, residents, and family members were instructed on hand hygiene and the appropriate use of gloves. Shortly the diarrhea stopped with just two more cases. The organism was Norwalk virus. It has killed many older adults in nursing homes because of their weakened conditions.

assessment of the home always should include mention of household pets and how the care of the pet is managed.

Kitchens and Bathrooms

Kitchens and bathrooms are great harbors for infections. Household assessments need to include bathroom inspection of towels, tooth-care items, sinks, tubs, and toilets. Instructions by the LPN include not sharing personal hygiene items such as razors and tooth-care articles. Kitchen assessments involve reviewing food preparation and food storage, as has already been mentioned. Personal cleanliness and hygiene may need frequent instructions. When instructing older adults about hand washing, the LPN should include cleaning under the fingernails. Older adults who love and care for others in the household would not want to be the cause of a loved one's illness.

SEXUALLY TRANSMITTED DISEASES

Many health-care providers are uncomfortable when considering sexually transmitted diseases (STDs) in older adults. One of the myths of aging is that older people do not participate in enjoyable sexual activity. The reality is that they can, and many do! The development of new medications, such as sidenafil (Viagra) and various vaginal creams, has the potential to increase sexual activity, as well as sexually transmitted diseases, in older persons.

Some people who have lived in monogamous relationships and have lost their companion may have sexual relations with one or more persons who have uncertain sexual histories. This factor can have a strong impact on an older adult's overall health. There are several STDs about which you, as the LPN in the community, should have a working knowledge. These STDs include syphilis, gonorrhea, chlamydiosis, hepatitis A, B, and C, HIV, genital warts, lice, and other viral and bacterial infections. These diseases generally are discussed in basic medical/surgical classes. Their impact and treatment in older adults do not differ from that of younger adults.

As the nurse, you need to teach older adults who are sexually active with more than one partner the signs and symptoms of STDs and to seek medical treatment for them immediately. Older adults tend to not discuss sexual matters with younger people. This is a barrier you need to overcome through caring and sensitive communication skills. Older adults need to realize the variety of STDs and the symptoms of the most common ones. They should be able to report their symptoms clearly so the appropriate tests can be performed for accurate diagnosis. Common symptoms are pain, discharge from the penis or vagina, abdominal pain, and genital lesions. Your responsibility is to teach the older adults in your care about STDs, their signs and symptoms, how to get appropriate care, and how to have safe sex.

Obtaining a Sexual History

Prevention of STD infections in the older population is the reason for obtaining a sexual history from the person. Some older adults are at little or no risk for STDs, whereas others may be at high risk. Health education, appropriate treatments, and stopping the transmission of STDs begin with the identification of at-risk behavior.

A sexual history is an integral part of a complete patient history profile. The right questions need to be asked to elicit responses that give key information about risk factors and patient behaviors. Open-ended questions are more likely to give responses that have the most pertinent information. "Tell me about your sex life" will give much more information than simply asking, "Do you have sex?"

Patients must be reassured that their responses are confidential. Developing a confidential relationship will aid the LPN in building a rapport of trust and confidence with the older adult. It is important to remember that the patient's values regarding acceptable sexual behavior may differ from yours, and you should not make personal judgments.

Some specific questions need be asked and may cause you, as the interviewer, to be uncomfortable. Questions such as "How many sexual partners have you had in the past 3 months?" or "Do you prefer to have sex with men, women, or both?" can seem intrusive. However, the answers can be very important when identifying potential risks for STDs. A complete sexual history should be included on the history form.

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome

The CDC (2002) is concerned about the rise of HIV/AIDS in people older than 50 years of age.

These homeless men are sexual partners and survive together on the streets. The elder man is HIV positive; it is a near-certainty that he will transmit the disease to his partner. Neither man has insurance; therefore, they are/will be unable to pay for the HIV medications that promote an improved quality of life.

Florida has the highest rate of HIV/AIDS in people over age 50 in the United States. There are approximately 87,000 people (CDC, 2002) with HIV/AIDS in the 50+ age group in this country, which constitutes approximately 10% of all persons with HIV/AIDS nationally. The increase in the disease in the older age group is attributed to the lack of education of HIV/AIDS directed toward older persons, as well as the performance-enhancing drugs that have increased sexual activity for older people.

The initial intervention you, as the nurse, need to undertake is sex education. People in their 60s, 70s, 80s, and beyond generally have not had the benefit of sex education on any level. They did not have the friendly chat with their mom, high school gym teacher, or a sex counselor. An intensive but sensitive interview may indicate that the older adult does not have a full working knowledge of his or her own reproductive system even after having multiple children. This is the place to start if your assessment indicates that there is a knowledge deficit in this area. Be careful to not patronize older adults, or in other words, do not treat them as though you are the "all-knowing" parent. Be a colleague and a friend. Explore the information together. Share only what is essential for good health unless the learners indicate a desire for more information. Allow them to share the wisdom that comes through the experience of having and raising children, often under very dire circumstances.

The second educational concept you need to teach sexually active older adults is safe sex. Many older people no longer feel a need to protect themselves sexually because they are not concerned about becoming pregnant. Your responsibility is to teach them that safe sex also means protection against STDs, most critically HIV/AIDS. Many older adults have never used a condom. It may be uncomfortable to teach someone old enough to be your grandparent how to use one. The easiest technique may be practicing putting a condom on a banana. It is acceptable to laugh and make the teaching fun. That will assist the older adult who is uncomfortable with the exercise to relax and learn better. Make the point that the only truly safe sex is abstinence or monogamy. Then emphasize that condoms are next in terms of safety and should always be used. Again, older adults often associate condoms with birth control, something about which they no longer feel concern.

Another point that needs to be explored with sexually active older adults is the type of disease HIV/AIDS really is. In this, the 21st century, many people view HIV/AIDS as a chronic disease. The common association is with diabetes mellitus. People recognize diabetes as a disease for which there is not a cure and one that requires a careful medication regimen. It also is seen as something with which millions of people live successfully. People like "Magic" Johnson, a former national basketball star with HIV, help perpetuate the chronic disease myth.

It is critical that the older adults you teach understand that HIV/AIDS is a killer disease, not a chronic disease. The medications that keep people with this disease alive must be taken every 4 to 6 hours around the clock. It requires setting an alarm during the night because doses cannot be missed. Those who think of HIV/AIDS as a chronic disease do not see the gastrointestinal distress and emotional agony that accompany this disease. It is a tragic process.

The patient care for hospitalized older adults with HIV/AIDS is similar to other fragile patients or residents. Be gentle and do not rush the care

POINT OF INTEREST

Recently, the Centers for Disease Control (CDC) changed the term *universal precautions* to *standard precautions* (CDC, 2005). This term means to treat all body fluids as if they are contaminated with a blood-borne pathogen.

given. Listen to the needs of the older person, and take the time to demonstrate genuine caring.

When caring for someone with HIV/AIDS, always use standard precautions. It is critical that you follow the medication regimen closely and report any adverse reactions immediately. Good nutrition and hydration also are important. You can encourage this by sitting with the older adult in a nonrushed manner and providing encouragement to eat and drink. The intake and output on older adults with HIV/AIDS should be carefully noted.

The person with HIV/AIDS is often a person who is dying. Review Chapter 9, "End-of-Life Issues in the Older Adult," and evaluate how you can apply the information to the person with HIV/AIDS. Do not judge the person to whom you are giving care. Some people are critical of HIV/AIDS persons and believe that they "deserve" the disease. That simply is not true. Do not be taken in by such thinking.

The responsibility you have as the nurse is to educate the sexually active older adult in an effort to promote avoidance of all STDs, especially the growing numbers of individuals with HIV/AIDS. If you are caring for a person with HIV/AIDS, you have a responsibility to assist him or her with management of the disease and to deliver quality palliative care.

Human Papillomavirus Infection

There are many types of human papillomavirus (HPV) that can infect the genital tract and anus of both women and men. Generally the resulting genital warts are not painful and, if visible, have a "fleshy" cauliflower appearance. The warts easily can be spread and increase in frequency with an increase in the number of sexual partners. A patient can be infected with multiple types of HPV at the same time. The LPN must be aware that some cancers of the genital tract are associated with HPV infections. Medical treatment should begin as soon as diagnosis is made.

Trichomoniasis

Trichomoniasis is a condition caused by a protozoan pathogen. Generally, symptoms are characterized by a foul-smelling yellow-green discharge. Women may complain of intense vaginal itching, especially at night. Pain and burning upon urination are common complaints with this STD. Redness and swelling may be present. Women more often have complaints with this STD than do men. All sexual partners should be treated.

Gonorrhea

Gonorrhea is caused by the bacteria *Neisseria gonorrhoeae*. In this disease, symptoms are much more pronounced in men than in women. Symptoms in men are large amounts of green discharge from the penis, as well as burning during urination. Testicular pain is frequently reported. Often, women present with abdominal or pelvic pain. Treatment needs to begin at once after diagnosis is made. All sexual partners need to be identified and treated.

POINT OF INTEREST

While I was working in the intensive care unit, an older adult woman came in very immunocompromised. She had lost a great deal of weight and was feeling very weak. She had an infection her body was not fighting. In the interview with her husband, I found out that the two of them had been married for about 6 months. The physician wanted an HIV test done on the patient. When I asked permission for the blood test from the husband, he began to cry and shared that he was HIV positive and had hoped his wife would not get the disease.

The woman immediately was started on an aggressive regimen of medication, but the most difficult thing for her was understanding why her husband had not told her about his illness before being married. She was both emotionally and physically devastated.

Chlamydia Trachomatis

Many people who are infected with gonorrhea are coinfected with chlamydia. Signs and symptoms of chlamydial infections are similar to gonorrheal infections. As the nurse, you need to assist in identifying sexual partners for treatment.

Syphilis

Syphilis is a complex disease and can manifest itself throughout the lifespan if it is not detected and treated. Generally, the description of the disease is based on signs and symptoms at the time the diagnosis is made. The first symptoms appear about 3 weeks after exposure. A chancre, or open painless sore, appears. The chancre can appear anywhere on the body. It is the classic symptom of primary syphilis. The sore resolves without treatment, but that does not mean the disease has disappeared.

Secondary syphilis is marked by a classic rash most prominent on the palms of the hands and the soles of the feet. You, as the nurse, should report these unique symptoms as soon as they appear so treatment can be started. These symptoms may last a few weeks or a year without treatment.

If syphilis is not treated in the primary or secondary stage, latent syphilis symptoms will present as neurological impairment, mental retardation, and memory problems. Syphilis may not be identified until the latent stage, when an older adult exhibits the symptoms of latent syphilis.

Treatment for syphilis is stage dependent. Fortunately, testing techniques are advanced and detection is usually made early, in the primary stage, when cure is likely to be successful. The exacerbating and remitting nature of the disease, moving from an acute phase to dormancy, makes this a difficult disease to diagnose. That is why a good sexual history is so important.

Genital Herpes

Genital herpes is caused by a virus, which is unfortunate because treatment options for virus infections are limited. Herpes usually present with blisters on the genital area. These blisters are fluid filled and very painful. Besides the blisters, other symptoms include itching, tingling, burning, or even achy joints. Transmission of the virus can occur with or without symptoms. As the LPN, you can educate the older adult about the transmission of the virus that causes genital herpes. Antiretroviral therapy is not curative and seems to only shorten the duration of symptoms and infectiousness.

Hepatitis B

Hepatitis B is transmitted sexually as well as by exposure to infected blood. A unique characteristic of hepatitis B is that a person can be in a "carrier" state. The carrier is always considered infectious. Fortunately, a vaccine against hepatitis B has been available for several years and provides excellent protection against exposure. You, the LPN, will need to instruct the older adult about the availability of vaccine and to use condoms or abstinence to prevent transmission. A small percentage of carriers will go on to develop cancer of the liver.

Hepatitis A

Hepatitis A is usually considered a disease caused by food or water, not by a sexually transmitted disease. Men who have sex with men are at risk for hepatitis A. Hence, hepatitis A is mentioned here as an STD in gay men. As mentioned earlier, hepatitis A vaccine is available, and you should encourage those at risk to receive the vaccine to prevent infection.

TUBERCULOSIS

In the early part of the 20th century, tuberculosis (TB) was a major cause of death in the United States. In the 1940s, new drugs became available to treat TB. The United States, unlike many poorer countries, had the resources to treat all cases of TB, and the disease was almost eliminated in this country before the 1980s. Worldwide, TB is the cause of many deaths and illnesses. Resources for TB treatment have been lacking in poorer countries and continue to be problematic for world health organizations.

Few new cases of TB were reported in the 1970s in the United States because of the use of the national "push" to treat the disease. That resulted in government funding sources being cut for TB services in the 1980s. Suddenly, new cases of TB began to occur. Human immunodeficiency disease (HIV) was identified at that time, and TB was diagnosed in some of the HIV patients. Was lack of funding for treatment a reason for an increase in TB? This question continues to be debated by the public health service because treatment protocols for TB have been complicated by a TB strain that is drug resistant.

POINT OF INTEREST

Drug-Resistant Organisms

The misuse of antibiotics has caused drug resistance. This means that the organism has become familiar with the antibiotic, which cannot now kill the organism. The organisms that infect our bodies have a great ability to change in order to survive. They become familiar with the antibiotics that are in the bloodstream. If there is not enough antibiotic, or if a wrong antibiotic is used, the organism can change its shape or chemistry so that the antibiotic cannot adhere to the organism and kill it. This is what drug resistance is.

The following is the best advice to decrease drug-resistant organisms:

1. Take antibiotics only when prescribed. It is just as important that if you start the antibiotic you also finish every pill. This will ensure the killing of the organism.
2. Don't take antibiotics if you have a cold or the flu. They will not do any good. Antibiotics do not kill viruses, which are what cause colds and flu.
3. Wash your hands. This will decrease the spread of drug-resistant organisms to other people who may have weakened immune systems that could easily be infected by the organism.
4. Don't treat people who have a drug-resistant organism as though they have the plague. Your protection is to wear personal protective equipment when touching an ill person's blood or body fluids.

A research study was being done to see if older adults in a nursing home had MRSA (methacillin-resistant *Staphylococcus aureus*) colonized in their nose, and, if it was present, the symptoms and level of illness were to be recorded. A beautiful, bright, 85-year-old mother of six girls and grandmother to 17 grandchildren agreed to be in the study.

The test came back positive that she had MRSA in her nose. She was not ill with this organism. After the study identified the MRSA, the nursing home placed her into solitary confinement. She could not go out of her room to participate in the daytime activities and had to eat all meals alone in her room. This was devastating to the woman, who was in the nursing home to enjoy friends and neighbors during the last years of her life. She was very social and enjoyed her time with her friends and with her large family. This woman was also instructed to not hold, touch, or kiss any of her children or grandchildren. She was horrified about having to live as she was being told. More important, this older woman clearly was given the wrong information.

When a person is colonized (not showing any signs of an infection) with a drug-resistant organism, these are the principles that should be taught:

1. Wash your hands before you leave your room. Basic hand hygiene with an alcohol hand rub will kill drug-resistant organisms.
2. If you have a cold or a cough, you need to use tissues and good hand hygiene.

In this case, the proper teaching provided this woman with a return to her usual quality of life so she could continue to enjoy her life in the nursing home and with her family.

It is a debatable question whether a person colonized with MRSA can easily pass it to another person. I would like to share that the woman who was in this study had a roommate who shared air space, a bathroom, and conversations with her for $2^1/_2$ years. A culture was done on the roommate and came back negative, showing that the colonized person had not shared the MRSA organism with someone who was in daily close contact with her over an extended period of time.

Make sure you understand the organism a patient has and whether it can or cannot be spread. I am sure having this woman out with her family and friends lengthened her life and added a tremendous amount of enjoyment. Correct education and information will take away the fear of drug-resistant organisms.

This occurred after the period of minimal treatment of TB in this country.

Older adults have a high probability for exposure to TB from when they were younger. In many cases, they were exposed but never developed the disease. The TB bacterium may lay dormant in the body for many years and never cause an active disease unless the immune system weakens. This can happen as people age. The signs and symptoms of an active TB case are night sweats, weight loss, low-grade fever, and chronic cough.

Tuberculosis screening should be conducted on all nursing home residents to identify undiagnosed cases for treatment. Staff and other residents need to be protected from TB if a case is identified. Chapter 14 addresses TB skin testing; you may want to review it. Sputum smears also will confirm a case of active TB. The LPN may be asked to collect a sputum specimen. The protocols at your facility dictate how the specimen should be gathered. Review the protocols, and ask questions if you are unsure of the procedure.

As the TB nurse, you will need to follow the medical orders closely and watch for signs and symptoms of complications with the drug protocols. It is possible you will be asked to watch the older person take the medications to ensure that the pills are actually consumed. The medications may cause some side effects in the older person, which is why there could be attempts at avoiding them. Direct observed therapy (DOT) has been found to be successful in ensuring that the medications are being taken as directed. The LPN may do this or choose a responsible family member to observe the medication therapy.

Medication regimens will be ordered specifically for persons with TB in your care. You need to be aware of medication doses, times to be given, and possible side effects.

As an LPN, you need to teach older adults with TB to wear a mask when in public or with people. You will need to support the older person because the mask is uncomfortable to wear, difficult to use, may cause an imbalance in blood gases, and may cause the person to be sensitive about needing to wear the mask. The mask will need to be worn until sputum smears confirm that the person is no longer infectious.

Hospitals have special ventilation rooms for people with TB to prevent the pathogen from being spread to other areas of the hospital. If the person is at home and weather permits, windows and doors should be opened to ventilate the home. Sunlight destroys the TB bacteria so excursions outside on a sunny day should be encouraged.

WEST NILE FEVER

West Nile fever is a new infection that has caused older people to become very ill. This infection has been confirmed in all states except Washington and is thought to have been brought to the United States by birds traveling on the wind currents from Africa. The mosquito is the vector that transfers the infection from birds to human beings. The symptoms are fever, chills, headache, aching bones, malaise, symptoms of respiratory infection, and muscle pain. Meningoencephalitis and pneumonia are complications of West Nile fever (cdc.gov, 2006). The LPN should advise older adults to protect themselves against mosquito bites by wearing long-sleeve tops and long pants and insect repellent from dawn to dusk. Keeping screens on windows and doors will help keep the mosquitoes out of the house. In addition, because mosquitoes breed in standing water, all containers, such as a bird bath, should be refreshed often.

Worldwide, mosquitoes are the cause of many serious diseases, such as malaria and dengue fever. All older adults should take precautions when planning to travel to countries where mosquito-borne diseases exist. You will need to remind the older person to wear proper clothing and have the individual consult with the physician as to the most appropriate insect repellent.

This 65-year-old man fishes year round. When it is "mosquito season" he protects himself with a long-sleeved shirt and an upturned collar. It still is possible to get bitten by a mosquito, but he is minimizing the danger by being cautious.

ANTHRAX

Anthrax has been suggested as a potential bioterrorism infectious agent. The anthrax bacteria has existed in the United States for centuries, and except in a few populations that are exposed to infected anthrax animals, there has not been an outbreak of this disease. Anthrax can be found in wild and domestic animals. The general population is not at risk for anthrax infection except in the case of bioterrorism. Anthrax infections can occur on the skin, in the lungs, or in the intestinal system. Skin infections may present as a depressed black eschar at the site of infection. Lung symptoms are similar to a respiratory infection. Intestinal infections resemble food-borne illnesses. It may be necessary to treat the infected person with an antibiotic.

AVIAN (BIRD) FLU

Research on a new infection, avian flu, is being conducted vigorously by various nations and the World Health Organization (WHO). The infection first was identified in Asian countries but now has been identified in several nations in Europe. Causes and treatments of avian flu are unknown. Most evidence suggests avian flu is related to unsanitary conditions where chickens are raised. People who care for the chickens or are eating the infected chickens are most at risk for the disease.

A great fear is that the virus causing avian flu will mutate and begin to spread from person to person instead of bird to bird. The concern is that the new infection may become worldwide and create a pandemic similar to the flu epidemic of 1918, which caused the death of millions of people. The avian flu is currently not treatable, with most cases resulting in death (cdc.gov, 2006).

Health departments in each community will provide instructions on recognizing symptoms and treatments for avian flu if this infection comes to your community.

The recent severe acute respiratory syndrome (SARS) epidemic is an example of how quarantine and quick reaction can prevent a pandemic. Scientists worked around the clock to learn about the transfer and treatment for the disease. Borders to countries were closed. People were checked for fever or other symptoms of SARS before being admitted to a country. Many people cancelled their travel plans and stayed home. All of these things assisted in controlling the disease from spreading. SARS and avian flu are examples of new infectious diseases that frequently appear. You need to keep yourself educated regarding infectious diseases and teach what you know to the older people within your care. In addition, be aware of your own use of standard precautions. Focus on your hand washing and your care of soiled materials. Masks, gloves, and gowns should be worn whenever there is a question of the spread of an infection. Err on the side of caution. Always protect yourself, as well as others, from any potential infection.

CONCLUSION

This chapter has discussed infectious diseases that have the potential to cause illnesses, even serious illnesses leading to death. The LPN has an important task to perform by assessing signs and symptoms of infectious diseases. The immune system changes with aging and may make it more difficult to recognize an infectious process. The LPN often is responsible for assessing older adults. Remember to consider the subtle signs and symptoms that could indicate an infectious process. They are elevated temperature, lesion, redness, swelling, and pain, among other possibilities. The LPN will need to consider other changes the older adult may demonstrate, such as becoming confused, demonstrating lethargy, and having loss of appetite. It is important for the LPN to be a critical thinker while performing an assessment on older adults.

CASE STUDY

Mrs. B. is 95 years old and was recently widowed. Mrs. B. and her husband immigrated to the United States from Germany 45 years ago. She has been in generally good health and is being treated for osteoporosis and a mild elevation in blood pressure. Mrs. B. has reported a persistent dry cough for 1 month. Her health history does not reveal any other health problems. Mrs. B. uses a walker to help her ambulate. She enjoys a close association with her daughter and church friends. She has lived alone for nearly a year because her husband resided in an extended care facility until his death. Mrs. B. insists on being as independent as possible but does allow family and friends to visit her and help her with some personal and household tasks. Mrs. B. prefers speaking in her native language, which is German.

Just before his death, it was discovered that Mr. B. had infectious TB. Mr. B. was plagued with a persistent cough and recurrent pneumonia for the last 5 months of his life. A full-scale contact investigation was initiated at the extended-care facility and among close family members.

A PPD (Mantoux) skin test was done on Mrs. B., and she was found to have 16 MM of induration. A chest x-ray scan revealed right upper lobe fibronodular calcification. It was suspected that Mrs. B. had a case of infectious TB. Medical orders were written for a sputum test to confirm the suspicion of TB and a liver function profile laboratory test and for medical treatment to be started. Results of the liver function test were normal. The sputum test came back 4+ for acid-fast bacilli. Mrs. B. did have active tuberculosis. The appropriate medications were started to treat the disease.

Mrs. B. is to wear a high-efficiency particulate air (HEPA) filter mask when in public places or anytime she is with other people. The mask will be necessary only until her sputum smears become negative for acid-fast bacilli. You are the LPN assigned to Mrs. B. as her home health nurse.

Discussion

1. What nursing care should the LPN implement?
2. How can the LPN help Mrs. B. maintain social contact with family and friends?

Solutions

What nursing care should the LPN implement?

1. The LPN should incorporate appropriate respiratory isolation measures until this patient is no longer infectious. The HEPA filter mask is worn for personal protection. If the weather permits, windows and doors should be open for sunlight and ventilation. It is important to note the sunlight will kill the TB bacterium and the ventilation can disperse any airborne bacteria.
2. The LPN should observe Mrs. B. taking all her medication. This is called DOT, or directly observed therapy. It means that the LPN would need to visit the home daily or designate a reliable family member or neighbor to ensure the medications are taken correctly. The objective of DOT is to ensure compliance with the medical regimen and, thereby, avoid building any drug-resistant TB bacterium.
3. The LPN will need to continually educate Mrs. B. on the importance of taking all the medications. You will need to teach Mrs. B. about the side effects of the medications. With any medication, you need to watch for generalized rashes, hypersensitivity, and shortness of breath that are associated with medication dosing. You are responsible for medication compliance and for observing for complications. Immediately report all changes to the RN case manager.

How can the LPN assist Mrs. B. with maintaining social contact with her family and friends?

1. As the LPN, you will need to help Mrs. B. to not feel socially isolated because of the need to limit visitors for infection control measures. You do not want her to become depressed or lonely. Make your own visits unhurried and pleasant. Make the effort to bring stories that will interest her. Reinforce the fact that this is a temporary situation and she can expect to return to her usual activities as soon as her sputum smears return negative. Once appropriate therapy begins, Mrs. B. could become noninfectious within 2 weeks.

CASE STUDY *(continued)*

2. As the nurse, you need to instruct Mrs. B. on how to wear a filter mask when in public or with others. The mask is uncomfortable when worn, even for short periods of time. It can impair ease of breathing and may promote feelings of claustrophobia. Changes in blood gases may occur when the mask is worn for any length of time. Mrs. B. may feel self-conscious when wearing the mask in public. She may prefer to stay at home until she is no longer infectious. As her nurse, you need to listen to her and support her in her feelings. Teach her the seriousness of wearing the mask despite the discomfort. Be sure she has access to the telephone and telephone numbers of her family and friends. (The numbers may need to be written in large print.) Does Mrs. B. have access to the Internet? E-mail is an effective way to communicate with people. If her communication needs are met, she will only have to wear the mask minimally.

3. Mrs. B. may experience feelings of anger, loss, guilt, or uncertainty or a host of other feelings associated with her disease. You need to be sensitive to her feelings. In many cultures, TB is a "taboo" disease because it is seen as a disease of the poor. TB is an emotionally charged disease, and you are the person to give social support to Mrs. B. to assist her in managing her feelings.

STUDY QUESTIONS

Select the best answer to each question.

1. The following are signs and symptoms of food-borne illness *except:*

a. Sudden onset

b. Abdominal pain

c. Vomiting and diarrhea

d. Cough

2. Which of the following items would not need to be taught to an older adult to prevent a food-borne disease?

a. Storing food safely

b. Maintaining a clean kitchen

c. Washing hands before and during food preparation

d. Wearing a HEPA filter mask when preparing food

3. In assessing the immunization status of an older female, the LPN needs to ask:

a. "Do you have trouble seeing red-green colors?"

b. "Have you had a DPT immunization in the past 5 years?"

c. "Have you had a pneumococcal vaccination?"

d. "How many sex partners have you had in the past 3 months?"

4. Many older adult diabetics are at risk for infections because they are not eating correctly.

T F

5. TB testing should be done on all long-term nursing home residents.

T F

13 Common Medical Diagnoses

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Identify differences between acute and chronic stages of common medical problems of older adults.
2. Describe at least two common physiological changes in each body system that are thought to be normal as the person ages.
3. Describe nursing care appropriate for chronic care of an older adult who has one or more of the common pathologies discussed in this chapter.

INTRODUCTION

Congratulations! You now are at the point where you will learn how to enhance and personalize the bedside nursing care you will give to older people. Notice that the points of emphasis are specifically on the physiology and psychology of older adults. You will recognize what makes gerontological nursing a specialty after reading this chapter and those that follow. Be open to the uniqueness of giving holistic care (care that involves the entire person) to older adults. Frame the care you give within a transpersonal caring format. The knowledge you will learn will be valuable to you throughout your entire career.

Older people develop multiple health-care and medical problems that often complicate the nursing and medical treatment plans. Older adults often have at least three chronic diseases or health-care problems by the time they reach 65 years of age. In contrast, younger people frequently see a physician or enter a hospital with a single health problem.

This chapter has been developed to provide information in three areas:

- The differences between the acute and chronic states of a problem or medical diagnosis. More emphasis is placed on problems related to chronic rather than acute situations because of the frequency of chronic problems in older adults.
- The differences between nursing care for acute and chronic medical conditions. For more detail regarding the acute phase of illness, the student is referred to the many texts that are available to explain signs and symptoms of the acute phase of medically diagnosed illnesses.
- The effect of the normal changes of aging on medical symptoms. These symptoms are discussed in terms of the specific effect that aging has on a health problem.

Five body systems have been selected for discussion in this chapter. The changes in these systems are commonly found with older adults in any setting. Frequently seen medical conditions are included as examples of the disorders that affect each system. Often these conditions do not occur alone. For example, two or more cardiac problems may be present at the same time, and arthritis often occurs with other chronic conditions.

PRIORITY SETTING 13.1

This chapter gives an excellent explanation of chronic disease. The priority here is for you to focus on the chronic disease information and be determined to really learn and understand it. Because you will spend 75% of your career caring for older adults, and older adults statistically (on average) have three chronic diseases, you need to know about them. Take the information in the chapter and learn it, and then build on it as you spend time in clinical areas. Ask questions of other nurses and the older persons with chronic diseases. Learn to understand how the diseases affect older people and their families, learn how to manage the illnesses, and learn how to assist the older person in managing the diseases, because they (the diseases) are there to stay.

ACUTE VERSUS CHRONIC CONDITIONS

Acute medical problems are those that develop rapidly. The person experiencing an acute problem notices symptoms for a few minutes to less than a month. The acute symptoms may be caused by some previous chronic condition, such as congestive heart failure (CHF), or the pathology may be caused by a change in body function that is related to aging. For example, changes in kidney function could induce acute renal failure. Conversely, an acute problem may be due to an infection.

Traditionally, chronic conditions exist for at least 6 months and create some disruption in biological, sociological, and psychological function. Examples include both physical and emotional conditions that are not limited to the older population. However, chronic health problems are common with older people. Approximately 80% of older people who live in the community have at least three chronic conditions. Arthritis, heart conditions (including hypertension), and sensory changes occur most frequently.

There are a number of ways to distinguish between acute and chronic medical conditions. Acute conditions may be thought of as requiring more immediate and often more sophisticated or technical levels of treatment. The goal in an acute condition is to cure the problem.

This woman has adapted to severe rheumatoid arthritis. She is unable to walk or straighten out her hands or legs, yet she lives a full and satisfying life. A major reason for her ability to manage is the support and love she receives from her family. In this picture, she is playing Scrabble with her husband. For them, it is legal to do words in both English and Japanese!

Chronic conditions develop over time and often are not noticed by the person with the problem until major deficits become manifest. These conditions tend to require more help from the informal system of caregiving, specifically from the family or home-health nurse. Often the older adult develops a partnership with members of the informal system to gain more control over the chronic disease. Cure is not the goal with chronic conditions. From a nursing standpoint, the goal is to provide care that is helpful in managing chronic diseases. This should be focused on assisting the older adult to function at the highest possible level in the physical, social, psychological, and spiritual arenas of life. Achievement of this goal should provide a higher quality of life for the individual and decreased morbidity (disability). An alternative goal is to work with an individual to enable the person to die with dignity: this is a realistic goal that needs to be acknowledged when working with people who have chronic, debilitating diseases. Chapter 9, which focuses on end-of-life care in the elderly person, will assist you in understanding this goal.

Nursing care requires observation of the patient's physical functioning, which makes this one of your responsibilities. In the acute phase of illness, it is essential that the nurse note responses to medical treatments such as medications or surgery. New signs and symptoms may arise because of such treatments. All changes must be reported because the new symptoms may be critical in determining whether to continue treatment, or they may indicate complications.

Nursing care for people with chronic diseases also requires the nurse to observe the person's physical functioning. In addition, it is important to have the observations of informal caregivers. The most critical information comes from the chronically ill person's observation of personal symptoms and overall condition. For treatment to be most effective, the person must be tuned in to the body's responses to treatment or to changes in total body function.

Various stressors may exacerbate a chronic but stable disease both in the short and in the long term. Such stressors can include uncertainty about the future, such as relocation or transition stress, starting a new treatment, or the development of an acute condition. For example, a patient with emphysema may develop pneumonia, and although penicillin may cure the acute condition, the pneumonia may cause a flare-up of the previously controlled chronic emphysema.

Many nurses and other health-care workers have difficulty working with people with chronic conditions. There is a tendency to look for time lines, to place limits on how long the condition may last, or to predict when it might get worse. It is critical for you, the licensed practical nurse (LPN), to recognize that each chronic condition has its own pattern. Some conditions, like cancer, may get progressively worse. On the other hand, for the person with a cerebrovascular accident (CVA), the recovery and return of ability depend on the part of the body affected. There is no accurate prediction or measure of recovery because of variable factors that differ from person to person. Other conditions may not change over months or years. This situation can be seen with multiple sclerosis, in which a person goes through a period of remission or absence of symptoms that lasts for a prolonged period.

Patients with a chronic health problem, such as hypertension, may have to learn to cope with a disease in which there are no visible signs of pathology. Some patients may not realize the disease is even present. Medications for hypertension often have side effects that cause patients to stop taking the drugs. Other patients stop taking their medication for hypertension when they feel good or believe the condition has been cured. This creates a very dangerous situation for the patient. It can occur with both physical and emotional conditions and is something that the knowledgeable nurse frequently assesses and works to deter. Chronic diseases require chronic (or long-term) treatments.

Working with people with chronic conditions is a challenge for the nurse. It is common

FOCUSED LEARNING CHART

Understanding the differences between acute and chronic diseases

Older adults have both acute and chronic diseases

Acute	Chronic
Develop rapidly	Exist for at least 6 months
Need immediate care	80% of community living elders have three chronic diseases
Often, more sophisticated care	Develop over time until major deficits are manifest
Goal is to cure the problem	Require assistance from informal caregivers (family, friends)
In older adults, the acute disease treatment may exacerbate one or more chronic diseases	The goal is not cure, but management

for people with chronic diseases to become discouraged. This type of nursing care calls on your creativity to assist the older person to conserve time and energy to participate in activities that have meaning for the individual. Fatigue should be prevented, and ways must be found to help the chronically ill person learn to cope with loss and change. Use of a self-care model in providing nursing care can help patients maintain their remaining abilities. The nurse, patient, and family form the team that is needed to encourage self-care. A crucial part of the team's function is maintaining good communication. This begins with an understanding of the past history of the older person. One part of that past history comes from a review of systems.

REVIEW OF SYSTEMS

To determine pathology and functional ability, a review of systems is used as part of the history and physical examination. This review covers all of the body systems in an orderly fashion. One purpose of the review is to uncover symptoms that may be associated with the current health problem.

Another goal is to identify chronic conditions that may have persisted for years and to learn how the person has managed those conditions over time. The review also is a method of gathering data that can help in deciding on the appropriate type of treatment for each individual. For example, some medications may not be appropriate if the person has problems with falling.

The review is especially useful for an older adult because:

- Older people frequently have nonspecific, atypical symptoms. The review helps to identify possible causes for present problems. It is a method of defining the usual and unusual for the individual.

- Changes of aging may affect two or more body systems simultaneously. The review can help to demonstrate how an interaction between systems occurs.
- Older people often have a complex history. Here, the review can help to tie the past into the present problem.

For the system review, each system and the usual questions asked are listed. Any positive response to a question is followed by other questions to determine the extent or duration of the problem and treatment, if any. It is desirable to have information about treatment used in the past and the effectiveness of those treatments. Treatments include medications bought over the counter (OTC) as well as those prescribed by a physician.

Pulmonary System

- History of frequent colds or upper respiratory infections?
- Cough? Productive or nonproductive of sputum?
- Appearance of sputum (not saliva)?
- Dyspnea whether on exertion, changing position (orthopnea), or during the night (paroxysmal nocturnal dyspnea)?
- Immunization history (pneumococcal vaccine [Pneumovax] and influenza)?
- Exposure to anyone with tuberculosis and knowledge about the purified protein derivative (PPD) test for tuberculosis?

Cardiovascular System

- History of hypertension?
- History of murmurs, irregular heartbeat, or palpitations?
- Fainting or falls, especially when changing position?
- Chest pain (at rest or after exercising) or presence of edema?
- Easy bruising? Varicose veins? Anemia? Blood clots (if so, where)?

Gastrointestinal System

- Food and fluid intake (a typical 24-hour food intake; number and size of glasses of water and other fluids)? Who prepares the meals? Any food intolerances? Likes and dislikes? Vitamins taken? Use of alcohol or tobacco?
- Stomach or abdominal discomfort before or after meals?
- Problems with bowels and frequency of use of laxatives (what types)? Presence of hemorrhoids (any bleeding, pain, itching)?
- Nausea or vomiting (under what conditions)?

Musculoskeletal System

- Pain, stiffness, or discomfort in joints (when or under what situations)?
- Pain or cramping in muscles (when and under what situations)?
- Weakness of arms or legs? Swelling in joints? History of broken bones or other injuries to muscles or bones?
- Ability to walk? Distance traveled before stopping and reason for stopping?
- Use of assistive devices such as cane or walker (if so, under what circumstances)?
- Type of daily exercise or activity?

Genitourinary System

- Difficulty holding urine and under what conditions?
- Burning, pain, or bleeding on urination?
- Sense of fullness in bladder even after urinating?

Women

- Number of pregnancies? Any problems?
- Symptoms associated with menopause?
- Vaginal drainage? Itching? Burning?
- If sexually active, any pain or discomfort?

Men

- Nocturia? Dribbling after urinating or difficulty starting to urinate?
- If sexually active, any problems?

Neurological System

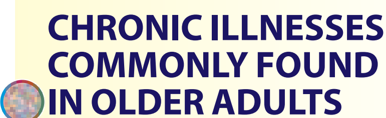
- Falls or fainting with or without dizziness? Steady or unsteady gait?
- Periods of amnesia or forgetfulness?
- Inability to hold onto objects?
- History of stroke?
- Difficulty with vision or hearing? Ask to describe.
- Loss of feeling or numbness in legs or arms?
- Headaches?

Endocrine System

- History of increased thirst, urination, or hunger?

- Dry skin, loss of hair, or thinning of hair?
- Intolerance to either heat or cold?

This review of systems provides only a baseline of information. As a physical examination is performed, the person frequently remembers other symptoms or events to be added to the history. Often, the first contact with any patient does not provide all the information that may contribute to an understanding of the person's health problems. The person may believe that symptoms were not important at the time, or the symptoms may simply have been forgotten, so that the review remains incomplete. Consequently, the systems review is always left open for additional information that may help with both the planning and continuity of care.



CHRONIC ILLNESSES COMMONLY FOUND IN OLDER ADULTS

This section provides some background information about chronic conditions frequently found with older adults. The primary focus is on continuation of care rather than on immediate treatment and nursing care.

Cardiovascular Conditions

Coronary Heart Disease

The term *coronary heart disease* (CHD) indicates that the heart muscle is not receiving a blood supply adequate to meet its needs. Included under this category are angina pectoris, myocardial ischemia and infarction, arrhythmias, CHF, valvular diseases, and hypertension. Three of these conditions are discussed to show how some of the changes of aging may compound a person's ability to manage the condition. The first example includes angina and myocardial infarction (MI).

A heart attack (MI) may be the first indication of CHD for an older person. This condition is found in both men and women over 65 years of age. The mortality rate for those older than 70 years of age is about twice the rate for younger individuals. Cardiovascular disease is the leading cause of death and disability in older adults. For the older person, the symptoms of a MI are often atypical. Instead of chest pain, there may be delirium or a change in behavior, fainting, stroke, dyspnea, or gastrointestinal symptoms such as nausea and vomiting. Chest pain occurs even less often in the person older than 85 years of age.

Because of the atypical symptoms, the diagnosis of myocardial ischemia or MI may be difficult in older people. For example, the electrocardiogram (ECG) may not be as specific in diagnosing an MI as for younger people because of age-related changes such as ventricular hypertrophy. The cardiac enzymes, especially creatine kinase (CK; also known as creatine phosphokinase, CPK) may not be elevated as much as in a younger person because of decreased muscle mass. Therefore, nurses who work with older people need to be alert to the possibility of an MI even when the usual signs do not appear.

Medical management for the older person is essentially the same as that for a younger person. Coronary artery bypass surgery, for example, has been demonstrated to be effective in older adults. Decreasing risk factors such as obesity, smoking, and hypertension also help decrease the probability of a heart attack. One goal of medical care is to avoid complications. CHF, arrhythmias, thrombi and emboli, and extension of the infarction are common complications. These may be prevented by close monitoring during the acute phase after an MI.

Some people restrict their activity following MI and become less capable of self-care. Decreased activity can lead to a situation called *deconditioning*. This may compound aging changes in the musculoskeletal system, such as decreased muscle mass and decreased muscle strength. The ability to balance activity and rest to avoid incapacity requires a strong cooperative effort among family, patient, and health-care personnel. Referral to cardiac rehabilitation may help the person to identify individual abilities and limitations and thus avoid deconditioning. Older people are capable of recovery and may return to their usual lifestyles. At other times, however, alterations in lifestyle may be necessary.

Congestive Heart Failure

The majority of people with CHF are older than 60 years of age. This condition is defined as one of congestion in the circulatory system owing to cardiac malfunction. The common causes of CHF in older adults include hypertension, heart valve calcification, MI, cardiac hypertrophy, arrhythmias, thyroid disease, and anemia. An acute episode of CHF can be brought on by treatment for other conditions. For example, overaggressive intravenous fluid replacement (too much, too fast) or medications such as beta blockers (e.g., propranolol [Inderal]) are common causes for some people. The symptoms of dyspnea and

frequent nighttime wakening often lead to fatigue and decreased activity.

The goal of medical treatment is to reduce the workload on the heart and help the heart pump better. Older people are able to maintain a normal cardiac output unless they are under physical or emotional stress. The presence of CHF is a pathology that can decrease cardiac output. Use of drugs such as digoxin is still a primary treatment. Digoxin is most frequently used when atrial fibrillation occurs with the CHF. Some older people have taken digoxin for many years. Periodic blood level evaluation of this drug is necessary to prevent toxicity and ensure that the drug is still needed. Other drugs include diuretics and those that increase dilatation of the blood vessels. A side effect with these drugs is falling, which results from a drop in blood pressure with change in position (orthopnea).

Nursing responsibility in chronic CHF includes monitoring the older person for:

- Presence of edema in feet, legs, sacral area, lungs, abdomen, and around the eyes. Look for increased fluid in any dependent parts and weight gain, especially when appetite is decreased. Often, people gain weight because of fluid retention but lose actual body weight. This type of weight gain and loss can lead to decreased endurance and increased workload on the heart. A weight record is helpful to monitor fluctuations daily to weekly, depending on severity or level of control of the CHF.
- Blood pressure changes with change in position (postural hypotension). Blood pressure and pulse should be checked after 5 to 10 minutes of rest in a flat position, again within 1 minute of sitting, and again 1 minute after standing. Also ask the person whether dizziness occurs with these changes. A drop of 20 mm Hg in pressure on changing position is significant. Patients need to be taught how to control balance before walking and how to use support equipment, such as a cane. The medication may need to be changed, or the patient may not be drinking sufficient fluid. Postural hypotension may result from a physiological change of aging in which the body does not respond to pressure changes. This is due to changes in pressure receptors in blood vessels. The cause of postural hypotension may be any or all three of the preceding possibilities.
- Maintaining a balance between rest and activity is critical to prevent fatigue and accompanying inability in self-care. Most patients find that they benefit from a daily routine that allows for short periods of activity followed by rest. During the acute phase, activity should be minimal. An example is sitting in a chair for 30 minutes three times a day. As cardiac function improves, increased activity is possible. The activity level should be determined by the physician and closely monitored by the nurse.
- Maintaining an adequate diet to prevent loss of lean body mass. The person's appetite may be decreased, or fatigue may be so great that five instead of three meals a day are needed. A reduced-salt diet (2 to 3 g/day) may be prescribed, although many people do well on a diet with no added salt and no foods that are high in salt. Decreased sodium intake may make food unappetizing and can cause anorexia. Use of spices instead of salt (e.g., cinnamon, thyme, lemon) and commercial salt substitutes may improve the taste of some food.

Hypertension

A blood pressure over 160/90 is regarded as hypertension (HTN) for any age group. This condition is the leading cause of death and morbidity in the United States. The prevalence of HTN increases with age, and about 40% of those over age 65 are affected. Men, African Americans, and obese people tend to be at greater risk. Most research now supports the need to treat a systolic HTN above 160 mm Hg and diastolic HTN over 90 mm Hg. Several factors associated with aging may predispose the older person to HTN. For example, stiffening of the aorta, increased cardiac afterload (the force needed to pump blood from the ventricle), and increased peripheral vascular resistance may be present. Changes in the baroreceptor reflexes may be indicated by fluctuation of blood pressure during physical activity

POINT OF INTEREST

When digoxin doses are too high, a common side effect is confusion. This often is not recognized as a cardiac symptom and, subsequently, is not always treated.

or emotional experiences. Other causes for HTN may include changes in the kidney and endocrine system due to aging.

Blood pressure measurement is one of the most important items of physical examination. The following are some guidelines for obtaining an accurate blood pressure reading in older adults:

- Allow the person to sit quietly for 3 to 5 minutes before taking a blood pressure reading. Older adults, especially when physically deconditioned, require more time to adjust to a baseline function even after a minor stress, such as walking into an examination area.
- Select the size of cuff appropriate to the person: the regular adult cuff may be too large or too small. Use of a pediatric cuff for small arms and a large adult or leg cuff for obese people is essential for accuracy. The cuff should be about 20% larger than the diameter of the arm.
- An auscultatory gap is often found with older adults. To avoid an inaccurate systolic reading, palpate the brachial artery and inflate the cuff in increments of 10 mm Hg while palpating. When the pulse disappears, inflate the cuff another 20 to 30 mm Hg, and then listen for the sounds as you deflate the cuff. The first sound may be followed by a gap of 20 to 30 mm Hg before the sounds are again heard.
- If this is the first contact with the older adult, take readings on both arms to determine whether there are differences of more than 10 mm Hg. If there is an arteriosclerotic plaque in the right subclavian artery, for example, the blood pressure is lower in the right arm. The correct reading is then obtained from the left arm.
- Determination of orthostatic hypotension is needed, especially when monitoring the effect of antihypertensive drugs. (See previous note under Congestive Heart Failure regarding technique.)
- If you have difficulty hearing the last sound for diastolic pressure, take the reading of a muffled sound as diastolic pressure. Make a note of this in your recording. One technique that can facilitate the diastolic reading is to elevate the arm above heart level.

Another nursing-care technique for someone with HTN is the monitoring of medications to ensure the maintenance of regular doses. This also will tell you the person's willingness to continue taking the drugs. The usual reason for a person to discontinue the drug or alter the dosage schedule is the experience of unpleasant side effects. The specific side effect varies with the class of drug (e.g., angiotensin-converting enzyme inhibitor, calcium channel blocker, diuretic). Examples of side effects that may cause the person to stop taking the drug include constipation, drowsiness, depression, cough, dizziness related to orthostatic hypotension, anorexia, and, in men, impotence. In addition, some patients stop taking diuretic medications if frequent trips to the bathroom interfere with their sleep or their daily activities.

When a person has had consistent systolic pressure reading of 150 mm Hg or above and then has a normal reading (120/80), further checking may be required. The drop may be caused by side effects of medication. It also could be an indication of a heart attack. The usual symptoms of an MI may not be present, but the person will be more fatigued and have less strength or energy to do things.

Teaching good health habits related to diet and exercise is also a nursing function. Some people may be placed on dietary restrictions, such as no added salt, reduced cholesterol, or reduced calories. Severe restrictions usually are not needed, but basic teaching is needed to alert older adults and their families to factors that can help control blood pressure. If these measures are successful, medications may not be needed.

Efforts to reduce blood lipid levels in people older than 75 years of age are still considered questionable by some practitioners. Measurements of fasting cholesterol and high-density lipoprotein (HDL) are minimal laboratory tests to determine lipid levels. The older person may have more difficulty than a younger person in changing a lifetime pattern of eating. Use of a food diary may help with this change. Periodic contacts with nursing staff should check not only adherence to the diet but also the person's reaction to the changes that have occurred. Emotional support provided in this way increases compliance with difficult dietary changes.

The use of regular exercise in controlling blood pressure is just as important for older people as it is for younger people. The physician may prescribe aerobic exercise, especially walking, as an adjunct to control blood pressure and weight. Regular exercise may be just as beneficial as medication for some people. When people do not exercise regularly, they tend to start too fast. Instructions should be given for a minimum of 5 minutes of warm-up and stretching and a gradual increase in the amount of time

spent in aerobic walking. Usually, the older adult can start with 10 minutes of aerobic walking two to three times a week. The time and frequency of aerobic activity can gradually be increased by 5 to 10 minutes each week. The person should be taught how to take a pulse to ensure that the pulse does not go beyond that person's maximum limit during the peak workout time. The maximum is based on resting heart rate and age. A cool-down period of at least 5 minutes also is needed following exercise.

Peripheral Vascular Disease

The maintenance of good vascular supply to the extremities is critical for older people. When blood vessels are affected by both arteriosclerosis and aging changes, the nutrition of tissues is impaired. Both arteries and veins may be involved at the same time. This results in a depleted oxygen supply and retention of waste products in the body.

Evidence of decreased vascular function is indicated by skin ulcers resulting from venous stasis. Venous stasis is marked by changes in the skin, such as thinning and dryness or overgrowth of epidermis. A permanent brown discoloration may appear because of small hemorrhages (petechiae). Any slight trauma to the area can break the skin and begin an ulceration. Prompt treatment is needed to avoid infection. Even when an ulcer is healed, the area is always at risk for further breakdown. Concern about the condition may cause the person to limit activity. Functional problems, for example, limited ability to ambulate, may result.

Prevention of further trauma and interference with blood supply is the guide for nursing intervention. Patients can be taught to:

- Keep the legs elevated when sitting, unless arterial insufficiency is also present.
- Avoid constricting clothing, such as hose with elastic bands.
- Avoid extremes of temperature (hot or cold).
- Keep the legs uncrossed when sitting.
- Use cotton socks or stockings and properly fitted shoes.
- Report any break in the skin as soon as possible.
- Avoid applying tape or any irritants (salves) to the area.

CRITICALLY EXAMINE THE FOLLOWING:

Read the patient care situation below. Ponder how you would resolve the situation. Give it your best thinking. Make some notes regarding what you decide. Be prepared to share your thinking in class.

Mrs. Patrick is your new home-health patient. She has been admitted and assessed by the registered nurse (RN), and your first visit is scheduled for this afternoon. Some of the things you think are significant from the RN's notes are that Mrs. Patrick is a 72-year-old, morbidly obese woman who underwent right total knee surgery 9 days ago (3 days hospital; 6 days nursing home). Lives alone. Home is on one level. Requires oxygen 24 hours a day because of right-sided heart failure with pulmonary hypertension. Has been on antidepressants for most of her life; finds them effective. Has HTN managed with medication. Knee replacement done because of severe degenerative osteoarthritis. Plans a second total knee within the next 3 months. Has joint pain in shoulders and hips. Admits to being deconditioned because of chronic joint pain. The RN has asked you to evaluate Mrs. Patrick and outline a plan to counteract her deconditioned state so her next knee surgery and her recovery from it will be easier on her. This requires some very creative critical thinking. Give yourself some time to consider this problem; ask others what they think would be effective; and think of Mrs. Patrick as a real person who really needs your help and knowledge.

Neurological Conditions

Cerebrovascular Accident

The third leading cause of death for older adults continues to be a CVA or stroke. This is true despite increasing emphasis on prevention. One risk factor for stroke is advanced age. Other risk factors include hypertension, diabetes mellitus, transient ischemic attacks (TIAs), and heart disease (such as a myocardial infarction or CHF). The mortality rate has declined over the past decade, yet about 40% of those who experience a stroke die within 1 month. About 60% of those who do survive must cope with some disability and physical impairment. Such coping may involve sensory or motor abilities, memory, or language and other communication skills.

There are several ways to classify strokes:

- By type: thrombosis (large vessel or small vessel, also called lacunar), embolism, or hemorrhage.
- Location of the ischemia or the infarction: the posterior or anterior circulation, such as

the brain-stem, pons, cerebellum, medulla, or cortex.

- Rate of development of the stroke: slow (sometimes called *stroke in progress*) or sudden and massive.
- Brain hemisphere: right or left hemisphere, or dominant or nondominant hemisphere. This last classification is used herein for the discussion of treatment and continuity of care.

Once the patient has been stabilized, usually in the hospital, planning for discharge and follow-up care is needed. Rehabilitation should begin as soon as possible, preferably in the hospital. Such an early beginning helps prevent the development of some of the physical complications of a CVA. Two common complications are contractures and skin breakdown. Continued care aids in regaining prestroke abilities, providing emotional support, and maintaining physiological defense mechanisms, such as resistance to infections.

Classification of stroke on the basis of the involved hemisphere is important because it points to the type of nursing care required. The goals for care and the way the nurse interacts with the patient are particularly affected. Frequently, the patient with a right hemisphere stroke:

- Has problems accurately determining level of abilities
- Has problems in learning because of a shortened attention span
- Is easily distracted from tasks
- Is unable to transfer learning from one situation to another
- May show poor judgment about the lack of ability that occurred because of the CVA and take risks leading to injury
- Is unable to determine distance or rate of movement of people or objects because of poor spatial perception
- Retains language abilities and can convince others of abilities that do not exist, such as stating, "I can walk," when in reality the person cannot safely do so
- May have visible deficits such as weakness or paralysis on the left, or nondominant, side of the body

In contrast, the person with a left hemisphere stroke will tend to have more visible disabilities. These disabilities include:

- Problems with language and physical function
- A need for adaptation of all activities of daily living if the dominant hand is affected
- A tendency to be more cautious than those who sustained a right hemisphere stroke in their behavior. The tendency is to take few risks and deny the extent of their abilities (rather than extent of disability).
- A tendency to engage in repetitious behavior, such as washing the same body part over and over again
- May have weakness or paralysis on the right, or dominant, side of the body

The goal of care for the person with a left hemisphere CVA is to improve his or her physical ability. Physical, occupational, and speech therapies should be included as part of the interdisciplinary team plan of care. Fatigue may require scheduled rest times, but a limit should be placed on the length of time allowed for rest.

Other losses also occur that are independent of the hemisphere involved. Neglect of one side of the body may first demonstrate itself in failure to eat food placed on one side of the tray or by failure to turn toward a visitor. Homonymous hemianopsia (loss of vision in the left or right visual field) (Fig. 13.1) or bitemporal hemianopsia (loss of the peripheral and/or temporal area of vision) may cause each of these symptoms. Therapy to teach the person to consciously look at a "total picture" of self and surroundings is needed.

Prevention of complications is a major component of poststroke care. After a stroke, the person is frequently at risk for infections (respiratory and urinary), falls, malnutrition, repeated strokes, and deconditioning due to lack of activity.

POINT OF INTEREST

Patients who have had a right hemisphere stroke are a challenge for you, the LPN, and the family. As the nurse, you have to help the patient and family cope with many frustrations. A major one is conflict between the patient and caregivers, which may result from the patient's denial of disability or from impulsive behavior (acting without thinking). The patient may be totally unaware of the effect of this behavior, and the family must be constantly alert to the potential for injury to self or others. This type of behavior may persist throughout the remainder of the person's life.

Homonymous hemianopsia

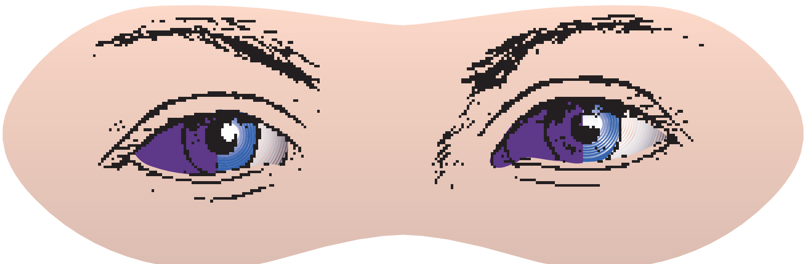


FIGURE 13.1. Homonymous hemianopsia results in the patient's ignoring the entire side of the body that he or she cannot see because of the stroke.

Prevention of complications includes all of the following:

- At a minimum, administering immunizations for pneumonia, influenza, and tetanus
- Keeping a routine for urination
- Monitoring fluid and food intake
- Monitoring medications
- Maintaining mobility and independence at optimum levels

Older people tend to drink inadequate amounts of fluid. Teaching both the older adult and family ways to ensure consumption of 1500 to 2000 mL of water per day is useful. Some people fill a quart bottle with water every morning and drink from that throughout the day, periodically refilling it. When encouraging fluids, however, be sure the person does not have difficulty swallowing. People with swallowing difficulties after a stroke frequently have more difficulty with fluids than they do with swallowing solids.

The patient's appetite may be affected by an inability to use a knife and fork. Occupational therapy should help with instruction on new ways for self-feeding. Meal plans may need to be altered to help the person lose weight or control sodium or cholesterol levels. Medications often are used to control HTN, cardiac arrhythmias, and blood clotting. When a person begins to feel better, it is common to believe some medications are no longer needed. It is critical that compliance with medications is frequently assessed. Accurate determination of blood pressure in the home or physician's office is essential. Listening to the apical heartbeat instead of relying on radial pulse is advisable. Laboratory work to follow prothrombin time and international normalized ratio (PT/INR) is critical (see Chapter 20). Following a set schedule to maintain a balance between rest and activity helps to minimize fatigue and to promote activity. Many older people who live at home may need continued follow-up after discharge from the hospital or nursing home. Home health care is important for the older adult to maintain optimum health.

Parkinson's Disease

Parkinson's disease (PD) is found more often in men than women. The condition can begin as early as the mid-40s, but it usually appears between 60 and 80 years of age. This is a chronic, progressive disease that is marked by slow movement, rigidity, unstable posture, and tremors at rest. There are some known causes for Parkinson-like symptoms but no known cause for PD.

The primary treatment for PD is medication, most commonly carbidopa or levodopa (e.g., Sinemet). Selegiline hydrochloride (Eldepryl) has proved beneficial for younger people but not for older adults.

CRITICALLY EXAMINE THE FOLLOWING:

It is important for you to understand clearly the difference between right-sided and left-sided CVAs. Take the time to outline a teaching plan for the family members (spouse and adult children) of a person with a right-sided CVA. There are some very important concepts that need to be taught to these family members. How can you do the teaching without causing them more distress? Actually write a teaching plan to submit to the faculty person. Title it at the top and put your name on it. Then make two columns. One could be "Concepts to Be Taught," and the second could be "Method of Teaching." Select three of the problems listed under right-sided CVA above and plan a creative and sensitive way to teach them to the patient and family.

This condition also requires active involvement of the person affected by the disease as well as the family. Education of the patient and family should be a primary objective for every nurse. Important information to be taught includes:

- Defining the disease and its problems
- Side effects and individual reactions to medications
- Methods to promote independence and activity while providing for safety

Some people with PD become very depressed and withdraw from social contacts. The person with PD can help to prevent depression by identifying times when fatigue occurs. The beneficial effect of medication may "wear off" close to the time for the next dose. Activity planned around these times of fatigue and decreased drug effect will help to maintain physical and social function.

As the disease progresses, the person is at risk for several complications. Infections, gastrointestinal problems, and injury from falls are most common. Respiratory infections occur when swallowing is affected. Aspiration of food and fluids can lead to pneumonia and malnutrition. Urinary tract infections may result from urinary retention and from inadequate fluid intake. Eye infections may result from seborrhea (a dandruff-like skin problem).

Constipation is a common gastrointestinal problem due to a lack of bulk-type foods and fluids. Problems swallowing can lead to anorexia. Nausea and anorexia are common side effects of the medications. Consumption of semisolid foods or those with the consistency of pudding and foods with a high water content, such as fruits, may help.

There is a tendency for the person with PD to be physically unstable. Many falls can be prevented by the use of a cane or walker. Safety devices should be installed in the home, such as handholds in the bathroom and banisters in the stairway. Floor coverings and furniture should provide a barrier-free route for walking. Shoes that fit well, are lightweight, support the foot, and do not cause either slipping or too much friction are needed.

The goal is to maintain the person's function for as long as possible. A secondary goal is to support the family as they help to manage the daily activities of the elderly person. Coping with the changes that usually occur is difficult for most families. Referral to support groups and helping with problem solving are two important nursing functions.

Sensory Losses

Many adults find that visual and hearing losses begin around 50 years of age. The eyeball changes shape for most people so they become farsighted and require glasses for near vision, for example, when reading. This aging change is referred to as presbyopia. Changes in the shape of the lens and a yellow discoloration may alter the person's ability to focus and to distinguish colors.

Three common pathological visual conditions experienced by older people include cataracts, glaucoma, and macular degeneration. Clouding of the lens resulting in cataracts is the most common pathology found with the eyes. Blurred vision and difficulty with nighttime driving may be the first clues of cataract formation. Current techniques for 1-day surgery have relieved the problem for most people who experience cataracts. Other eye conditions, however, require more adjustment.

Glaucoma is still a major cause of blindness and results from increased pressure in the eye that destroys the optic nerve. Central vision is usually retained, but peripheral vision is lost. People speak of having "tunnel vision." This condition is generally controlled with medications instilled in the eye daily. All people older than 40 years of age should have a yearly examination for increased intraocular pressure (above 22 mm Hg).

Macular degeneration destroys the point of maximum sight—the macula. Blindness does not result, but the person loses central vision. Peripheral vision is retained around that central blind spot. Increased magnification helps many people. Some people learn to adjust head positions in order to use peripheral vision. Use of zinc and vitamin B supplements has been effective for some people in decreasing the extent of this degeneration.

Hearing loss increases with aging and is noted more among men than women. This condition may be due to an aging change called *presbycusis* that occurs without previous injury or other known cause. Hearing difficulties carry both social and emotional consequences because communication with others suffers. Many people tend to talk more loudly to those who are hard of hearing. Speaking loudly results in sounds becoming more muddled, so that comprehension is worse. Some people are helped by the use of hearing aids, whereas others cannot be helped in this way because of the type or extent of hearing loss. Adjustment to a hearing aid may be difficult

These ladies reside in a nursing home and have multiple chronic diseases. Both of them have visual losses. The first lady is blind, and the second lady is legally blind but can see shadows and shapes. With the holistic care provided them in the nursing home, they are safe as well as satisfied with their lives.

because of lack of finger dexterity. The inability to tune out distracting noises also may discourage individuals from using the aid.

The person with either visual or hearing loss should be informed about available services. Centers for the visually impaired in large cities can provide materials to assist people with using their remaining vision. Often, people can be taught ways to compensate for the loss. Audio amplifiers are available for the hearing impaired. These devices can provide greater amplification and are especially useful in open-room areas.

Some general guidelines for nurses working with visually or hearing-impaired older adults are listed below:

- Face the person before beginning to speak. Avoid sitting in front of a window or light so there will not be any glare. Glare reduces the ability of a person to read lips.
- Speak clearly and slowly so that words are distinct.
- Try not to exaggerate your speaking voice.
- If possible, use a low pitch when speaking.
- Touch the person to indicate where you are.
- Identify yourself by name and explain why you are there.
- Keep the patient's glasses and hearing aid clean.
- Refer to local, state, or national resources for assistance (e.g., centers for the visually impaired, audiologists, Lion's Club for help with glasses).

Pulmonary System

Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a pathological condition resulting from exposure to irritants (especially tobacco smoke) and is not limited to older people. Chronic bronchitis, asthma, and emphysema are included in this very broad category. Chronic obstructive pulmonary disease is the fourth leading cause of death for those older than 65 years of age. The primary signs and symptoms are cough and shortness of breath. The lungs become hyperinflated, and the diaphragm flattens. The person must use abdominal and intercostal muscles (accessory muscles) to breathe. Use of these muscles requires more energy than use of the diaphragm.

Some older adults who develop a barrel chest appear to have developed COPD. Their appearances may be due to increased residual volume of air because of destruction of the alveolar walls. In this condition, there is less lung surface for diffusion of gases. Alternately, the person may have a severe kyphosis of the thorax. This condition should not be confused with COPD.

Different forms of COPD have distinct symptoms; however, the end result for all forms is chronic lung disease that has a strong negative impact on physiological and emotional function. Often, there is one event, usually an infection, that causes the person to recognize the chronic nature of the condition. There is no typical pattern to the disease process, except that COPD is progressive and serious complications do occur, especially repeated infections. Hypoxemia may result with any form of COPD.

The adjustments a person with COPD has to make in lifestyle, habits, and work can be overwhelming. Prevention of complications is the primary goal of chronic care. Each person (and family member or significant other, when available) needs to have knowledge about the disease

process and how to aid in self-care. Teaching self-care includes:

- Ways to prevent infections with balanced diet, balanced rest and activity, avoidance of situations in which spread of infection may occur, and use of influenza and pneumococcal immunizations
- How to recognize signs and symptoms of infection, such as increased cough, change in sputum, and decreased tolerance for activity
- Instruction in self-medication, including the use of oxygen, the purpose of each medication, and side effects to be expected
- How to keep track of the medication schedule and medications to avoid, such as cough suppressants
- Explaining the need for adequate hydration (2000 mL/d unless other conditions, such as heart disease, rule this out)
- How to distinguish between anxiety and airway obstruction, on the one hand, and measures to control both, on the other
- How to develop a support group or how to locate one

Musculoskeletal System

Osteoarthritis and Degenerative Joint Disease

Osteoarthritis is the major chronic condition reported by older adults. The incidence of arthritis increases with aging. Destruction of the joint cartilage occurs, often followed by overproduction of tissue at the joint margins. The result is a visible enlargement of the joint, especially in the knees and fingers. The most common form, degenerative joint disease (DJD) or primary osteoarthritis, develops from an unknown cause. Inflammation of the joint usually does not occur. Primary arthritis is permanent and progressive. However, it also can fluctuate or vary in intensity. Secondary osteoarthritis develops from a combination of physical stress on joints and a medical problem such as diabetes or inflammation. Gout and rheumatoid arthritis are examples of this form.

The person with DJD usually reports joint stiffness in the morning with limitation of motion and muscle aches, cramps, or spasms. The extent of these symptoms varies from person to person. Some people have very little joint pain or stiffness. Others may experience joint pain most of the day. There is no specific treatment. The goals for treatment include:

- Control of pain with nonsteroidal medications, such as ibuprofen
- Weight loss if the person is overweight
- Maintaining activity
- Coping with physical and lifestyle changes

To reach these goals, it is usually helpful for the person to understand the nature of the condition and to avoid the use of ineffective ("quack") treatments. It also is important to learn to identify events or activities that increase and decrease pain in order to promote self-care.

Another critical aspect of care is to teach the older adult to use medications to prevent pain rather than to control pain after it has started, for example, before activity or on a routine basis. Meal planning is another challenge. The meals should meet but not exceed caloric needs. (This can be a problem for those with low income, minimal sources of emotional support, or lack of energy to change eating habits.) The nurse should teach the patient and family to plan activities around the time of day when the person feels best and there is less pain.

Learning the proper use of moist heat, physical therapy exercises, and equipment (e.g., a walker) to decrease pain or stress on joints can be done with a physical therapist. Keep in mind that the walker or other equipment may need to be examined to ensure that it is appropriate for the person's needs. The nurse should focus on teaching the older adult self-expression to maintain self-esteem, decrease depression, and promote social interaction. Referral to an arthritis support group and use of their teaching materials may be helpful to older persons and their families.

Osteoporosis

The term "brittle bones" has been used to describe this condition. Actually the bone is not brittle, but bone mass is decreased because bone is reabsorbed faster than it is formed. This results in greater risk for fractures. There are two forms of osteoporosis: type I and type II. Type I osteoporosis is found primarily with women after menopause and is thought to be related to lack of estrogen. White women with fair complexions and women (white and Asian) with small body build are especially at risk. Type II osteoporosis can occur in both sexes with increasing age. (See Box 13.1 for other risk factors.)

Type I affects the spongy (trabecular) portion of bone such as the ends of long bones. Type II affects both compact bone found in the middle portion (diaphysis) of long bones and trabecular bone. Regardless of type, the person may not be

BOX 13.1 Risk Factors for Osteoporosis

Positive family history for osteoporosis
Inactivity or immobility
Low calcium intake (below 800 mg/d)
Gastric or small bowel resection
Smoking
High intake of alcohol
High intake of caffeine
Long-term use of glucosteroids or anticonvulsant drugs
Hyperparathyroidism
Low body weight

aware that he or she has osteoporosis until minimal trauma results in a fracture of a rib or wrist.

A major goal when working with someone with osteoporosis is to maintain safety. Injury due to a fall, especially a hip fracture, is one of the most frequent consequences. The resulting loss of mobility and restriction of activity creates emotional problems and places the person at risk for other physical problems such as skin breakdown and constipation. In addition, treatment is long and costly.

A major nursing responsibility is to teach the person and family to identify hazards in the home and community. Some simpler techniques that can be used to help maintain safety are the use of grab bars by the toilet in the tub or shower and the use of a sliding board or tub chair for bathing. The house should be carefully examined for safety hazards such as "trippers" (e.g., scatter rugs, electric cords, uneven pavement, and pets). The patient should be taught to maintain postural balance by rising slowly and avoiding sudden movement or hyperextension of joints such as neck and hip. Another area in which teaching is beneficial is the identification of risk factors, for example, limiting use of caffeine sources to one a day. Limiting the use of tobacco and alcohol may help decrease the progress of osteoporosis. Increasing the consumption of sources of calcium, such as fortified low-fat milk, yogurt, and cottage cheese, will also increase the intake of vitamin D. Do not recommend cottage cheese to someone with CHF because of the high sodium content.

Metabolic and Endocrine Diseases

Non–Insulin-Dependent Diabetes Mellitus

Non–insulin-dependent diabetes mellitus (NIDDM) is more common with older adults than the insulin-dependent form. Although the pancreas continues to produce insulin, the amount is not sufficient for carbohydrate metabolism. The reason for this pathology is not clear. Some people believe that a virus is responsible for triggering the destruction of the beta cells that produce insulin in the pancreas. This view is consistent with the state of immunodeficiency that is present with aging. Others believe that the body becomes resistant to insulin as the percentage of body fat increases and lean body mass (muscle) decreases with aging. The latter belief has been supported by the effect of weight loss on control of hyperglycemia.

The main complication of NIDDM is hyperglycemic coma. When this happens, the serum glucose level is elevated, but ketosis is not present as it is with insulin-dependent diabetes mellitus.

There is no cure for NIDDM, but usually it can be controlled with diet alone. When the person is overweight, a reduced caloric intake coupled with regular exercise is recommended. Oral hypoglycemic drugs may be used if control is not achieved with diet and exercise. Some older adults may need insulin when control is not achieved. In most instances, medications should be avoided because they may cause hypoglycemia.

The usual precautions for diabetes are needed for people with NIDDM. The types of complications found in diabetes mellitus, such as skin lesions and renal and neurological problems, also may be typical of aging. Therefore, teaching about skin care, protection of the feet, periodic eye examination, dental care, and

POINT OF INTEREST

The ways older people demonstrate symptoms of NIDDM are different from those of younger people. Older people tend to have anorexia, dehydration, confusion or delirium, incontinence, and decreased vision. In addition, it is not unusual for the older person to have high triglyceride and cholesterol levels along with high glucose level.

Older adults with diabetes mellitus can live reasonably normal lives if they are willing to attend to the details of managing their disease. If they are unable to do so, they need a caregiver to manage the disease for them. This lady was able to attend her granddaughter's college graduation because of her determination to live well with diabetes.

recognition of infections is just as important for people with NIDDM as for those who are insulin dependent. The nurse also needs to teach the older adult how to follow a regular schedule involving medication, diet, exercise, and blood glucose monitoring.

Hypothyroidism

This condition has been found to be common, especially among older women. The presence of a low thyroid level is often overlooked because of the similarity between the symptoms of hypothyroidism and characteristics of aging. Symptoms of hypothyroidism, which are thought to be typical among older adults, are fatigue, memory loss, slowing of thought processes, slowed speech, intolerance to cold, loss of equilibrium, constipation, and sleep apnea.

The current belief is that older people benefit from treatment with thyroxine, even if they have subclinical hypothyroidism. Caregivers often attribute behavioral changes in an older person only to aging. Even small deficits of thyroxine or small increases in thyroid-stimulating hormone can result in slowed reactions. This should be a clear safety alert for every nurse.

Hypothyroidism is common among older women. The symptoms often are ignored because they are confused with characteristics of aging. People must be taught how to recognize signs and symptoms of overmedication or undermedication for this disease. It is especially important to monitor respiratory and cardiac function as well. People usually begin to notice improved function within a few days of starting treatment.

CONCLUSION

Although all of these conditions have been discussed separately, you probably have noted that there are similarities in approaches that can be used. Involvement of the patient has been stressed throughout. The need for exercise, high-quality meals with lowered caloric intake, and prevention of complications are three common themes. The following case study serves as an example of thinking out a unified approach to the care of a person with chronic conditions.

CASE STUDY

Mrs. O. is an 82-year-old widow who has lived alone since the death of her husband last year. She was able to care for herself with all activities of daily living and had help with light housekeeping, shopping, and banking. During the past 6 months her energy and endurance have lessened, and she has gained 10 pounds. Her appetite has not changed, and her food intake is reported to be the same. Her social activities include church and contact with her three children and grandchildren at least once a week. Mrs. O. has been told she has beginning cataracts in both eyes, which need to be checked every 2 months. The only symptoms she has noted are blurring of vision and increased glare, especially at night. She has been treated for several medical problems, including osteoarthritis, HTN, and CHF. Current medications include:

Ibuprofen	650 mg q.6h. to control arthritic pain
Hydrochlorothiazide	12.5 mg q.d. for hypertension
Digoxin (Lanoxin) and Lisinopril (Zestril)	0.125 mg and 20 mg QD, respectively, for congestive heart failure
Current weight	175 lb
Height	5′6″

Her mental status has been intact, and she takes pride in her good memory.

An appointment with her physician resulted in hospitalization for 4 days. The following were reported on admission: BP 187/98; P = 90 (apical) irregular beat; R = 24 with some dyspnea on exertion. The physician heard inspiratory crackling in both lower lung bases (posterior) up to the midscapular area. He made a tentative diagnosis of acute CHF with atrial fibrillation. After 4 days in the hospital, she was sent home. Lanoxin was increased to 0.25 mg q.d., and Mrs. O. was given a no-added-sodium diet and was told to decrease the amount of fat in her diet.

Discussion

1. What nursing approaches, especially monitoring through home care or physician office visits, can you suggest that may have helped to prevent this acute attack and hospitalization?
2. What chronic health-care problems might interfere with total self-care? What activities needing increased assistance might you anticipate?
3. What positive characteristics of Mrs. O. could be used to help her monitor her own health condition?
4. What referral sources can you think of that could be of help to Mrs. O.?

Solution

1. You should consider the desired effect of the medications, the possible side effects of each, and whether there are any interactions among the medications. In addition, consider how frequently blood pressure needs to be checked (probably every 1 to 2 weeks after a medication is started; consider the use of a home-health nurse to monitor this or use of a senior center if there is one where blood pressure monitoring can be done). Check for edema, especially in the lower extremities, sacral area, and lungs. The area of edema depends on whether heart failure is right sided or left sided: right-sided failure results in edema in the lower extremities, sacral area, and abdomen; left-sided failure results in fluid in the lungs. In each case, the location of edema is related to where the backup of pressure occurs. Monitoring also should include a review of food actually eaten: 24-hour diet recall, keeping a diary of food eaten, and looking at salt content as well as quantity of food and fluids. Even after a patient has been on medications for some time, reviews of diet, activity, ability to take medications as

prescribed, and even ability to pay for the medications (to avoid skipping doses) are needed. One critical factor to monitor is weight. People with CHF may have increases in weight because of fluid retention and not because of an increase in lean body mass. They may look healthy because of that weight, but fluid accumulation decreases their ability to function by putting more stress on the heart; cardiac output available for both daily activities and endurance are, thereby, decreased.

2. You should discuss the effect of gradual loss of vision with possible development of cataracts: what does this do to the person's ability to take medications as ordered, to shop, to use transportation, to use the telephone, and to feel safe, especially at night? When that person also is hampered by osteoarthritis, a vicious circle may develop. Chronic pain may limit activity, which, in turn, creates more stiffness and decreased range of motion. As a result, the person needs to exert more energy to do even simple housekeeping and leads a more sedentary lifestyle; so the cycle continues. When these limitations are superimposed on the chronic conditions of HTN and CHF, the person may gradually lose not only the ability but also the desire for self-care. These psychosocial losses are then added to the physiological losses, and the need for assistance with activities of daily living is increased. You also might want to discuss the differences between acute and chronic pain and the effect of chronic pain on daily activities, perception of self-care abilities, involvement in social activities, and the effect that complaints about this type of pain have on social interaction.

3. One could make some assumptions that would need to be checked out about involvement with family. The case history indicates that Mrs. O. has been able to be self-sufficient and that she has some support from family members. Family tends to be the first line of defense for older people, and only if family help is not available will they rely on community support or formal and governmental agencies. The history of the individual is usually a good indication of what that person will do as an older adult provided that there is some support when problems occur. Apparently Mrs. O. has good cognitive ability and is capable of learning. Therefore, teaching and helping her to establish a program of monitoring herself (such as weight, food intake, type of food, shopping for inexpensive food) and teaching her ways to simplify housekeeping, conserve energy, and develop a daily schedule to do energy-requiring activities when she has the most energy could be very effective. Involvement of the patient in developing this program of care is essential. Allow the patient to be part of the decision-making process.

4. Look at community resources in her area. Investigate the county agencies on aging, home-health agencies, nutrition programs, transportation resources, and availability of neighbors or friends as well as family. What help is available to assist with visual problems? Control of arthritic pain, such as water aerobics? Physical therapy? Talk to or visit some of these resources to determine if they will help Mrs. O.

STUDY QUESTIONS

Select the best answer to each question.

1. Chronic health conditions differ from acute conditions in which of the following ways?

- **a.** Chronic conditions begin at an earlier age.
- **b.** Acute conditions tend to take time developing.
- **c.** Chronic conditions require active work by patient or family.
- **d.** Acute conditions occur only once and then disappear.

2. A review of systems helps the nurse identify which of the following?

- **a.** Possible interaction among health-care problems
- **b.** Whether the person has been taking care of his or her health properly
- **c.** How much the patient can remember about past health history
- **d.** To whom the patient should be referred based on a system need

3. When a person has right-sided neglect caused by a stroke, one way to ensure the patient's continued attention to both sides of the body is to do which of the following?

- **a.** Observe for equal length of both arms
- **b.** Observe the condition of the skin and mucous membranes on the affected side
- **c.** Continue to teach the patient to strengthen the unaffected side and to avoid overuse of the affected extremities
- **d.** Continue to approach the patient from the unaffected side to encourage communication

4. One of the major concerns with older adults who have chronic conditions such as osteoarthritis is lack of activity. Which of the following is an unwanted result of decreased activity?

- **a.** Diarrhea
- **b.** Poor hygiene
- **c.** Loss of sense of touch
- **d.** Deconditioning

5. An older person with a chronic condition such as HTN may not take prescribed medications routinely. The main reason for this is which of the following?

- **a.** Inability to remember a medication schedule
- **b.** Lack of symptoms that indicate blood pressure is high
- **c.** Fear of becoming dependent on the medication
- **d.** Conflicting information about the purpose of the medication

14 Physiological Assessment

Kathleen R. Culliton

Learning Objectives

After completing this chapter, the student will be able to:

1. Describe two unique aspects of physiological assessment for older adults.
2. Describe at least three normal aging changes for each body system.
3. List two tools that are commonly used to evaluate functional status.
4. Discuss the importance of nutrition to the physiological well-being of the older adult.
5. Describe at least two important components to include in a home assessment.

INTRODUCTION

This chapter provides you with the opportunity to learn how to do a holistic assessment. Holistic assessments go beyond the physical assessment and include all aspects of the older person's life. The ability to perform a holistic assessment requires a high level of thinking and a sophisticated ability to process information. This is your chance to learn and then really do something significant for the older adults in your practice. This chapter outlines the parts of a physical, functional, discharge, and wellness assessment. The interrelationship between physical health, psychological well-being, and safety (Fig. 14.1) is highlighted. You, as the licensed practical nurse (LPN), need to be prepared to make a complete and thorough holistic assessment of the older adult in an effort to improve the person's overall health and happiness.

PHYSICAL ASSESSMENT

The techniques for physical examination included in this chapter are not all-inclusive of the techniques used to conduct a total examination. However, this assessment outline assists you in completing a head-to-toe physical examination of an older adult. It is important to remember to report any abnormal findings to the registered nurse or the physician.

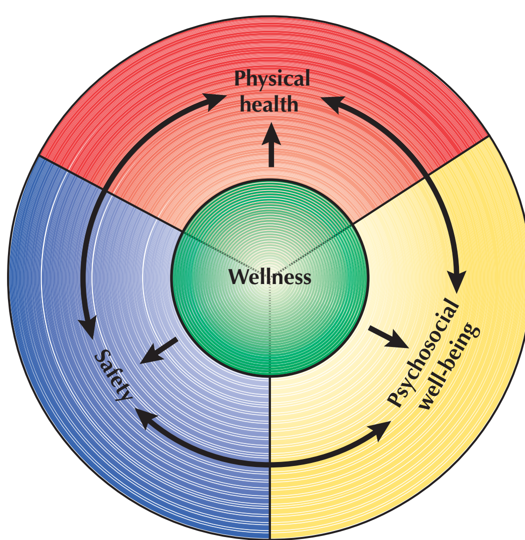


FIGURE 14.1. The interrelationship of physical health, psychosocial well-being, and safety.

PRIORITY SETTING 14.1

It is impossible for me to say that learning how to assess one system over another is the priority for this chapter. You simply need to learn it all! However, in the process of learning how to do a head-to-toe assessment, there is a simple list of priorities. Here is my list. You may want to:

1. Learn how to auscultate and palpate so you can trust what you hear and feel. The only way to do this is to practice. When I was learning physical assessment, I would literally play "nurse" (as opposed to doctor) with my daughter and her friends. She and a friend would lay on the carpet and lift up their shirts. Then I would listen to one and the other, comparing what I heard. I would do the same with palpation. Once I was comfortable listening and palpating on children, I went to my five sisters and coerced them into letting me listen. I would do it over and over and over again. For me it honestly took 50 practice assessments before I could trust what I heard or felt.
2. Once you have mastered the basic skills, you need to focus on the body one system at a time. Do heart assessments until you are really good. One way of learning is to watch nurses and physicians do assessments. Some are not detailed enough and others are terrific. Be sure to NOT pick up any bad habits. Once you can do hearts really well, move on to another system. Your personal objective should be to have all of the systems well learned by the time you graduate. People will respect you for these skills, and most importantly, the people in your care will benefit from what you know.

HISTORY

When taking a history on any system, there is information you need in order to have an accurate record of the person's overall health. You need to know the person's:

- Exercise plan
- Eating patterns, including recent weight loss or gain

This woman smokes a pack of cigarettes a day and seldom leaves her house. Based on this information, what other questions should you ask her about her health as you take her history?

- Consumption of alcoholic beverages, caffeine, and water
- Sleep patterns
- Smoking habits, or lack of them
- Stress management techniques
- Sexual activity
- Medication record, both prescription and over the counter

Once you have the holistic information listed above, you need to take a history and do an examination of the person's physiological systems. The following information will serve as a guide. If you identify aspects of the assessment or history that you do not understand or know how to do, discuss your concerns in class or privately with the faculty person. I am sure you have been taught how to do a history and physical on middle-aged adults. What you are learning in this chapter is not extremely different, yet it does include the aspects of a history and physical that are related to people who are growing older. It is important that you learn to adapt from one age group to another as you do your work of nursing.

You will find the following information written and presented in a very didactic manner. That is for ease and efficiency in your study of the material. It is specific and straightforward. So, please read on; I have tried to not deter you along the way with stories or casual information. Get into this material and master it. The nurse who can do an excellent history and assessment of a specialty group of people, such as older adults, is very desirable as an employee. An even more important point is that you will have the skills and knowledge to "pick up" on a subtle symptom, such as "painless" heart attacks most older adults have. That is important to know because it may save a life.

The material in this chapter is divided into three basic skills for doing an assessment. They are history, inspection, and palpation, if it is appropriate.

REVIEW OF SYSTEMS

Head, Neck, and Face

History

Evaluate the older adult's medical history for head injury, increased level of stress, thyroid dysfunction, neck injury, or infection.

Physical Examination

The assessment of the head and neck is the same for older adults as for younger people.

Inspection

Observe the older individual's head position. Note the size, shape, symmetry, and proportion of the head. If it appears abnormally large or small, measure the circumference or distance around the head. Evaluate hair distribution, pattern of baldness, and dryness of the scalp. Note if lice are found in the hair. The presence of lice demands immediate intervention. Assess the face for color, symmetry, and distribution of facial hair. Evaluate facial muscles by having the older adult demonstrate different facial expressions: raise eyebrows, close eyes, puff out cheeks, smile, show teeth, and frown. Note any wrinkles or dryness of the skin. Note the size of the neck. The trachea should be aligned with the midline of the suprasternal notch. Observe for symmetry of the neck muscles. Are they equal in size? Note venous distention, involuntary muscle tension, or swelling in the neck. Assess the active range of motion (ROM) of the neck by having the older adult tilt the head backward, forward, from side to side, and in a circular motion. ROM of the neck should be completed without limitation or pain.

Palpation

Palpate the alignment of the trachea. Palpate the cervical muscles, and note any tenderness. Palpate the carotid pulses one at a time. What does the pulse feel like? Is it bounding? Weak? Or does it have a vibration-type movement? As the older adult moves the neck, palpate over the spinal area for crepitus. Crepitus is a slight grating sensation that occurs when you palpate, and it is not normal.

Abnormal findings include edema of the face (especially around eyes), involuntary facial movements (tic, tremor, droop), lack of symmetry, unusual size and contour, and tenderness.

Nose and Sinuses

History

Ask the older adult to describe any problems with the nose or sinuses. Note that epistaxis (nosebleed) is more common in older adults than in younger adults.

Physical Examination

Inspection
Observe the size, shape, and color of the nose. Note any flaring of the nostrils during breathing and any nasal drainage. Ask the older person to tilt the head so you can examine the nasal cavity for swelling, drainage, polyps, and bleeding. The nasal mucosa should be moist and dark pink. Frequently, men have an increased amount of nasal hair. Assess the movement of air through each nostril by occluding the nostril not being examined and asking the older adult to inhale and exhale through the nose. Assess the older adult's ability to smell by asking the person to identify different common smells (almond, vanilla, cinnamon, coffee). It is abnormal for the smell to be perceived differently in each nostril.

Palpation
Palpate the nose for tenderness or masses. Abnormal findings include swelling of mucosa, bleeding, discharge, perforation, polyps, and deviation of nasal septum. It is uncommon to find nasal blockage, infection, crusting, and dryness.

Eyes

History

The nurse needs to discuss the following: vision changes, pain, excessive tearing or discharge, diplopia, infection, and cataracts. Ask whether the person wears glasses. When are the glasses worn? When was the last ophthalmic examination?

Physical Examination

Inspection
Assess both the external eye and visual acuity. Examine the eyes for position and alignment. Note the symmetry of the eyebrows, eyelashes, pupils, and irises. Changes in the appearance of the eyelids can be due to systemic diseases such as hyperthyroidism, myasthenia gravis, or palsy. The eyes should be evaluated for redness, swelling, and discharge. Pupils should be equal in size unless they have been unequal throughout life or have become unequal as a result of surgery or trauma. They may react more slowly to light than they did in the person's youth. Normally, the pupils are black, equal in size, round, and smooth. If the older adult has cataracts, the pupils may appear cloudy. Before testing visual acuity, you, as the nurse, need to make sure that adequate light is available. If the older adult wears glasses, the lenses should be checked for cleanliness and alignment because those two factors can affect visual acuity. The line of the bifocals may cause double vision if the glasses are misaligned. Evaluate distant vision with a Snellen's eye chart. Test each eye separately, with and without glasses. After testing separately, test the eyes together with and without glasses. Any person with 20/40 vision or less should be referred to a physician or nurse practitioner. To test near vision, use a newspaper or other conventional reading material; measure the distance from the face to the reading material. Have an alternate plan if the person cannot read. A possibility is to have the person look at an artistic picture and describe the details to you.

Ears

History

The nurse needs to help determine the effect of hearing loss on the older person's life. Does the older adult use any corrective devices, such as amplifiers or hearing aids? The following are some questions that can be used to elicit a history: have you experienced pain from your ears? Have you had dizziness? In what situations? How long did it last? What relieved the dizziness? Have you had any discharge from your ears? What color? What consistency? Did it have an odor? Have you experienced a sudden or rapid change in your hearing? What were you doing when it occurred? Does it come and go?

Physical Examination

Inspection
Observe the older individual in conversation. Does the person lean forward or cup a hand to the ear to hear? Is a loud speaking voice used? Does the person request repetition of what has been said? If hearing loss is identified, speak to the person in a normal tone of voice and speak

toward the better ear, if there is one. Assess the ear for size, shape, symmetry, redness, inflammation, swelling, discharge, and lesions.

Palpation

The surface of the skin of the ear should have a smooth texture. Palpate around the ear and ask the older adult whether any pain or tenderness is present.

Mouth and Throat

History

The first aspect of history taking related to the mouth is to establish whether the older adult has any dental complaints. The following questions can be used to elicit a history:

Do you have any pain or discomfort? Are any of your teeth especially sensitive to hot or cold temperatures? Have you noticed any swelling in your mouth or throat? Do you have any difficulty chewing or swallowing? How does food taste? Is your mouth dry?

Do your dentures fit properly? Do you have any sores or lesions in your mouth or throat? How often do you brush your teeth, dentures, or tongue? Do you use dental floss? If so, how often? When was your the last dental examination? What was the result? Do you clean your dentures at night in a cleaning solution?

Physical Examination

Inspection and Palpation

Inspection and palpation are used concurrently during the oral cavity examination. Use a gloved hand and a gauze pad to perform this part of the examination. If the older adult wears dentures, remove them before starting the examination. Evaluate both the fit of the dentures to the gums or alveolar surfaces and the dentures themselves. Dentures are considered to fit improperly if there is inflammation and ulceration of the palate, mucosa, and alveolar ridges. Examine the dentures for cracks, missing pieces, and rough edges. Dentures should be stable and remain securely fixed during chewing. Underlying tissues should be pink and adhere tightly to the bone. There should not be food, debris, or excessive denture adhesive on the inside of the denture. If the older adult does not have dentures, examine the teeth. Note the number and position of teeth. Are they in good repair, or can you see cavities and broken teeth? The gums should be pink, moist, and smooth. Inspect for signs of inflammation and lesions. The hard palate should be pale. The soft palate should be pink. Inspect for inflammation, lesions, pallor, and any purulent drainage or a white coating on the tongue. The uvula should be midline and red. It should move up as the older adult says "Ah." Tonsils, if present, should be small, pink, and symmetrical. Check the gag reflex with a tongue blade. Both the top and bottom of the tongue should be examined. A smooth, painful tongue may indicate vitamin B_{12} deficiency. The tongue and mucous membranes should be pink, moist, and free of swelling and lesions. The tongue should relax on the floor of the mouth. Varicose veins on bottom surfaces of the tongue are common. To examine the tongue, ask the older adult to stick out the tongue. While you hold it out with a piece of gauze, inspect all sides of the tongue and the floor of the mouth. Report any white, scaly patches. The lips should be moist, smooth, and pink. Check the corners of the mouth for cracks. These cracks are a prime spot for *Candida* (yeast) infections.

Neurological System

History

Does the older adult have any problems with headaches? Shaking or trembling? Confusion or memory loss? In assessing the neurological system, the nurse also should ask if the older adult has experienced seizures. Is there an existing seizure disorder? What type of treatment has been received? What were the circumstances occurring before, during, and after the seizure?

When taking a history on an older adult, it generally is useful to get information from the family as well as the individual being assessed. Remember that in many older people, long-term memory (LTM) may be based on facts that have been altered to "make the story better."

Physical Examination

Inspection

Initially, examine the older adult's level of orientation. Is the person alert, lethargic, or nonresponsive? Oriented to place, time, and person? As the older adult answers questions, observe the face for symmetry of movement when smiling, talking, grimacing, or frowning. Evaluate the older adult's appearance throughout the examination. Is the person dressed appropriately? Is the person wearing multiple layers of clothing? If so, are they appropriate for the weather outdoors? Is there body odor? Does the person appear well groomed? Is the older adult's behavior appropriate? Evaluate the strength and symmetry of the older adult's upper and lower extremities. This is commonly done by asking the person to squeeze your hands. Ask the person to walk across the room and observe the gait for symmetry, balance, and coordination during ambulation. Note any weakness.

Peripheral Vascular System

History

Some key history questions related to peripheral vascular functioning are listed below: do you have diabetes? Do you wear garters or girdles? Do you wear ankle-, knee-, or thigh-high hosiery? When you take off your hosiery, is there an indentation in your leg that does not go away for several minutes? Do your shoes fit tightly? Do you have pain in your calves after walking? Do you ever experience pains, aches, numbness, or tingling in your calves, feet, buttocks, or legs? Are there any activities that you cannot do because of pains and aches in your extremities? What aggravates your pain? What relieves the pain? Does walking or climbing stairs cause pain? Do you ever notice change in the color of your extremities, that is, red, blue, or pale? Have you noticed any hair loss over any part of your legs? Does your family have a history of problems with the legs? Do you sit for long periods of time with your legs crossed? Do you experience swelling of your legs at the end of the day? Does swelling return to normal in the morning?

Physical Examination

The physical examination of the peripheral vascular system includes inspection, palpation, and auscultation. The nurse should always compare one side of the body with the other when using these assessment methods.

Inspection

Skin color should be evaluated with the older adult lying down. Inspect the upper and lower extremities. Venous insufficiency is indicated if the legs are cyanotic when they are dependent (hanging down) or when petechiae or broken pigmentation is present on the skin over the legs. Chronic venous insufficiency is common in the elderly population. If the legs become pale when they are elevated and turn dark red when they dangle, arterial insufficiency is indicated. The signs of chronic venous insufficiency are as follows: distended tortuous veins, hair loss, hyperpigmentation, cool or normal skin temperature, and pretibial edema/pedal edema that is worse during the day but improves at night when the older adult lies down to sleep. The signs of chronic arterial insufficiency include thin, shiny, atrophic skin; hair loss over feet and toes; thick and rigid toenails; and cool skin. Edema of the legs and feet should be noted. The nurse may choose to record the width of the edematous area by using a measuring tape. When measuring the legs to assess edema, be sure to measure at the same place on each leg. If you wish to monitor changes in edema, lightly mark the location on the leg you are measuring with a felt-tipped marker and measure in the same place each day. Stasis ulcers are rare with varicose veins, but they commonly occur with deep vein insufficiency. Venous stasis ulcers are located on the sides of the ankles. Arterial ulcers may involve toes or places where the skin has been bumped or bruised.

Palpation

Check the skin temperature of the older adult's arms and legs by using the back of your hand. Increased temperature can be caused by a localized response to inflammation. Cool temperature indicates decreased blood flow. Peripheral pulses should be evaluated by using the pads of the index and middle fingers. The pulse is evaluated for rate, rhythm, amplitude, and symmetry. Normal vessels feel smooth and resilient. In most older adults, increased resistance to compression may be palpated because of rigid and tortuous artery walls. The nurse should practice palpating the pulses of both a young person and an older person to be able to differentiate the changes associated with aging. Pulses should be evaluated one at a time (carotid, brachial, radial, femoral, popliteal, and dorsalis pedis). They should be regular, strong, and equal bilaterally. Lack of symmetry between extremities indicates possible impaired circulation. If you have diffi-

culty finding a pulse, feel throughout the area where it is expected to be and vary the pressure of your finger. Be sure you are not feeling your own pulse. The rate you feel should be different from your own heart rate. If you had difficulty finding a pulse, you can mark its location with a felt-tipped pen once it is found.

Cardiac System

History

Older adults should be asked questions for assessment of cardiac disease risk factors, that is, smoking and exercise. Do you have any problems with dyspnea (explain this means shortness of breath)? Does your shortness of breath increase with activity (dyspnea on exertion)? Do you have chest pain? When does it occur? What are you doing when it occurs? Is the chest pain relieved by rest?

Physical Examination

Inspection

A cardiac physical examination procedure is the same for both older and younger persons. The older adult should be evaluated while lying down, sitting up, and standing. Observe the neck and chest to detect any visible pulsations, lifts, or heaves. The heartbeat is usually not visible, but it may be if the individual is emaciated. It is abnormal to observe the heart beating on the chest wall of an older adult who is obese or of normal weight. Note any cough, shortness of breath, venous or abdominal distention, or cyanosis of mucous membranes and nailbeds. The legs, ankles, and feet should be observed for edema.

Palpation

Feel the front of the chest over the heart for any thrills, heaves, or lifts. A thrill is palpable vibration. A lift or heave is a pulsation that is more forceful than anticipated. There should be mini-

FOCUSED LEARNING CHART

Leading cause of death and disability in older adults

Mortality rates in older adults are twice that of younger adults

Assessment	Diseases	Management
Smoking	Myocardial infarction (MI)	Understand medications
Dyspnea	Congestive heart failure (CHF)	Smoking cessation
Dyspnea with exercise	Valvular disease	Appropriate exercise plan
Chest pain	Angina pectoris	Manage obesity
Chest pain relieved by rest	Arrhythmias	Decreased sodium intake
Edema	Hypertension	Low-fat diet
Irregular heartbeats	Peripheral vascular disease	No constricting clothing
Weight gain	Coronary heart disease	

mal changes in the pulse when the older adult changes positions between lying, sitting, and standing. Press on the nailbeds and observe for the return of a pink color. This should occur quickly and is called capillary refill. It is abnormal for a refill to take longer than 2 seconds. Skin temperature should be palpated for unusual coolness or heat. The blood pressure should be checked using the orthostatic technique you learned in the last chapter. Orthostatic hypotension is a common problem with older adults.

Auscultation

Older adults have more rapid and less distinct heartbeats. Many older persons live normal, everyday lives with chronic atrial fibrillation. Any irregularity of the heartbeat noted while listening to the heart should be reported to the RN or physician. Infrequent extra beats (ectopic) are fairly common. Another common abnormal finding is a heart murmur. A heart murmur is caused by thickened and rigid heart valves and decreased strength of myocardial contractions. It sounds like a hum or click and results from turbulent or backward flow of blood through the heart. If detected, it should be reported.

Respiratory System

History

Questions that are used to assess an older adult's respiratory status include: do you have any difficulty breathing? Do you get short of breath with exercise or exertion? Do you have a cough? Is your cough dry or productive? What color and consistency is the mucous that you cough up? Is there any blood in the mucus? Dyspnea or difficulty breathing is not a part of normal aging. It is often related to congestive heart failure (CHF), pneumonia, anemia, and other lung diseases. It is present in only one-half of older persons with pneumonia. The first signs of pneumonia often include a nonspecific deterioration in health, for instance, slight cough, altered mental status, and tachycardia.

Ask the older adult if there is any history of lung disease. If so, what effect does it have on activities of daily living (ADLs)? Is oxygen used? Ask questions to determine if the older adult is using oxygen safely in the home. Other questions that can be used to elicit history of lung disease are as follows: Do you live in an area that has air pollution? Have you or any member of your family ever had tuberculosis? What is the date of your last chest X-ray study? Have you had the pneumonia vaccine (Pneumovax)? If so, when did you receive the Pneumovax? Have you had an influenza shot this year? Have you received one within the last year? Have you had a tuberculosis skin test? When?

Physical Examination

Inspection

In the older adult population, barrel chest, slight use of intercostal muscles, and slightly prolonged respirations may occur normally. If these signs and symptoms occur suddenly, they should be considered abnormal. The respiratory rate for normal older adults is 12 to 24 respirations per minute. A rate of 24 or greater is considered tachypnea. Observe for the use of accessory muscles and nasal flaring. A rate of less than 12 respirations per minute is considered bradypnea. Overt signs of the lower oxygen levels resulting from bradypnea include decreased consciousness, confusion, and lethargy. The character of respirations also should be evaluated. A normal respiratory rate is even and unlabored. The older adult's skin, lips, and nail color should be inspected for cyanosis and pallor. Posture while sitting and standing should be noted. Posture affects the ability to breathe.

Palpation

The anterior and posterior chest should be palpated for masses and tenderness of the ribs. The tracheal area should be palpated for any deviation.

Auscultation

Remember that an older adult can become dizzy from hyperventilation if asked to take deep breaths for a long time. Allow the person periods of normal breathing between deep breaths. Listen fully to inspiration and expiration. Softer vesicular sounds and diminished breath sounds in the bases of the lungs are normal. Listen for abnormal (adventitious) sounds. These sounds are superimposed on the normal breath sounds. Crackles are often heard when the older adult has CHF or pulmonary edema. Crackles result from air passing through moisture and sound like hair being rubbed between the fingers. Scattered crackles in dependent lung segments of some older adults should not be mistaken for bronchitis or CHF. If the crackles disappear after coughing, they are not pathological. If they are present after coughing, pathology may be present. Wheezes are a whistling noise caused by air passing through a narrowed airway. This happens with bronchospasm and swelling of the bronchioles. It is commonly heard in chronic obstructive pul-

monary disease (COPD) and in older adults with asthma. Pleural friction rub is due to inflammation between the membranes lining the chest cavity. It sounds like leather rubbing together.

Gastrointestinal System

History

In taking a gastrointestinal (GI) history, the nurse needs to focus on nutritional status, bowel habits, and medications. Ask the older adult or family member to give a 24-hour recall of the older person's diet. Evaluate the reported intake for nutritional balance. Is it full of fatty foods? Is it low in fiber? Does it have a high starch content? Calculate the amount of fluids the older adult drinks in a 24-hour period. The older adult needs 2000 to 3000 mL of fluids per day. Continue with more health history questions: How do you tolerate eating and drinking? Do you have problems with swallowing? Do you have the sensation that food is stuck in your throat? What is your bowel routine? Do you have abdominal pain? Do you use laxatives? Have you used laxatives in the past? How long did you use them? What kind of laxatives? How often were they used? Have you experienced any recent injury or infection?

Physical Examination

Inspection

Inspect the skin of the abdomen and note any lesions caused by rubbing of belts or corsets over the years. Check for fungal rashes in skin folds of those who are obese or incapacitated. Does the abdomen look rigid? If so, refer the individual to the RN or physician. Abdominal rigidity can indicate bowel obstruction.

Auscultation

Listen to the abdomen with your stethoscope. Mentally divide the abdomen into quadrants that intersect through the umbilicus. Auscultate each quadrant until you hear bowel sounds, or if there are no bowel sounds, listen continuously for 5 minutes. Bowel sounds are decreased in the older adult because of decreased gastric motility that accompanies normal aging. While the history was being taken, did the older adult complain of pain in the abdomen? Ask the older adult to point to the area of pain. Right lower quadrant pain may indicate appendicitis. Left lower quadrant pain

FOCUSED LEARNING CHART

Adventitious (abnormal) breath sounds

	Crackles	Wheezes	Plural friction rub
Pathology:	CHF or pulmonary edema	COPD Asthma	Inflammation between membranes lining chest cavity
Caused by:	Air passing through moisture	Air passing through narrowed airway	Inflammation
Sounds like:	Hair being rubbed through fingers	Whistling noise	Leather rubbing together
Report to RN if:	Coughing does not relieve crackles	Present	Present (is very painful)

may indicate diverticulitis. Tenderness at the base of the xiphoid process may indicate stomach pain, hiatal hernia, or referred pain from the aorta. Palpation will provide further information.

Palpation

Relaxation of the abdominal muscles enhances palpation. If the older adult is obese, palpation may be difficult. If you palpate a mass in the abdomen, it could indicate diverticulitis, fecal impaction, mesenteric thrombosis, or cancer.

Integumentary System

History

History taking is the most important aspect of the skin assessment. The most common skin complaints are pain, pruritus (itching), paresthesia (numbness), and dermatitis. The nurse needs to find out as much as possible about any skin problem mentioned. Questions to ask include: Do you have any skin problems? What kind? How were they treated? Are you allergic to any drugs or environmental allergens? What are they? How long have you had the allergy? Have you been exposed to an infectious disease? What is your history of sun exposure? What is your skin care regimen? Evaluate all medications the older adult is taking. Anything that can cause an allergic reaction, no matter how long the product has been used, should be discussed. Common allergens are soaps and topical medications.

Physical Examination

Inspection

Look at the older person's skin in a well-lit room. Skin folds should be evaluated for dampness, irritation, and fissures. Common skin folds are under the breasts and inguinal areas. Observe the scalp, behind the ears, the fingernails and toenails, genitalia, buttocks, and face. How clean is the older adult's skin? Is there an odor present? Assess skin color for variations that are not uniform and have changed since the previous examination. Note any pallor, jaundice, cyanosis, erythema, petechiae, and ecchymosis. Older adults with deeply pigmented skin tones should be evaluated for changes in color such as duskiness, graying, and blackish areas. Jaundice in a person of color should be evaluated on the hard palate and the soles of the hands and feet. Check pressure points over bony prominences, especially on individuals who are debilitated or immobilized. Pay particular attention to the areas over the scapulae, back of the head, earlobes, hips, heels, coccyx, and elbows.

The Braden scale is one common assessment tool used to evaluate the risk of pressure ulcer formation. This is a helpful assessment to complete on every older individual who enters a health-care setting. It will provide baseline information on the older person's risk for pressure ulcer formation. Individuals at high risk should have preventive measures implemented from the start. The Braden scale (Fig. 14.2) also can be used for periodic assessment of the older person. If the older adult's risk for pressure ulcer development increases over time, new and more aggressive interventions for prevention should be implemented.

Evaluate the skin for lesions. Some lesions are normal. Table 14.1 describes normal and abnormal skin lesions. Note the consistency of the lesions. If there has been a change in color, consistency, edges, or growth, the lesion may have changed from normal to abnormal.

Palpation

Check the skin for turgor. Gently pinch the skin on the forehead or anterior chest to see how quickly it returns to place. Poor turgor may be a normal aging change. It also could indicate dehydration and/or malnutrition. Palpate skin texture and note the temperature. Notice if the skin has become rough, dry, or coarse. Normally, the skin is smooth with some dryness. Check the skin temperature with the back of your hand. During this evaluation, note the symmetry of temperature and texture.

Musculoskeletal System

History

The most common musculoskeletal complaints are related to the joints. Complaints include pain, stiffness, redness, limitation in movement, and joint deformity. If the older person complains of pain, determine where the pain originates and where it radiates. The most common soft tissue problem is pain in and around the shoulder joint. If the older adult has a sudden onset of low back pain, report it to the registered nurse (RN) or physician. This could mean a compression fracture of the spine.

Physical Examination

Inspection

If possible, observe the older adult while the person is participating in ADLs and instrumental activities of daily living (IADLs). (See Functional Assessment section in this chapter.) This

Braden Scale

FOR PREDICTING PRESSURE SORE RISK

Patient's Name ______ Evaluator's Name ______ Date of Assessment ______

SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited:** Unresponsive (does not moan, flinch, or grasp), due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR Has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR Has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	
MOISTURE Degree to which skin is exposed to moisture	**1. Constantly Moist:** Skin is kept moist almost constantly by perspiration, urine, and so on. Dampness is detected every time patient is moved or turned.	**2. Very Moist:** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist:** Skin is usually dry, linen requires changing only at routine intervals.	
ACTIVITY Degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	

FIGURE 14.2. Braden scale for predicting pressure sore risk. (From Braden, B. J. & Bergstrom, N. [1992]. Pressure reduction. In G. Bulechek & J. McCloskey [Eds.], *Nursing Interventions* [2nd ed., p. 63]. Philadelphia: W. B. Saunders, with permission.)

MOBILITY Ability to change and control body position	**1. Completely Immobile:** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slightly Limited:** Makes frequent though slight changes in body or extremity position independently	**4. No Limitations:** Makes major and frequent changes in position without assistance.
NUTRITION Usual food intake pattern	**1. Very Poor:** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and/or maintained on clear liquids or IVs for more than 5 days	**2. Probably Inadequate:** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR Receives less than optimum amount of liquid diet or tube feeding	**3. Adequate:** Eats over ½ of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered OR Is on tube feeding or TPN regimen, which probably meets most of nutritional needs	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation
FRICTION AND SHEAR	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction	**2. Potential Problem:** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times	

FIGURE 14.2. (continued)

TABLE 14.1. Normal and Abnormal Skin Lesions

Lesion	Description
Normal Skin Lesions	
Seborrheic keratosis	Raised; vary in size; tan to black in color; appear warty or greasy; frequently appear on trunk.
Senile purpura	Vivid purple patch; well demarcated; eventually fades.
Senile lentigines	Brown; irregularly shaped patches; age or liver spots; occur most frequently on back of hands, forearms, and face.
Cherry angioma	Bright; ruby red elevated area; frequently found on trunk; common; insignificant; increase in size and number with age.
Sebaceous hyperplasia	Yellowish, flat, solid elevations with central depression; looks like a small doughnut; common on face, forehead, and nose; more common in men.
Abnormal Lesions	
Senile or actinic keratosis	Precancerous; superficial patch covered by a persistent scale; common on sun-exposed areas.
Squamous cell carcinoma	Firm, red-brown nodule; may arise from senile keratosis; common on sun-exposed areas and in fair-skinned clients.
Basal cell epithelioma	Starts as pearly colored solid elevation on face or ear; ulcerates leaving a crater with an elevated border and depressed center.
Malignant melanoma	Brown, black lesion; may have flecks of red, white, or blue irregular border, irregular surface; arise from moles or appear as new pigmented, irregular lesion.
Lentigo maligna melanoma	Less aggressive form of malignant melanoma specific to the elderly; arise from lentigens that enlarge laterally.

Source: McGovern, M., & Kuhn, J. K. (1992). Skin assessment of the elderly client. *Journal of Gerontological Nursing* 18(8), 40–41, with permission.

allows the nurse to assess range of motion (ROM), muscle mass, and level of independence in self-care. Some decline in ROM is expected. There is a general rigidity of the lower extremities.

Observe the older adult's ability to walk. Have the person ambulate a specified distance to determine endurance. It is normal for older men to have a slight anterior-flexion of the upper body while the arms and knees are slightly flexed. Note the kind of shoes worn by the older adult. Intervention is necessary if the person has an unstable gait yet wears high-heeled shoes. Have the older adult transfer in and out of the bed and chair, on and off the commode, and from the commode to the bathtub. Observe for symmetry of movement. Determine if the person needs assistance. Some older people may be independently mobile with the use of a wheelchair. Assess their ability to maneuver the wheelchair in the environment. Check the older adult's feet for lesions and deformity because these can interfere with gait and mobility. As with physical examination of all of the systems, report all abnormal findings of the musculoskeletal system to the RN or physician.

Reproductive System

History: The Female Patient

Although questions about sexual functioning and the reproductive organs may be uncomfortable for both the nurse and the older adult, it is important to ask them. Ask the older woman if she knows about breast self-examination (Fig. 14.3). If not, there is a need for education on the subject. Do not be surprised if she is familiar with breast self-examination and does it regularly. Many older women are more compliant than younger women in performing this examination. Inquire about symptoms of breast cancer. Does the person have any pain, nipple discharge, lumps, skin discoloration, or change in breast shape? Is there any family history of breast cancer or other cancerous conditions? Determine if the older woman has used estrogen or other medications that affect the breasts, such as digitalis, thy-

If you were assigned to assess this man on admission to the nursing home where you work, what observations could you make even before talking to him? His right arm is hanging without good positioning or apparent control. Does this man have a muscle or enervation problem in the arm, or has he possibly had a left-sided stroke? He is in a wheelchair. Why? His complexion is slightly ruddy. Is it from the broken vessels that often occur with excessive alcoholic consumption? He is not smiling.

roid drugs, and antihypertensives. Has the older woman ever had an abnormal Papanicolaou (Pap) smear? If so, was she treated? Did she receive any medications for menopausal symptoms? Was there any unusual bleeding since menopause? Some common physical complaints that older women experience with intercourse include vaginal dryness, pain, and limited mobility from arthritis. These complaints should be addressed and ways to deal with them should be suggested. Lubricants and using different positions during intercourse, such as the side-lying position, can help the older woman manage these concerns. Note the discussion in Chapter 12 on sexually transmitted diseases.

History: The Male Patient

The older man should be evaluated for symptoms of benign prostatic hyperplasia (BPH). Is there any change in the urinary stream? Any dribbling of urine? A sense that the bladder is not completely empty after urinating? Is there urinary frequency? Urgency? Burning during urination? Does the older man experience nocturia? How often? Review his medications and note whether he takes diuretics or an anticholinergic that might worsen BPH. Does he realize the importance of checking his breasts periodically? It is possible for males to develop breast cancer, but not as often as women do.

Physical Examination

Inspection

During the examination process, you should inspect the external genitalia on both the male and female older adult. Assess for skin or mucous membrane lesions, rashes, discoloration, hair loss, inflammation, discharge, asymmetry, and circumcision.

Urinary System

History

In gathering information about the urinary tract, the nurse needs to discover the chief complaint and the nature and extent of the older adult's underlying problem. The most common complaints are urgency to void, leakage when changing position, pain on urination, frequency of urination, voiding small amounts, and incontinence caused by coughing, sneezing, and laughing. The subject of urinary incontinence frequently causes the older adult to feel embarrassed. Incontinence may cause the older person to withdraw from usual social contact for fear of having an accident. It is also a major risk factor for pressure ulcer formation and urinary tract infections. Thus, despite the difficulties and embarrassment that may be associated with discussing incontinence, it is a serious problem that can have multiple untoward effects. If the older adult reports any complaints related to the urinary tract, determine the person's normal urinary and bowel habits before the symptoms began. Assess the past medical history for childbirths, previous surgeries involving the lower abdomen and pelvic floor, renal disease, and bladder cancer. Evaluate the older adult's medications. Diuretics and antiparkinsonian drugs can affect the urinary system. Periods of prolonged rest or immobility can cause urinary stasis. Urine that is allowed to pool in the bladder creates a favorable environment for the development of infection. To empty the bladder fully, it is important for the older adult to be able to use the sitting-with-legs-dependent position. Full

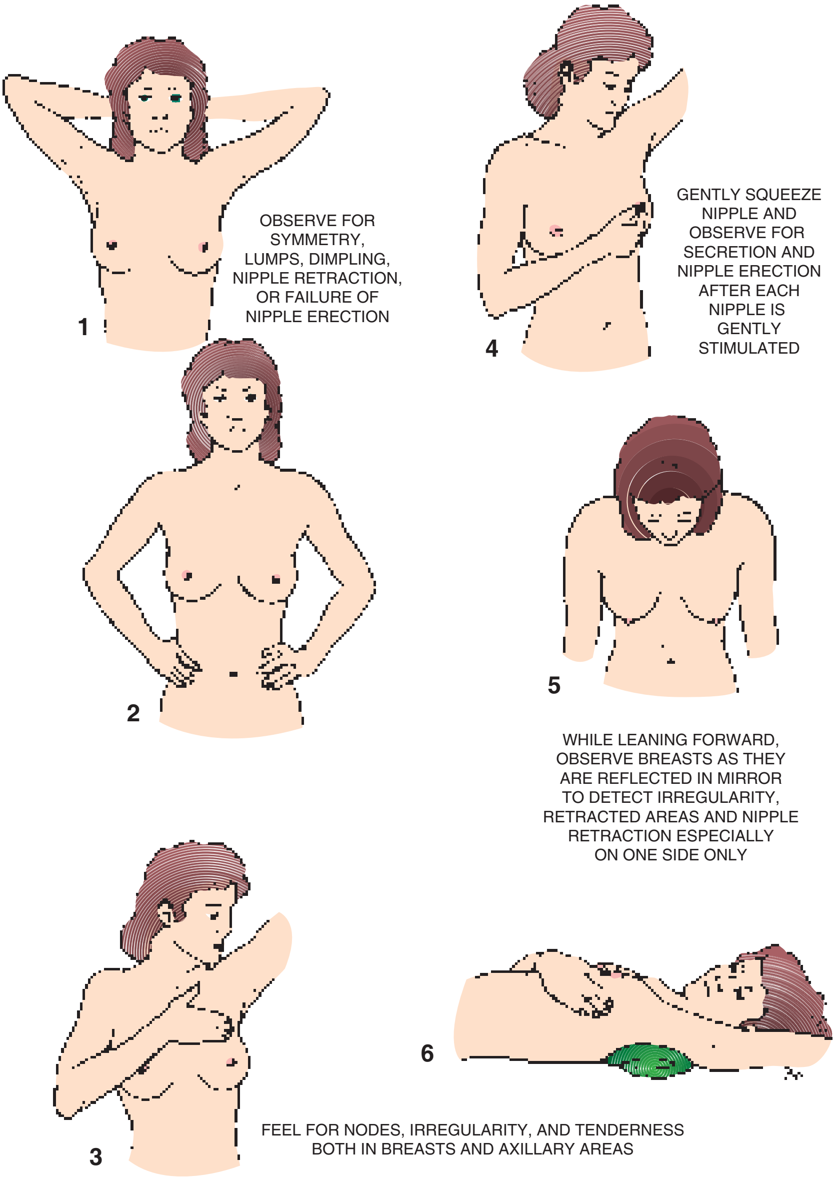


FIGURE 14.3. Breast self-examination. (From Venes, D. [Ed.]. [2005]. *Taber's Cyclopedic Medical Dictionary* [20th ed., p. 288]. Philadelphia: F. A. Davis, with permission.)

bladder emptying may not be possible on a bedpan. Decreased fluid intake results in low urine volume and infrequent urination. This can create pooling of the urine and increase the risk for infection. It also can lead to dehydration, elevated blood sugar levels, and electrolyte imbalance. These conditions may manifest themselves in the older adult through alterations in mental status.

Physical Examination

Inspection

Assess urine amount and color for the presence of any sediment.

Palpation

Palpate the abdomen for distention of the bladder and signs of pelvic discomfort or masses.

FUNCTIONAL ASSESSMENT

For an older adult, a functional assessment is as important as a physical assessment. Very often, the older person demonstrates changes in function as the first or only sign indicating the onset of illness. Although the older person has many chronic illnesses, these typically are not problematic until function is affected.

Functional assessment includes a holistic approach to evaluating the older adult that includes physical, cognitive, and social function. Physical function is comprised of the individual's current health status in addition to how well the person performs ADLs and IADLs. Cognitive function includes the individual's memory, judgment, and thinking abilities. Cognitive function is discussed in Chapter 16 and is not included in this section on functional assessment. Social function involves a psychosocial approach to determine how the individual interacts with the environment and with others.

Functional assessment involves evaluating the older adult to determine what the person can do (strengths) and cannot do (deficits). What the health-care team members see as a deficit may not correlate with what the older adult views as a problem. Both the older adult's true abilities, as assessed by the nurse, and the older adult's perception of these abilities must be considered.

Functional assessment assists in setting realistic goals. Cure, as a goal, is not appropriate for an older individual with chronic, irreversible conditions. The goal for this person would be to maximize functional strengths and compensate for deficits to achieve and maintain optimal independence in function.

In almost any health-care setting, the nurse is the health-care professional who spends the most time with the older adult. This affords the nurse many opportunities to observe the client's physical functioning. A decline in functional ability may represent a change in an underlying chronic disease or the onset of a new acute illness. Monitoring functional status helps track improvements and setbacks. It also indicates when additional services are needed. Use of a formal tool to evaluate functional status allows the nurse to validate, monitor, and clearly communicate clinical impressions to other members of the interdisciplinary health-care team (IDT).

Activities of Daily Living

The Katz ADL scale (Fig. 14.4) is widely used to assess ADLs. It is a well-rounded tool that is appropriate for use in most settings, including home, hospital, and nursing home. ADLs are those performed in taking care of oneself. The following areas are considered ADLs: bathing, dressing, toileting, feeding, ambulating or transferring, and continence. Direct observation is the most valid indicator in assessing ADLs. Watch the older adult perform ADLs and check for abnormal body movements. Rate the older adult on each of the ADL items of the Katz scale. Using the scale supplies specific information on how the older adult performs in each of the ADL areas, and the composite score can give you and others on the IDT an overall view of the person's level of ability. The score also gives an objective means to monitor progress over time. Goals in each of the ADL areas can be set on the basis of scores on the scale.

Instrumental Activities of Daily Living

Instrumental activities of daily living include the ability to use the telephone, cook, shop, do laundry, manage finances, take medications, and prepare meals. These activities are needed to support independent living. Lawton's scale for IADLs is used widely (Fig. 14.5).

If possible, observe the older adult while the person is performing IADLs. Look for abnormal body movements such as tremors or twitching, for lack of balance, or for poor vision. In addition to checking the person's ability to complete the IADL, it is important to assess the older adult with regard to safety. The older person may be able to cook a meal, but if the burner is left on, a serious safety concern exists.

Many times, in completing an IADL assessment, the nurse must rely on reports from the older adult or family members. Keep in mind that individuals tend to overrate their abilities and family members tend to underrate them.

Tools for assessing ADLs and IADLs are used to measure the older person's ability to do self-care and home-care tasks. They can be used to help identify needed services and to monitor the progress or deterioration of the older individual.

Social Function

Social function is how the older adult interacts with self, the environment, and others. It is the degree to which a person functions as a member of the community. Cultural and socioeconomic background and the older adult's environment define and limit social activities and relation-

Activities of Daily Living (ADL) Scale

Evaluation Form

Name ______________________________ Day of evaluation ______________________

For each area of functioning listed below, check description that applies. (The word ''assistance'' means supervision, direction, or personal assistance.)

Bathing—either sponge bath, tub bath, or shower		
☐ Receives no assistance (gets in and out of tub by self, if tub is usual means of bathing)	☐ Receives assistance in bathing only one part of the body (such as back or a leg)	☐ Receives assistance in bathing more than one part of the body (or not bathed)
Dressing—gets clothes from closets and drawers, including underclothes, outer garments, and using fasteners (including braces, if worn)		
☐ Gets clothes and gets completely dressed without assistance	☐ Gets clothes and gets dressed without assistance, except for assistance in tying shoes	☐ Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed
Toileting—going to the ''toilet room'' for bowel and urine elimination; cleaning self after elimination and arranging clothes		
☐ Goes to ''toilet room,'' cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning)	☐ Receives assistance in going to ''toilet room'' or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode	☐ Doesn't go to room termed ''toilet'' for the elimination process
Transfer		
☐ Moves in and out of bed as well as in and out of chair without assistance (may be using object for support, such as cane or walker)	☐ Moves in and out of bed or chair with assistance	☐ Doesn't get out of bed
Continence		
☐ Controls urination and bowel movement completely by self	☐ Has occasional ''accidents''	☐ Supervision helps keep urine or bowel control; catheter is used or person is incontinent
Feeding		
☐ Feeds self without assistance	☐ Feeds self except for getting assistance in cutting meat or buttering bread	☐ Receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids

SOURCE: Courtesy of Sidney Katz, MD. Reprinted with permission.

For additional information on administration and scoring refer to the followig references:

1. Katz S. Assessing self-maintenance: activities of daily living, mobility, and instrumental activities of daily living. *J Am Geriatr Soc*. 1983;31:721–727.
2. Katz S, Akpom CA. A measure of primary sociobiologic functions. *Int J Health Services*. 1976;6:493–508.
3. Katz S, Downs TD, Cash HR, et al. Progress in development of the index of ADL. *J Gerontol*. 1970;10(1):20–30.

FIGURE 14.4. The Katz Activities of Daily Living Scale. (From Katz, S., Ford, A., & Moskowitz, R. [1963]. The index of ADL: A standardized measure of biological and psychosocial function. *Journal of the American Medical Association* 185, 914. Copyright 1963, American Medical Association, with permission.)

ships. Self-concept affects the older adult's ability to perform self-care activities. Psychological interventions may be necessary to enhance the older person's self-esteem before achieving independent functioning.

CONCLUSION

This chapter contains a great deal of information about performing a holistic physical assessment

Instrumental Activities of Daily Living (IADL) Scale

Self-Rated Version Extracted from the Multilevel Assessment Instrument (MAI)

	Item	Score
1	Can you use the telephone	
	without help,	3
	with some help, or	2
	are you completely unable to use the telephone?	1
2	Can you get to places out of walking distance	
	without help,	3
	with some help, or	2
	are you completely unable to travel unless special arrangements are made?	1
3	Can you go shopping for groceries	
	without help,	3
	with some help, or	2
	are you completely unable to do any shopping?	1
4	Can you prepare your own meals	
	without help,	3
	with some help, or	2
	are you completely unable to prepare any meals?	1
5	Can you do your own housework	
	without help,	3
	with some help, or	2
	are you completely unable to do any housework?	1
6	Can you do your own handyman work	
	without help,	3
	with some help, or	2
	are you completely unable to do any handyman work?	1
7	Can you do your own laundry	
	without help,	3
	with some help, or	2
	are you completely unable to do any laundry at all?	1
8a	Do you take medicines or use any medications?	
	(If yes, answer Question 8b) Yes	1
	(If no, answer Question 8c) No	2
8b	Do you take your own medicine:	
	without help (in the right doses at the right time),	3
	with some help (take medicine if someone prepares it for you and/or reminds you to take it), or	2
	(are you/would you be) completely unable to take your own medicine?	1
8c	If you had to take medicine, can you do it:	
	without help (in the right doses at the right time),	3
	with some help (take medicine if someone prepares it for you and/or reminds you to take it), or	2
	(are you/would you be) completely unable to take your own medicine?	1
9	Can you manage your own money	
	without help,	3
	with some help, or	2
	are you completely unable to handle money?	1

SOURCE: Lawton MP, Brody EM. Assessment of older people: self maintaining and instrumental activities of daily living. *Gerontologist*. 1969;9:179–185. Reprinted with permission.

For additional information on administration and scoring refer to the following references:

1. Lawton MP. Scales to measure competence in everyday activities. *Psychopharm Bull*. 1988;24(4):609–614.
2. Lawton MP, Moss M, Fulcomer M, et al. A research and service-oriented Multilevel Assessment Instrument. *J Gerontol*. 1982;37:91–99.

FIGURE 14.5. Instrumental Activities of Daily Living Scale. (From Lawton, M. P., & Brody, E. M. [1969]. Assessment of older people: Self maintaining and instrumental activities of daily living. *Gerontologist* 9, 179–185. Copyright © The Gerontological Society of America, with permission.)

as well as a functional assessment. To be an effective gerontological nurse, you need to be very good at both of these skills. There is a great deal of information in this chapter. The only way you will learn it is to go over it several times, practice asking the questions, and practice the skills. Have the courage to use the skills (even with a cheat sheet) whenever you go to your student clinical assignments. This is not a chapter to read and then move on to the next one. This is the one you need to internalize through rereading and practice. Best wishes!

CASE STUDY

Miss S. is an 85-year-old woman who has been admitted to the medical unit where you work. She has been there for 2 days while being treated for CHF. You are assigned her care for the next 12 hours. In a report, you are told Miss S. is uncooperative and incontinent. Miss S. is responding well to her medication regimen for the CHF and will be discharged tomorrow.

Discussion

1. What is your priority in terms of assessing Miss S. today?
2. How will you meet the requirements of the priority assessment items?
3. What other points of concern should you address in your assessment?
4. How will you do that?

Solutions

In doing a holistic assessment, it is important that you determine the underlying cause of the "little" problems as well as the big ones. The big problem for Miss S. is the management of her CHF. According to the report, that is going well. Of course, you need to verify that her medical treatment is still managing her symptoms. This is the priority concern because it is life threatening as well as the reason she was admitted to the hospital. How will you assess the CHF? Here are some suggestions:

1. Assess for edema by checking her ankles, abdomen, lumbosacral area, and hands for swelling and listening to her lungs for adventitious breath sounds.
2. Is she able to perform her ADLs without dyspnea?
3. Does she understand her medication administration?

Now, let's consider her incontinence and lack of cooperation. Some nurses would not be concerned about these items, but because you are committed to holistic nursing care, these concerns are important to you. One idea should come to your mind right away. Assume Miss S. is on furosemide (Lasix) for the CHF. Lasix is associated with increased urination. At age 85, this probably is a major inconvenience for this person. Has she cut down on her fluid intake in order to decrease the stress urination and incontinence, which has resulted in an electrolyte imbalance and confusion? This is what I would investigate as I did my assessment. It will be a very serious problem if it is not resolved before Miss S. goes home.

STUDY QUESTIONS

Select the best answer to each question.

1. The following are normal aging changes except:

- **a.** Presbyopia, presbycusis
- **b.** Presbyopia, urinary incontinence
- **c.** Kyphosis, ptosis
- **d.** Osteoporosis, arteriosclerosis

2. Activities of daily living include:

- **a.** Shopping
- **b.** Managing finances
- **c.** Bathing
- **d.** Using the telephone

3. A common tool used for evaluating ADLs is:

- **a.** Lawton's scale
- **b.** The mini-mental status examination
- **c.** The Katz scale
- **d.** a and c

4. A common symptom of myocardial infarction with the older adult is:

- **a.** Chest pain
- **b.** Lethargy
- **c.** Confusion
- **d.** b and c

5. An important health problem the nurse should help the older adult prevent is:

- **a.** Fecal impaction
- **b.** Dehydration
- **c.** Malnutrition
- **d.** All of the above

15 Common Clinical Problems: Physiological

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Identify the age-related factors that place the older adult at risk for impaired mobility and describe how the nurse can assist in maintaining mobility.
2. Define two categories of risk factors for falls in the older population.
3. Identify two categories of incontinence.
4. Explain how prompted voiding and habit training schedules can be used by the nurse for prevention or reversal of incontinence.
5. Identify the mechanical and physiological risk factors for pressure ulcers.
6. Discuss the problems pertaining to adequate food intake in the older population.
7. Describe two sleep disorders common to older adults.
8. Define iatrogenesis and list common iatrogenic problems experienced by older persons.

INTRODUCTION

With aging, every body system undergoes some changes. These changes, although not necessarily resulting in illness or disease, cause health problems that are more prevalent in the older age group. As you learned in a previous chapter, most people who are older than 65 years of age have multiple chronic diseases. The combination of normal aging changes and underlying chronic diseases means that the older person has less physical reserve than a younger person has to respond to the increased demand of an illness. With diminished physical reserve, the older adult is less capable of adapting to physical stressors and is at increased risk for suffering such clinical problems as immobility, falls, incontinence, pressure ulcers, and alteration in nutrition and sleep. This chapter reviews the clinical problems that are common to older adults. In addition, effective management approaches, based on nursing diagnoses, are discussed.

ALTERATION IN MOBILITY

The process of aging, combined with the presence of chronic illness, places the older adult at risk for developing an alteration in mobility status. Immobility is a major medical disability for the aged and one that is frequently overlooked by health-care providers. Immobility often leads to numerous complications for older people in long-term care facilities, as well as for people in the hospital and in the community. Nursing management is essential to maintaining and improving one's ability to be mobile.

The Musculoskeletal System

Normal aging changes that occur in the musculoskeletal system increase the risk of developing problems related to mobility. The bones of an older person are less dense and more brittle. This is due to changes in the formation of bone at the cellular level. As a result, older adults are likely to develop osteoporosis and to suffer the subsequent risk of bone fractures.

With a fracture, mobility is restricted still further. Mechanical stresses, such as walking and standing, tend to stimulate the process of bone formation. When the body is immobilized, there is bone dissolution. This process is called *disuse osteoporosis,* and it will make the bones of the older person still more brittle.

Generalized muscle weakness is also a normal aging process. There is a noticeable decrease in muscle strength with aging. The antigravity muscles are most affected by this change so that standing up can be a difficult movement. In time, if muscles are not used, walking, balancing, and turning become severely impaired. At complete rest, muscle strength can decline at a rate of 5% a day. *The loss of muscle mass is not just a symptom of generalized deterioration, but it is also a factor in the risk of falling.*

The mobility of the joints is affected by the length and composition of the muscle fibers. When there is immobility, the muscles that bridge the joint shorten. With decreased muscle length, as well as thickening of the joint cartilage (the connective tissue that surrounds the moveable surfaces of the joint), the joints become stiff, which seriously impacts the ability of the person to move.

Osteoarthritis, or degenerative joint disease, occurs in 83% to 87% of people when they are between 55 and 64 years of age. It is marked by deterioration of the cartilage and formulation of new bone at the joint surfaces. With aging, the cartilage is less elastic, thicker, and more easily stretched. As a result, the joint is stiff and there is decreased range of motion to the joint. Over time, the older adult can lose the ability to mobilize efficiently as a result of stiffness in the joints. As joints are immobilized, contractures (a permanent contraction of the muscles that bridge the joint) can develop and further limit mobilization.

PRIORITY SETTING 15.1

The priority for this chapter is easy to identify. After you understand the content of this chapter, you need to assist every older adult to whom you give care to achieve his or her maximum physical ability. Keep that thought in mind and do not stray from it. By doing so, you will enhance the lives of all of the older people in your care.

The Cardiovascular System

Many of the changes in the cardiovascular system that accompany aging are closely related to inactivity. Similarly, these aging changes can be exacerbated, or become more severe, when there are prolonged periods of immobility. One such aging change is in oxygen consumption, which is referred to as $\dot{V}O_2$. $\dot{V}O_2$ measures the body's ability to transport oxygen from the atmosphere to

FOCUSED LEARNING CHART

Alteration in mobility related to aging

Respiratory System	Cardiovascular System	Musculoskeletal System
Decreased efficiency of gas exchange by alveoli	Decreased cardiac output	Generalized muscle weakness
Decreased vital capacity	Pulse rate does not increase efficiently with exercise	Osteoarthritis
Decreased elasticity of lung tissue	Decreased O_2 (O_2 consumption)	Bones more brittle (osteoporosis)
Structural compromise • Rigidity of rib cage • Kyphosis • Osteoporosis		Shortening of muscle fibers

the various tissues of the body. In aging, as well as during periods of immobilization, this ability decreases. $\dot{V}O_2$ is affected by cardiac output (the amount of blood pumped from the heart to the body), which is known to diminish in aging. Physical exercise causes the active tissue to use more oxygen and eliminate carbon dioxide, which increases cardiac output. With prolonged immobility, cardiac output during exercise does not increase as efficiently as in an active ambulatory person.

Oxygen consumption and cardiac output also are known to decrease with aging. This change is evident from the fact that the pulse rate of an older person does not increase in response to exercise as efficiently as in younger people. After physical exertion, the pulse takes longer to return to a normal level. The inefficient cardiac response to activity causes activity intolerance.

The Respiratory System

As is true of all of the systems, aging changes to the respiratory system put the older person at risk for complications when immobility is present. Normal anatomical changes in the aging body compromise lung function. Increased rigidity of the rib cage, kyphosis, and osteoporosis reduce the compliance of the chest wall, making it more difficult to inflate the lungs fully. The reduced compliance of the chest wall makes it more challenging for the older adult to maintain activity, and it also increases the potential for complications caused by immobility. The lungs of most older adults have diminished vital capacity (the amount of air that can be expelled from the lungs following inspiration). Other changes include less-efficient gas exchange by the alveoli and less stretchability of the lung tissue. The result is impaired ventilation and decreased blood supply to the lungs. Such changes may not only hinder the older person's ability to move but, more important, place the older patient at increased risk for developing atelectasis (collapsed lung) and pneumonia when immobilized.

Response to Illness

Chronic health problems may cause older people to restrict their movement. For instance, poor eyesight may cause someone of any age to avoid activity because of fear of falling over an obstacle. Pain in the joints due to arthritis or pain in the lower extremities due to impaired circulation generally limits ambulation and causes older adults to become sedentary. Shortness of

FOCUSED LEARNING CHART

Oxygen consumption in cardiovascular systems of older adults (V_{02})

V_{02} measures the body's ability to transport oxygen from the atmosphere to the tissues in the body; simply put, it is the amount of blood pumped from the heart.

Ability for 0_2 consumption decreases (decreased V_{02}) with:
Aging
Immobility

Physical exercise causes:
More O_2 to be used
More CO_2 to be eliminated
Increased cardiac output, resulting in an increase in V_{02}

breath or angina secondary to chronic cardiopulmonary disease also may cause the individual to avoid activity.

Acute health problems can lead to immobility. The onset of an acute illness, whether or not it requires hospitalization, may lead to confinement in bed. Often well-meaning family and health-care providers actually encourage immobility. Bed rest often is ordered during hospitalization for an acute illness. Unfortunately, unlike a younger person, the older adult who is on bed rest deteriorates rapidly and may develop irreversible complications. Although rest can promote healing, immobility promotes deterioration. Prolonged immobility is detrimental to both the physical and mental health of a person of any age. When immobilized, the older person can develop complications such as contractures, pneumonia, pulmonary emboli, thrombophlebitis, pressure ulcers, incontinence, constipation, renal stones, dehydration, loss of appetite, and psychological problems related to sensory deprivation and depression.

NURSING IMPLICATIONS

Nurses, as well as the older people to whom they give care, need to be aware that promoting physical activity not only prevents complications but

POINT OF INTEREST

Although immobility is a prevalent health problem, it often is not addressed in the care of the older adult. Identifying immobility as a patient-care problem and intervening to prevent it are central to nursing care of the older person. In addressing mobility needs, the licensed practical nurse (LPN) may prevent complications and shorten the length of time the older person is in the hospital or nursing home.

This woman has severe physical limitations, but she can get around because she is in the right type of wheelchair for her needs. She can see to read, as noted by the book she has in her lap. Observe that she is clean and neat, with matching clothes, jewelry, and a nice haircut and nails. What do these things say about her?

also slows the rate of the aging process. In the hospital setting, the time for enforced bed rest needs to be limited as much as possible. As soon as it is medically safe to do so, the nurse needs to ensure that the patient is up and out of bed. If orders for bed rest are in effect, it is the nurse's responsibility to inquire whether such orders can be changed. Even transferring the patient from a supine to a sitting position has beneficial effects. While on bed rest, older adults can be taught isometric and active range-of-motion exercises. If the patient is incapable of performing these exercises independently, then the nurse must assist the patient in meeting this need through passive range-of-motion exercises.

As soon as it is medically indicated, the older person should be ambulated with assistance. This intervention is as important to the person's health as receiving the proper medication or a dressing change. Nursing staff should support physical therapy services by ensuring that appropriate, sturdy footwear, eyeglasses, and any assistive devices such as canes or walkers are available. Because of reimbursement issues, hospital stays are becoming shorter. Therefore, as soon as the patient is physiologically able, attempts to restore functional ability should begin.

As in the hospital setting, promoting functional mobility is central to the care of the older person at home or in a nursing home. The nursing home environment offers different possibilities for fostering mobility. Unlike the hospital setting, where the presence of an acute state may impede the nurse's attempts to restore function, the nursing home environment allows the nurse to monitor and promote mobility over an extended period of time. All residents should be considered for assisted walking unless the underlying chronic illness absolutely precludes such an activity. The older person who does not walk deteriorates even further and eventually loses all ability to walk. Family members and other caregivers for the older adult who lives at home need to be taught the importance of mobility.

POTENTIAL FOR INJURY FROM FALLS

As with alteration in mobility, the potential for falls is closely related to many of the bodily changes that occur with aging. The aging of the musculoskeletal system, which may cause a deterioration in mobility, also may increase the older person's risk for falling. One-third of adults who are older than 65 years of age living in the community and one-half of those older than 80 years of age fall each year. In nursing homes, a fall rate of two per resident per year has been reported. Most falls do not result in serious injury; however, 250,000 falls per year result in hip fractures, and 1500 persons 65 years of age or older die each year as the result of a fall or fall-related injury. The presence of chronic illness accompanying the aging process places all older adults at increased risk for falls.

When an older person falls, the person often becomes fearful of falling again. This may cause the older adult to limit activities and to become more withdrawn and dependent on others, less mobile, and more at risk for future falls. Caregivers also may place restrictions on the older person's mobility to prevent another fall. At home, the family may admonish the older person to restrict activities so that a fall will not occur again. In the health-care setting, restraints should never be used to prevent the risk of

another fall. These options do not promote health for the person.

Factors that predispose to falling are typically divided into two categories: intrinsic and extrinsic. Intrinsic factors include factors inherent to the individual, such as normal aging changes, deficiencies in health status, changes in mental status, immobility, and changes in functional ability. Extrinsic factors refer to environmental conditions, which may include poor lighting, slippery floors, inappropriate or poorly placed furnishings, and inadequate footwear. Falls among older adults often stem from the presence of intrinsic factors that hinder the older person's ability to manage the environment or from environmental conditions (extrinsic factors).

Intrinsic Factors

Age-related changes in posture, balance, gait, and vision predispose the older person to falls. Postural changes are common in older people and are due to a decline in strength and flexibility. In older adults, the head tends to be carried forward, the shoulders may be rounded, and the upper back may have a slight curvature, or kyphosis. Changes in posture and spinal alignment can affect balance and increase the risk of falls.

Posture and Balance

The body's ability to maintain its coordination in a standing position and to react to prevent a fall is dependent on coordination among the musculoskeletal system, the neurological system, and the visual system. Postural sway occurs when one or more of these three systems is not functioning at an optimal level. Balance problems are associated with postural sway, which can cause falls. Prolonged bed rest, aging changes, medications, and the presence of some chronic diseases are contributors to postural sway.

Postural reflexes play a role in fall prevention by responding to disturbances in balance during standing or walking. With aging, these reflexes become slower; therefore, older people are less able to "catch" themselves when they trip or begin to fall. Inactivity may result in a slower response to disturbances in balance.

Gait

With aging, the gross motor movements necessary for maintaining posture and gait, or walking, are altered. The gait of older people often is marked by decreased speed and step height; small, hesitant steps; diminished arm swing; and stooped posture. These changes are almost universal in the population older than 80 years of age. The alterations in speed of movement and maintenance of upright posture adversely affect balance and often lead to a higher incidence of falls by older adults.

Vision

All older people experience changes in vision as part of the normal aging process. With aging, there is a decline in visual acuity, peripheral vision, depth perception, night vision, and tolerance for glare. The loss of vision that accompanies aging is a risk factor for falls because there is a decreased ability to focus on objects at a distance and to judge distances correctly. The result is that an older person may miss a step or trip over a curb. The decline in peripheral vision may cause an individual to trip over objects at the edge of the visual field. Visual deficits can compound a gait disability because vision is necessary to maintain stability while walking.

These normal, age-related changes in posture, gait, and vision, when compounded by the presence of an underlying chronic or acute illness, make falls the leading cause of death from injury in the group over 65 years of age. Because of the presence of these intrinsic factors, many older people are less capable of coping with the extrinsic factors that may be in the environment.

Extrinsic Factors

At least 50% of the falls affecting older adults result from environmental factors. Such factors may include clutter in the halls, inadequate lighting or glare, or unsafe furniture or equipment in the person's immediate area. Attempting to function in an area that is not designed to accommodate the aging person's needs can diminish the older person's confidence. The individual may begin to fear falling and eventually become more sedentary. Such behavior eventually leads to a loss of function and an increased need to depend on others for activities of daily living.

Nursing Implications

As health-care providers, it is important for nurses to understand the role that both intrinsic and extrinsic factors play in falls. The individual's ability to maneuver safely in the immediate environment is best monitored by the nurse. In both the home and the institution, most falls occur in

CRITICALLY EXAMINE THE FOLLOWING:

You have been asked to present the educational section at the next staff meeting. Your nurse manager has requested that you develop a teaching plan for your colleagues regarding the importance of mobility in older adults. You were asked to discuss two former patients who had mobility problems. As part of your lesson plan, write out the reasons an older person should be mobile. Identify ways mobility can be done successfully with the following former patients. They are as follows:

1. An 87-year-old man with a fractured hip. He is deconditioned (a word from a previous chapter; do you remember it?), yet insists he can walk "by himself."
2. A 72-year-old woman who is "pleasantly confused" while recovering from a fractured femur. She is experiencing a great deal of pain and thinks you are her son. Address both patients' ambulation plans. Bring your best lesson plan to class to share with others.

the bedroom and the bathroom. Therefore, it is important to assess the older person walking about the bedroom, getting into and out of bed, and getting on and off the toilet. Only by assessing the individual's ability to manage these daily activities in their own environment can you, the nurse, begin to anticipate needs and take steps to prevent a fall before it occurs.

Having assessed the older person's safety, the nurse, along with members of the interdisciplinary health-care team (IDT), should plan care according to the observed need. For instance, the nurse may observe that the older person cannot safely get on and off the toilet independently and may advise the individual not to attempt this maneuver unassisted. If the person is not cognitively intact, you may use a toileting schedule to discourage the individual from attempting self-toileting when you, the LPN, or other caregivers are not present to assist. If the older person cannot safely ambulate alone, the IDT may decide that physical therapy is indicated or that a program of daily assisted ambulation should be initiated. Older adults who cannot safely stand or walk unassisted, but who may still attempt these actions, should not be left alone for extended periods of time. One idea is to bring the person out of the room so staff members can observe the older adult and in that way keep the individual safe. When someone who is not safe is left alone, mobility alarms would help the staff know when the individual is getting up unassisted. Mobility alarms can be attached to both the bed and wheelchair. All members of the team need to remember to remove clutter and to maintain clear walking paths for older people, to adjust lighting to provide an optimum environment, and to wipe up spills from the floor as soon as they occur or are noticed.

ALTERATION IN ELIMINATION

Urinary Incontinence

Urinary incontinence, a problem that affects approximately 10 million Americans, is defined as an involuntary loss of urine that is sufficient to be a problem. It is a problem most often seen in the elderly population; 15% to 30% of noninstitutionalized people older than 60 years of age and half of all nursing home residents are affected. The cost of caring for individuals with urinary incontinence is approximately $7 billion annually for individuals living in the community and approximately $3.3 billion for nursing home residents.

Even greater than the economic cost are the psychological and social costs to the individual who is incontinent of urine. Incontinence is seen as a major reason older adults are placed in nursing homes. Furthermore, people who are incontinent may feel embarrassed and socially isolated. They may withdraw from participation in social activities and become depressed. Incontinence is associated with the development of other health problems, such as skin breakdown, behavioral disturbances, and urinary tract infections.

Age-Related Changes Affecting Incontinence

Although incontinence is more prevalent in the older population, it is not a normal aspect of aging. There are, however, a number of age-related changes that make the older person susceptible to developing incontinence. In older adults, the bladder capacity diminishes to about half that of younger adults. The diminished ability of the kidneys to concentrate urine makes urinary frequency and nocturia (excessive urination at night) common problems for the older person. In addition, many older people experience sudden and unexpected contractions of the detrusor

At age 83, this woman is incontinent. Many older adults admitted to nursing homes are put there because their family members cannot manage the problems associated with incontinence. This lady wears briefs, which are changed by the nursing home staff on a regular basis, and quit dehydrating herself in an effort to control the incontinence. Her health has improved because of increased fluid intake, and the staff members keep her clean and free of urine odor.

muscle (the smooth muscle that makes up the outside wall of the bladder), which cause an urgent need to void. Changes in the central and autonomic nervous systems of the older person cause a decreased ability to contract the external sphincter of the bladder, which further exacerbates urinary urgency. Many postmenopausal women experience thinning and weakening of the muscles of the pelvic floor and the urethra due to estrogen loss. In men, an enlarged prostate, often associated with aging, may lead to urinary retention, irritability of the detrusor muscle, and bladder spasms.

The urinary urgency that many older people experience often leads to incontinence in an institutional setting. When the older adult cannot go to the toilet independently or as often as needed, incontinence is likely to result. This is further exacerbated by the immobility that results from being ill or from needing medical interventions such as intravenous therapy.

Types of Incontinence

For the nurse to intervene in the management of incontinence, it is important to understand the underlying causes of incontinence. Incontinence can be a result of a chronic problem, or it can be the result of an acute situation.

Acute Incontinence

Acute or transient incontinence is incontinence that occurs because of the presence of another medical problem and often resolves when the underlying illness is treated. The following mnemonic demonstrates the possible causes of acute incontinence:

D: Delirium
R: Restricted mobility, retention (acute)
I: Infection, inflammation, impaction
P: Pharmaceutical, polyuria, psychological

Delirium is an acute confusional state that is brought on by an acute illness and that disrupts the physiological homeostasis in the older patient. In a delirious state, the person is not aware of the need to void, nor does the person have the capability to get to the toilet.

Restricted mobility, as already discussed, is a common cause of incontinence in the elderly population. Acute urinary retention is often caused by anticholinergic and narcotic medications and may result in overflow incontinence.

Urinary tract infections (UTIs) cause frequency, urgency, and painful urination. This condition can lead to increased bladder contractions and incontinence. Many residents in long-term care have bacteria in their urine, a condition that is asymptomatic and does not require treatment. However, when bacteriuria is accompanied by urinary incontinence, the patient should be treated and the effect of the treatment on the incontinence should be noted.

It is important to remember that fecal impaction often obstructs the bladder outlet and may cause overflow urinary incontinence. In overflow urinary incontinence, the bladder retains urine, and when it reaches its capacity, the individual begins to drip or leak urine. In postmenopausal women, the changes that occur in the lining of the vagina and urethra because of lower levels of estrogen may cause inflammation and weakening of the pelvic floor, which can, in turn, cause incontinence.

Many drugs can cause urinary incontinence. The following is a list of drug groups that adversely affect the older person's ability to maintain continence:

- Sedatives/hypnotics
- Antipsychotics
- Narcotics
- Anticholinergics
- Alpha-adrenergic blockers
- Diuretics

Endocrine disorders that lead to hyperglycemia or hypercalcemia may cause urinary incontinence. Psychological causes that have been associated with urinary incontinence include depression and confusional states.

Nursing Implications

As nurses, it is important to understand that most instances of bladder incontinence are transient and, very often, reversible. In most cases, acute or transient incontinence can be resolved with treatment of the underlying illness or with discontinuation of a causative drug. Incontinence should never be accepted without first ascertaining that the older person has been assessed for underlying conditions and that treatment has been initiated.

Chronic Incontinence

There are four types of persistent or chronic incontinence. Incontinence is considered to be persistent if it continues after reversible causes have been ruled out or treated. Persistent or chronic incontinence usually has a gradual onset, worsens over time, and occurs when there is a failure to either empty or store urine.

Urge Incontinence. Urge incontinence is the most common form of incontinence in long-term care facilities. It is closely associated with stroke and Alzheimer's disease. In this type of incontinence, the patient or resident feels the urge to go but does not have enough time to get to the toilet before the urine is released.

Stress Incontinence. Stress incontinence occurs when a small amount of urine is released after there is a sudden increase in intra-abdominal pressure caused by coughing, sneezing, laughing, or lifting. This type of incontinence results when the bladder outlet sphincter is incompetent or weak. Stress incontinence is more common in women and is often a result of damage to the pelvic muscles during childbirth.

Overflow Incontinence. Overflow incontinence is present in approximately 15% of nursing home residents. It is caused by bladder outlet obstruction that results in impaired bladder emptying. When the bladder is not emptied sufficiently, the resident experiences frequent dribbling of urine.

Functional Incontinence. Functional incontinence results when the individual is unable or unwilling to attend to toileting needs. In this situation, the bladder and urethra function normally, but cognitive, physical, psychological, or environmental impairments make it difficult for the older person to get to the toilet. Inaccessible toilets, unavailable caregivers, depression, and inability to find the toilet are all possible causes of functional incontinence.

Nursing Implications

Treatment of urinary incontinence is based on the underlying cause. Medication intervention may be used to treat infection, replace estrogen, or stop abnormal bladder muscle contractions and tighten sphincter muscles. Surgical intervention is used to correct anatomical anomalies and remove obstructions. Behavioral interventions require that the health-care professional provide education and positive reinforcement to the older adult and family members. At times, behavioral interventions may be used in combination with medical or surgical interventions.

Behavioral Interventions

Behavioral interventions, which are most often provided by nursing personnel, are also called training procedures and include the following:

- Bladder training (retraining)
- Habit training (timed voiding)
- Prompted voiding
- Pelvic muscle exercises

These techniques are most helpful with stress and urge incontinence.

Bladder retraining is used to restore the normal pattern of voiding by inhibiting or stimulating voiding. The goal is to lengthen the period of time between voidings. This is best done by instructing and assisting the individual to learn to suppress the urge to void in an attempt to increase the amount of urine the bladder can hold. This technique is used with individuals who are capable of understanding and remembering the instructions. Most bladder-retraining schedules begin with a schedule of toileting every 2 hours and gradually increasing the amount of time between voidings.

Prompted voiding is different from bladder training in that the goal is not to increase bladder capacity but rather to teach the incontinent person to be aware of toileting needs and to request assistance from the caregiver. In this technique,

the person is asked to try to use the toilet at regular intervals and is praised for maintaining continence and using the toilet. The schedule that is followed usually involves toileting on awakening, after meals, at bedtime, and, if awake, at night. More voiding times can be added if the individual's voiding schedule indicates that need. This intervention works well with moderately confused people.

Habit training works best with cognitively impaired or confused people and requires the caregiver to take the patient to the toilet at regular intervals. The toileting schedule may be every 2 to 4 hours, or the caregiver may toilet the individual on awakening, after meals, at bedtime, and at night, if awake.

Kegel's exercises are used to alleviate stress incontinence. The goal of such exercises is to strengthen the pelvic floor muscles. Patients who are taught Kegel's exercises must be cognitively intact and willing to participate in this exercise regimen. The exercise consists of the person contracting the pelvic floor muscles and holding them for 3 to 4 seconds and then relaxing the muscle. This should be done 10 times in succession at least twice a day.

In dealing with incontinence, nurses play a key role in both education and treatment. Incontinence is not a normal part of aging but is more prevalent in the aging population. Many forms of incontinence are reversible, and all attempts should be made to assess, treat, and resolve incontinence when it is present.

Constipation

Bowel functioning and the avoidance of constipation are common concerns for older adults. Many older people were raised during a time when anything but a daily bowel movement was considered abnormal. The concern regarding this problem is appropriate because numerous age-related changes in the gastrointestinal system make constipation more likely.

It is probable that an older person has an extended gastrointestinal transit time as a result of slower peristalsis. More water is removed from the stool when it is in the colon for longer periods of time. This causes the stool to become harder and more difficult to pass. Immobility, decreased exercise, and a lack of fiber and water in the diet are common problems in the older population, and these factors tend to exacerbate the tendency to become constipated. Certain drugs also may lead to constipation and include the following:

- Aluminum-containing antacids
- Anticholinergics
- Calcium carbonate
- Iron salts
- Laxatives (when abused)
- Opiates
- Phenothiazines
- Sedatives
- Tricyclic antidepressants
- Diuretics
- Calcium-channel blockers

Immobility is particularly problematic in the maintenance of regular bowel movements. Muscular atrophy, a loss of tone in the muscles of the intestine, and generalized weakness of the muscles necessary for the expulsive mechanism of evacuation occur during periods of immobilization. The overuse of laxatives also causes a loss of muscle tone in the bowel.

Immobility not only affects the physiological functioning of the gastrointestinal system, but it also prevents the individual from interacting efficiently with the environment to meet the needs of the body. Factors such as strange environments, disruption of the usual elimination patterns, being forced to defecate in an unnatural position in unnatural surroundings (as occurs with the use of a bedpan), and suppressing the urge to defecate because of the inability to get to the toilet will inhibit normal defecation.

Nursing Interventions

Nursing interventions aimed at prevention of constipation should be focused on establishing a regular pattern of bowel elimination that is not associated with straining or discomfort. It is important for the older person's overall health to attempt to correct constipation without resorting to the use of laxatives. These interventions should include increasing physical activity, increasing water intake, increasing dietary fiber, and establishing a regular bowel routine. Regular exercise stimulates motility in the gut.

The older adult should be encouraged to drink 1500 to 2000 mL of fluids daily unless this is contraindicated by other health problems. Dietary fiber also plays an important role in the avoidance of constipation. Fiber holds water, thus making the stool softer and bulkier, which speeds the passage of stool through the intestine. It can be difficult to increase fiber in the diet of the older person because of lifelong dietary preferences and poor dentition. It may be helpful to consult a dietician. Although prunes and prune juice are often used to combat constipation, they

may not be the best choice. Prunes have only 2 g of fiber per prune, and prune juice has none. Furthermore, prunes mimic the action of cathartics, and there may be rebound constipation when the use of prunes is discontinued.

Assisting the patient to develop a regular bowel routine is an essential part of bowel maintenance and one in which you, as the nurse, play a pivotal role. In facilitating regular bowel routines, the nurse must assess how much, if any, assistance the person requires in getting safely to the toilet. The use of bedpans should be avoided if at all possible, but when they are used, the patient should be in an upright position unless this position is contraindicated. The nurse also needs to ensure that regular toileting times are maintained and that privacy is provided during toileting time.

ALTERATION IN SKIN INTEGRITY: PRESSURE ULCERS

A pressure ulcer is defined as any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are an extremely serious health problem that can lead to pain, extended hospital stays, and further complications from infection. In hospitals, the pressure ulcer rate has been estimated to be as high as 29.5%, and in nursing homes it is estimated to be 23%. Older persons are particularly at risk, with those older than 70 years of age accounting for 71% of all patients with pressure ulcers. A mortality rate of approximately 60,000 deaths per year is associated with pressure ulcers. In nursing homes, 66% of those residents who develop a pressure ulcer die. It is estimated that patients with pressure ulcers require 50% more nursing care than those without them. Because pressure ulcers are, for the most part, preventable, maintaining adequate skin integrity is a quality-of-care issue for all nurses. Even more important than knowing the various treatment modalities is knowing how pressure ulcers develop. You need to become an expert in prevention techniques.

Risk Factors

Mechanical Risk Factors

Four mechanical factors that contribute to the development of pressure ulcers are pressure, friction, shearing, and moisture.

Pressure. Pressure ulcers usually occur over bony prominences where normal tissue is squeezed between the internal pressure of the bone and an external source of pressure or friction, such as the chair or the bed. External pressure that lasts long enough and is sufficient enough to decrease blood flow results in inadequate oxygenation and nutrition to the area and the subsequent development of a pressure sore. Immobility is the most important risk factor in the development of pressure sores. Pressure of high intensity that is left unchecked for more than 2 hours can result in irreversible tissue damage.

Shearing. When the head of the bed is elevated more than 30 degrees and the person slides toward the foot of the bed, shearing occurs. In this situation, the skin over the sacrum does not move, whereas the subcutaneous tissue and gluteal vessels are stretched. This results in rupture of the blood vessels. Subcutaneous fat, which lacks the ability to stretch, is particularly vulnerable to injury from shearing forces. Sores that develop on the sacrum, heels, and anterior tibial region are most probably a result of shearing. When shearing and pressure are both present, the amount of pressure necessary to cause tissue damage is half the amount that causes tissue damage when shearing is not present.

Friction and Moisture. Friction occurs when the skin is moved across the sheets, such as when the person is being pulled up rather than lifted up in the bed. The result of this motion is damage to the epidermis, which can lead to ulceration or a break in the skin. Moisture caused by perspiration or incontinence can increase the friction between the surface and the skin. Moisture also can cause maceration (softening of the skin), which weakens the skin and increases the risk of infection. In the presence of moisture resulting from urinary or fecal incontinence, the risk of pressure ulcer development on the sacrum and buttocks increases fivefold. Incontinence is a strong predictor of skin breakdown.

Physiological Risk Factors

In addition to mechanical forces, there are also factors that are inherent to the individual that increase the risk of skin breakdown.

Aging Skin. Aging skin increases the likelihood of developing pressure ulcers because it is less resistant to the mechanical forces that can damage the skin. With advancing age, there is a decrease in the thickness of the cell layers of the epidermis, a flattening in the epidermal/dermal

interface, and a loss of subcutaneous tissue. In turn, these changes cause impaired wound healing and decreased thermoregulation, causing the skin to become more fragile.

Immobility. Immobility, combined with the age-related changes of the skin, greatly increases the risk of pressure ulcer formation. Normally, spontaneous body movements that occur during sleep and throughout the day protect the skin from pressure. A number of situations, however, prevent the body from spontaneous movement. These include a physical disability, loss of sensation, the presence of pain, or the use of sedating drugs or anesthesia.

Malnutrition. Another physiological factor that can lead to pressure ulcer formation is malnutrition. Deficiencies in zinc, iron, vitamin C, and protein adversely affect the health of the skin. The more severe the malnutrition, the more severe the pressure ulcer is. In older adults who have had weight loss or who are underweight, it is important to check the albumin level of the blood. A serum albumin level below 3.5 g/dL indicates that nutritional intervention is necessary to prevent skin breakdown. Malnutrition and the subsequent weight loss lead to loss of muscle mass and subcutaneous tissue. This diminishes the body's protective padding and increases the pressure over the bony prominences.

Staging

Pressure ulcers are graded according to the degree of tissue damage. The staging of a pressure ulcer dictates the type of treatment to be implemented. Staging provides a means of describing an ulcer that allows for the ulcer to be monitored over time. A commonly used staging criteria is presented in the following list:

Stage I: Nonblanchable erythema of intact skin. (The skin is reddened, even in the absence of direct pressure.)

Stage II: Partial-thickness skin loss involving epidermis or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full-thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, the underlying fascia (the fibrous membrane covering the muscles). The ulcer presents clinically as a deep crater with or without undermining (connecting) of adjacent tissue.

Stage IV: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (for example, tendon or joint capsule). Undermining and sinus tracts also may be associated with stage IV pressure ulcers.

Prevention

Assessment of risk is a vital first step in prevention of pressure ulcers. If a person is found to be at risk for developing pressure ulcers, then interventions to prevent skin breakdown can be initiated before an ulcer develops. A number of assessment tools are available. If necessary, review the Braden Scale presented in Chapter 14.

Assessment should be done within the first 24 hours of admission to a hospital or nursing home and repeated 24 to 48 hours following admission. Ongoing assessment is necessary to prevent new skin breakdown. This should be done every 24 to 48 hours in the hospital, monthly in the nursing home, and whenever there is a change in the person's condition. Once the older adult is found to be at risk for alteration in skin integrity, preventive measures should be aimed at reducing pressure on bony prominences, preventing shear or friction, keeping skin clean and dry, and providing adequate nutrition and hydration.

To reduce pressure, the patient should be repositioned at least every 2 hours. This decreases the amount of time that pressure is exerted on any one body part. The appearance of reddened areas indicates that more frequent turning or other interventions may be indicated. When placing an older adult on either side, a wedge should be placed behind the patient to prevent the individual from lying directly on the trochanter (the bony prominence located below the neck of the femur). Although at one time it was common practice to massage reddened areas over bony prominences, this is no longer the practice. To do so may exert pressure on the area and may cause further breakdown of the small capillaries. In some cases, it may be necessary to use pressure-relieving devices, such as air-, water-, or gel-filled chair pads or mattresses, as well as foam heel protectors and mattresses. The use of egg-crate mattresses, although common, does not provide sufficient pressure relief to prevent pressure ulcers. Walking programs and passive and active range-of-motion exercises not only improve muscle strength and joint flexibility but are important in the prevention of skin breakdown as well.

To reduce friction, persons should be lifted and not pulled when repositioned. The use of a lift sheet or a turn sheet is essential to distribute

the patient's weight evenly and avoid undue friction and stress on the skin. Shear can be reduced by decreasing the amount of time and frequency that the person's head is elevated in the bed. When out of bed and in a chair, the patient should be repositioned at least every 2 hours, and long-term sitting should be discouraged. While in the chair, the individual needs to be examined for appropriate posture and alignment because an inappropriate sitting posture can lead to pressure ulcers and increased shearing forces.

Although skin should be kept clean and dry to prevent pressure ulcers, older adults do not need to be bathed daily. Excessive bathing and rubbing can be drying and damaging to the skin. Using a mild cleansing agent that does not promote dryness and patting the skin dry are essentials of good skin care for the older person.

Treatment

Sometimes, despite vigilant nursing care, a pressure ulcer does develop. Often an underlying disease state can defeat attempts to prevent skin breakdown. The treatment of pressure ulcers is extremely individualized, and there is much controversy as to which treatments and skincare products to use. The technology and products for treatment of pressure ulcers are changing every day. Treatment is aimed at promoting a healing environment by providing adequate circulation and oxygenation to the impaired tissue and maintaining a clean and dry wound area. Exudate should be removed as much as possible, and infection should be treated with the appropriate antibiotic. Any necrotic tissue needs to be debrided or removed before treatment of the ulcer can proceed. This should be done only under the supervision of a registered nurse.

CRITICALLY EXAMINE THE FOLLOWING:

You are a home-health nurse for an 79-year-old woman who is cared for by her husband with drop-in visits from three daughters. Sarah, the patient, is home bound because of general fatigue and postoperative bilateral total knees. She can ambulate with a cane but is fearful and will not leave the house except on rare occasions. She says she is happy to be at home with her husband and not to have the arthritic knee pain. The problem? She is in bed and a recliner chair most of the day and night. Her husband lifts her to and from the chair and bed when Sarah is "too tired to move herself."

You have noticed that Sarah's buttocks are reddened, as are her heels. What should you do about your assessment? Focus on a teaching plan for this couple. (I know this is the second teaching plan you have been asked to do in this chapter. My hope is that after doing the first one, and sharing it with your fellow students, this one will be easier to write.) What do they need to know about pressure ulcers? What is the best way for you to share the hazards of immobility with Sarah? What can you do to prevent the stage I pressure ulcers from developing into something worse? Do your best thinking and be prepared to share it with the class.

ALTERED NUTRITIONAL STATUS

Adequate nutrition is essential to the maintenance of health, prevention of disease, treatment of chronic illness, and recovery from acute illness. When the body is inadequately nourished, the individual is more likely to develop an illness and is less able to recover from illness. Caloric or protein malnutrition is present in 12% to 50% of the older population.

To be adequately nourished, the body must have a sufficient intake of carbohydrates, fats, proteins, vitamins, minerals, and water. Difficulty obtaining appropriate nutrition can be a result of lack of knowledge about good nutrition, inadequate income or means of obtaining the appropriate foods, lack of socialization (which may lead to disinterest or overindulgence in food), or housing that is not adequate for storing and preparing nutritionally sound meals. The older person's diet is often lacking in calcium, vitamin C, riboflavin, niacin, and iron. A deficiency of any essential nutrient can cause changes to the body that, if left unchecked, can lead to illness.

Risk Factors

Anorexia (loss of appetite) is a major cause of inadequate nutritional intake in the older population. Poor dentition, poorly fitting dentures, or the lack of dentures may make it difficult for the individual to chew, and a soft or puree diet may be unappetizing. Not only may diminished mobility make it difficult for the older person to obtain and prepare food, but a sedentary lifestyle may lead to a decreased appetite. Polypharmacy, a situation not uncommon with the elderly, can adversely affect appetite by altering taste sensation, impair-

ing cognition and mood, or interfering with the absorption of nutrients. Other causes of anorexia in older adults may include the increased incidence of chronic illness, social isolation, depression, and unappetizing institutional foods.

Changes in the metabolism of older people translate into changes in nutritional requirements of the body. With aging, there is a decreased metabolic rate. This means that the body requires fewer calories for maintenance. Decreased mobility and the loss of muscle mass associated with aging also suggest that older people may need to decrease their caloric consumption. However, older adults use more energy than younger people to do the same activities. Therefore, if the individual is active, there may actually be a need to increase the caloric intake. Furthermore, with aging, the body does not metabolize protein as efficiently, so older people may need more protein in their diet.

Maintaining adequate nutrition in older persons who have a disease process poses a particular challenge to the nurse. People with advanced dementia may have weight loss even when there is an adequate intake of nutritional requirements. It is suspected that this weight loss may be due, in part, to the increased use of antibiotics in a population that tends to have a higher rate of infection. Neuroleptics, another commonly used class of drugs in the demented patient, also may cause a loss of appetite. It has been postulated that there may be a disturbance in the metabolism of patients with advanced Alzheimer's disease, and this, too, may account for the unexplained weight loss in this population. The term "failure to thrive" has been used to describe another entity associated with weight loss. Failure to thrive occurs when some elderly nursing home residents experience a gradual decline in physical and cognitive functioning associated with weight loss, withdrawing from food, withdrawing from human contact, and exhibiting signs of depression.

Assessment

Assessing the nutritional status of the older person can be a difficult task for the nurse. The recommended daily allowance (RDA) that is established by the National Academy of Science Research Council is one way of monitoring how well an individual is meeting nutritional requirements. It is important to realize, however, that the RDA does not consider the specific needs of the population older than 65 years of age. Furthermore, additional nutrients that may be needed as a result of infection or chronic illness are not addressed by the RDA.

Further complicating the assessment for malnutrition are the changes of the aging body itself. Many of the physical manifestations of malnutrition are similar to changes that are associated with aging. These changes include dry, thin hair; dry, flaky skin; sunken eyes; dry oral mucosa; weight loss; and muscle weakness. Using skinfold measures to estimate percentage of body fat may not yield accurate information because mean body mass (muscle tissue) decreases with age. Probably the most reliable indicator of adequate nutritional intake is a normal serum albumin level (3.5 to 5.5 g/dL). Monitoring an individual's weight over time is also an appropriate means of recognizing alteration in nutritional status.

Nursing Implications

To re-establish adequate nutritional intake, health-care providers should strive to maintain oral feedings, possibly with appropriate modifications. This may mean making the diet more palatable with foods that have different textures and flavors. Providing the individual's food favorites whenever possible is also a good approach. Asking the help of family to provide favorite foods for the older person may be necessary. Making sure that the older person has dentures and that they fit well and then providing a diet that is appropriate for the individual's dental status is imperative. Everyone responds well to meals that are served in an attractive manner and in an environment that is relaxed and pleasant. Nursing staff should strive for this kind of atmosphere during mealtime by not raising their voices and trying to keep noisy dietary carts out of the eating area. Eyeglasses help the resident to see the food on the tray, and hearing aids allow the resident to socialize with tablemates during mealtime. It is important that the nurse make sure that the individual has whatever assistive devices are needed to make the eating experience a more pleasant one.

If despite these efforts, the patient's nutritional status does not improve, the nurse needs to consider other interventions. It may be necessary to offer more assistance with meals. The individual may need to be fed or have containers opened or may just need ongoing gentle encouragement throughout the meal to continue eating. Often, gently touching the arm or shoulder while encouraging feeding helps the older adult to attend to the task of eating. Touch is a caring behavior that indicates both value and respect for the person being touched. Older people often are

This father-and-son team have lived together since the father's discharge from a nursing home. He was admitted for falling and for generalized weakness; he was malnourished. The son enjoys cooking and caters to his father's wishes, which has improved the older man's health remarkably. Now, the two of them go to the nursing home to visit the father's friends there.

not touched or hugged frequently and generally respond positively to the act of being touched. A nutritional supplement also may be needed.

The dietician should assist in deciding what, if any, supplements are needed. Liquid dietary supplements are best offered between meals so that the supplement is not substituted for the meal itself. The supplement can provide a large percentage of the RDA requirements but does not completely meet all dietary requirements.

Tube feedings and parenteral feedings can be used when all other attempts at oral feedings have failed. However, these methods have numerous complications. Striving to maintain adequate oral intake should be the goal of all nursing personnel. Adequate nutrition affects every aspect of the individual's health and well-being.

SLEEP PATTERN DISTURBANCES

Older people often complain of not getting enough sleep or not feeling well rested after sleeping. Indeed, sleep disturbances do increase with age. It is estimated that sleep pattern disturbances affect half of those over 65 years of age who live at home and two-thirds of those living in institutions.

Normal Sleep Patterns

A review of normal sleep patterns is necessary to understand the changes in sleep patterns that tend to occur with aging. There are five stages to normal sleep. Refer to Chapter 8 if you need to review this material.

Age-Related Changes in Sleep Patterns

In the course of aging, people tend to sleep less than 8 hours per night. Older people have an impaired capacity to maintain sleep; therefore, sleep tends to be marked by more frequent and prolonged awakenings during the night. In addition, stage IV and REM sleep diminish. In extreme old age, changes in cerebral blood flow and organic brain syndrome also are associated with a shortening of the REM stage of sleep.

The sleep patterns of older people can be disturbed by such factors as needing to void frequently during the night (nocturia) and changes in vision and hearing that cause incorrect perceptions of their immediate environment. These changes can lead to ineffective sleep or sleep deprivation. Sleep deprivation is marked by fatigue, tiredness, eye problems, muscle tremor, muscle weakness, diminished coordination and attention span, apathy, and depression.

Sleep Disorders

In addition to age-related changes in sleep patterns, there are sleep disorders that are common to older adults. Sleep apnea affects 20% of the older population. This is a medical condition in which breathing stops for 10 seconds or longer numerous times throughout the night. Sleep apnea is associated with high blood pressure, obesity, heart disease, and stroke. Death can result because of the effect on the cardiovascular and respiratory systems. The affected patient complains of excessive daytime sleepiness and constant interruption of sleep. Cessation of breathing for 10 or more seconds, followed by very loud snoring or choking, is the primary objective symptom of sleep apnea. It often is discovered first by night-shift personnel when the patient is admitted to the hospital or nursing home. The treatment for sleep apnea is usually

weight reduction, continuous positive airway pressure (CPAP), oxygen, and, occasionally, surgery. CPAP is a technique that forces air down the nose, through the throat, and into the lungs; it is used during sleep for those who have been diagnosed with sleep apnea.

Sundown Syndrome

Sundown syndrome is another disorder that affects many older people. Sundown syndrome is defined as the appearance or exacerbation of symptoms of confusion associated with the late afternoon or evening hours. This syndrome is marked by behaviors such as agitation, restlessness, confusion, wandering, and screaming that occurs usually in the evening hours (sundown). Little is known about this disorder, which is a tremendous management problem for caregivers. Risk factors for sundown syndrome seem to be impaired mental status, dehydration, being awakened frequently during the night for nursing care, and recent relocation either to a new room or to the institution.

Nursing Interventions

Sleeping medications, tranquilizers, and sedatives are commonly used to promote sleep but should be avoided at all costs in older persons. Sedatives and barbiturates that depress the central nervous system may lead to other problems by depressing vital body functions, lowering basal metabolic rate, decreasing blood pressure, and causing mental confusion. Sleeping medications decrease spontaneous body movements that may lead to skin breakdown. Most of the medications used to promote sleep are not efficiently metabolized by the aging body, and thus the person may experience a hangover effect the next day. In addition, these drugs tend to cause blurred vision, dry mouth, and urinary retention. Because it is known that the aging person cannot sleep as long as a younger person can, it is unreasonable to put an individual to bed at 8 p.m. and expect that person to stay in bed until 7 a.m. the next day.

There is much the nurse can do to promote sleep without resorting to the use of medications. Meeting the individual's comfort needs by offering back rubs or snacks such as warm milk, assisting with toileting needs, providing socks or an extra blanket to increase body temperature (which may be diminished in the older person), repositioning, and alleviating pain are just a few of the nursing interventions that may reduce insomnia. If these interventions do not promote sleep, it is prudent to allow the older person to come out of the bed and perhaps sit for a while in a comfortable chair near the nurses' station. This may reassure the individual of the surroundings and prevent attempts to get out of bed unassisted, perhaps risking a fall. During the daytime, increased motor activities and time out of doors, if possible, have been found to promote sleep.

IATROGENESIS

Iatrogenic disorders can be defined as disorders that a person acquires as a result of receiving treatment by a physician, nurse, or other member of the IDT. Iatrogenesis also can occur if the patient does not receive treatment when it is indicated or receives incorrect treatment. The older person often presents with numerous chronic conditions that require complex interventions, numerous medications, and increased exposure to the health-care system. This puts older adults at increased risk of suffering untoward effects of medical treatment. Iatrogenic disorders include those previously discussed in this chapter: immobility, falls, incontinence, malnutrition, pressure ulcers, and disturbances in the sleep–wake cycle.

Studies have found that 30% to 40% of people older than 65 years of age suffer from iatrogenic complications. Common causes of iatrogenesis in the hospital are misuse or overuse of drugs, prolonged immobilization, nosocomial (hospital-acquired) infections, and malnutrition and dehydration secondary to preparation for diagnostic tests. In the nursing home, common iatrogenic disorders include immobilization, adverse drug reactions, falls, pressure ulcers, and nosocomial infections.

Iatrogenic disorders often cause a vicious circle in which one disorder quickly leads to another. For instance, consider the older person who is admitted to the hospital for abdominal discomfort. This person is unable to sleep and is prescribed a sleeping pill. Having taken this medication, the person is groggy when getting out of bed and sustains a fall. The staff, not wanting the patient to be hurt again, assigns a volunteer to sit with the person to remind him or her not to get up. The older person is now unable to get up and suffers from some of the adverse sequelae of immobility, such as incontinence, disorientation, and pressure ulcer formation. In time, the person's muscles become deconditioned, and the next time the patient is assisted out of bed, there is another fall, the person suf-

fers a hip fracture, and the cycle continues. One can see what a high price is paid for the negative effects of medical and nursing interventions.

CONCLUSION

The health-care needs of older adults are multiple and complex. Health-care providers often are not educated in the normal aging process or the older person's response to illness and health-care interventions. As a result, the layperson as well as the health-care provider may believe that there is little that can be done to improve the health status of older adults. Not only is this not true, but this attitude can lead to a self-fulfilling prophecy in which older people are expected to be ill and to experience functional decline. In turn, assessment and interventions aimed at correcting the illness, promoting function, and averting a subsequent decline may not be initiated, and the older person is likely to become more ill and more dependent on others. Licensed practical nurses can and should play a pivotal role in ensuring that the health-care needs of the older person are being met. They also need to be aware of the problems that besiege the older person as a result of medical interventions. It is important to know that iatrogenesis can be prevented. Many of the clinical problems that the older person faces, both in health and in illness, can be averted or alleviated with nursing interventions that are focused on improving and maintaining wellness and promoting function.

CASE STUDY

Mrs. S. is an 84-year-old widow who was admitted to the hospital following a right cerebrovascular accident (CVA). Her medical history includes hypertension, atrial fibrillation, and bilateral total hip replacements due to degenerative joint disease. Before the CVA and this hospitalization, she was living in her own apartment, where she was social and able to meet her own needs except for shopping and heavy housecleaning. Her family did those things for her. When admitted to the hospital, she was found to have left-sided weakness and some speech problems, although she could be understood.

The family is planning to admit her to the nursing home; they do not know if she will be able to return to her apartment, but they are hopeful that she will be able to go to an assisted-living apartment. The report given to the nursing home from the hospital includes the following facts:

- During her hospitalization, she became incontinent. A Foley catheter was placed to control the urinary incontinence, but she subsequently developed a urinary tract infection, so the catheter was removed.
- She developed aspiration pneumonia, which the physician assumed was due to aspirating food because of a swallowing deficit from her stroke. Her diet was changed to puree, and she has had no further episodes of aspiration, although she is taking only about 30% of her diet.
- She has started physical therapy and has progressed from the parallel bars to short distances with a walker. She does not own a walker, so she has not walked on the unit, only in the therapy department.
- Mrs. S. has not spoken much during her hospitalization, although she follows simple directions. The nurse thinks that she "might be a little confused at times."
- Her blood pressure is well-controlled with diuretics.
- The family is very concerned that if she falls, she may damage the hip replacements, and they have requested that she be restrained.

Discussion

Examine the list of facts in the case study for iatrogenic problems. How would you prevent such problems? How would you deal with them?

Solution

In this case study, there are a number of iatrogenic problems that the nursing staff should address. The report from the hospital notes that Mrs. S. had a Foley catheter inserted because she was incontinent. The question the nurse should be asking here is, "Why is Mrs. S. incontinent?" True, the incontinence can be a result of damage from the stroke, but until attempts are made to take the patient to the bathroom, one cannot be certain. It may be that Mrs. S., having had a stroke that affected her speech, could not tell the staff that she needed to go. She may have to go to the bathroom as soon as the urge presents itself. A prompted voiding schedule would be helpful in beginning to assess whether this incontinence is reversible. A Foley catheter should not be the first intervention used in the presence of incontinence. In this case, the use of the catheter prolonged the hospitalization by causing a urinary tract infection.

Another possible iatrogenic problem may be aspiration pneumonia. In this case, iatrogenesis may be a result of something that should have been done that was not done. In a patient who has had a stroke and who has difficulty talking, one should consider the possibility of a swallowing deficit. Therefore, a patient such as Mrs. S. should never be left alone to eat. In addition, the nursing staff should be assessing her during mealtime for any difficulty swallowing. If a difficulty is noted, a speech and swallowing consultation is warranted. Once the diet was changed to puree, Mrs. S. apparently had no further problems with swallowing but had a decreased nutritional intake. Again, the nurse needs to assess the patient to understand why the diet is not being taken. There may be a number of reasons. The patient may not like her diet, she may still be having difficulty swallowing and is afraid of choking again, or she may be depressed and without an appetite.

It is indeed a positive step that Mrs. S. has been started on physical therapy and is walking, but there is more that the nursing and therapy

staffs can do to promote functional ambulation. Walking does not have to be done just in the therapy department. The therapist needs to lend a walker to Mrs. S. or to instruct the family to buy one for her so that ambulation can be done on the nursing unit. Therapy takes place for only about 1 hour a day. Walking the patient on the unit augments therapy, improves the patient's gait, helps her to regain her confidence in her functional ability, and prevents the negative effects of immobility.

The nurse reports that Mrs. S. might be confused; however, there is little evidence here to support that conclusion or to suggest that confusion should be expected. From the report, Mrs. S. was not confused before her hospitalization. If she is confused, it may be related to the urinary tract infection, the pneumonia, the relocation to the hospital, or the depression from the stroke. The possibility of confusion should not deter the nurse in any way from pursuing a plan of care that focuses on promoting the highest level of functional ability for this patient.

The family requests that Mrs. S. be restrained to prevent injury to her hip replacements. Instead of a restraint, the staff needs to consider ways of preventing a fall so that the family will not believe that a restraint is needed. Some possible fall-prevention interventions might include helping the patient to understand her limitations, toileting the patient at regular intervals, promoting lower-extremity strengthening through exercise, keeping the patient out of her room and within sight of the staff, and perhaps using an alarm if the patient is unpredictable in her attempts to get up. Because Mrs. S. is on diuretics, one would want to assess her for orthostatic hypotension as a possible fall risk factor. Honoring the family's request for a restraint may serve only to cause contractures, skin breakdown, a worsening of her urinary incontinence, depression, and general deconditioning related to immobility. The family needs to be educated to the dangers of using restraints. The use of restraints will not promote a positive outcome for this patient.

STUDY QUESTIONS

Select the best answer to each question.

1. An example of an intrinsic risk factor for falls in the older person is:

- **a.** The use of diuretics
- **b.** Weakened muscles in the lower extremities
- **c.** Glaring lights in the hallway
- **d.** The use of a cane

2. To promote mobility in the older adult, the nurse would:

- **a.** Turn the patient every 2 hours
- **b.** Encourage the patient to cough and take deep breaths
- **c.** Ask the family to bring in the patient's walker from home
- **d.** Assume that the physical therapist is helping the patient to walk

3. The best way to promote urinary continence in the older person is to:

- **a.** Stop giving the diuretic because it causes the patient to have urinary urgency
- **b.** Obtain a urine specimen for culture and sensitivity
- **c.** Offer the bedpan every 2 hours
- **d.** Assist the patient to the toilet in the morning, after meals, and at bedtime

4. When seeing a reddened area on the patient's coccyx, the nurse would do all but one of the following interventions:

- **a.** Turn the patient every 2 hours
- **b.** Ask the doctor to order a medication to treat the skin
- **c.** Help the patient to the toilet more frequently
- **d.** Measure how much of the diet the patient is taking every day

5. Which of the following is not an example of an iatrogenic disorder?

- **a.** Falling because of dizziness after receiving medication for pain relief
- **b.** Depression because of a stroke
- **c.** Incontinence because the patient could not find the bathroom
- **d.** Loss of weight because the patient cannot chew the food that is provided

16 Psychological Assessment

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Identify three cognitive functions.
2. Describe two benefits of using a standardized examination to screen for cognitive functioning.
3. Identify four uses of psychological assessments.
4. Describe the impact of depression on the mental status score.

INTRODUCTION

Psychological assessments are essential tools in identifying the mental health of older adults in all health-care settings. Such assessments provide the basis for determining how much of a return to normal an individual can expect to achieve. Psychological assessments are important in any health-care setting, but especially when the focus is restorative care.

Restorative care, in its truest application, requires a body–mind–spirit connection. Relate this concept to Jean Watson's theory of caring—the two theories are conceptually the same, and it is hoped that they are beginning to have meaning for you in your practice. Nurses practicing within this framework are concerned with the physical indications that a person is declining, such as falling, incontinence, and immobility. Behavioral, or psychological, indicators have received less prominence in terms of restorative care. Some examples are failure to eat and a decline in functional level, such as severe memory loss or confusion without a physiological basis.

Although one can expect a certain amount of decline in older people who have vascular and central nervous system (CNS) disease, it is important to identify the psychological areas of decline and recognize when interventions are essential. Maintenance of mental health and cognitive functioning is as important to restorative care as is maintenance of physiological processes. Nurses working with elderly people need to understand basic concepts of mental health and cognitive function so they can participate in the older adult's care more effectively. Assessment tools provide a brief, methodical approach to noting changes commonly found in individuals with cerebrovascular diseases, delirium, and dementia disorders.

MENTAL HEALTH

Over the years, clinicians in the field of mental health have tried to diagnose symptoms, traits, and patterns of behavior that identify disease. The view that identification and treatment of disease establishes health is known as the medical model. The simplest definition of mental health, then, would be the absence of identifiable disease. A more positive approach is to define the traits of the mentally healthy personality.

Practitioners use terms that have been formulated by theorists to describe and discuss psychological problems. Words such as *id, ego,* and *superego* are used by therapists who base their practice on Sigmund Freud's theory. *Enmeshment* is a term used by some family therapists to describe interactions among family members that keep them dependent on each other. A therapist practicing within a Gestalt framework may focus on the feeling experiences of an individual.

PRIORITY SETTING 16.1

The most important priority you can set when assessing older adults psychologically is to be able to do an effective assessment very, very well. You can't fake an assessment and assume it will do any good for the person who is ill. Pick one of the assessments in this chapter and learn it well. Read about it in professional journals, talk to experts about how they perform the assessment, and look for a mentor. The mentor could be an experienced nurse or nurse practitioner. Let your mentor know you want to be expert at doing the MMSE, for example. Perhaps your mentor will talk to you about the things he or she does or perhaps take you along as he or she does assessments. You cannot assess people unless you have paid the price to develop the expert skill required to do an excellent assessment. So, get busy! Pick one tool and stick with it until you are really, really good.

The current trend is to identify wellness in mental health. Although it is difficult to define wellness, some of its characteristics have been described by psychologists, nurses, and physicians. Some of these characteristics are given in the following list:

- A clear meaning and purpose in life
- A strong reality orientation
- An ability to cope creatively with life's situations
- A capability for open, creative relationships

Mental health is not necessarily a product of good nurturing or of a life of positive experiences. There are individuals who function well in life—for example, they maintain a satisfying job and career, have a family, and make a contribution to their community—despite poor nurturing and environmental handicaps. Most views of mental health now embody a continuum of health and illness. This continuum is dynamic

Review the four characteristics of mental health, and then look at this lady's face. You would need to interview her to determine whether or not it is true, but she does have the appearance of someone with purpose and meaning in her life.

rather than static. There are a number of situations that have an impact on the functioning of an individual. These situations include the following:

- The death of someone close
- Unemployment
- The birth of a child
- Relocation

Any individual, if sufficiently stressed, can demonstrate some signs of impairment. One concept refers to the continuum of functioning as a scale of the differences in people. Individuals who are higher on this scale require more stressors to impair their functioning than individuals who are lower on this scale. These individuals choose a life course based on thought and conviction rather than on impulse, and they show an ability to stand by a belief that is different from that of their peer group.

It is important for nurses working in the field of gerontology to identify and promote positive mental health traits. Nurses can then reinforce healthy traits and interactions in older persons. This is nursing care being given in the nursing model (Watson's theory) rather than the medical model. Because it is nursing model care, it is both caring and holistic, which are strong traits of the profession of nursing and characteristics you want to work to develop as a licensed practical nurse (LPN).

Cognition

Cognition is a mental activity concerned with processing information. It refers to a broad range of mental behaviors, including awareness, thinking, reasoning, and judgment. This process is very complex and involves a number of abilities or functions. Because it cannot be directly observed, many psychologists define cognition in terms of cognitive functions. There are a number of ways of conceptualizing the cognitive functions. One scientist's definition is perceiving, thinking, remembering, communicating, orienting, calculating, and problem solving.

Memory

In general, the more active people have been, the better their overall memory is as they age. A dysfunction in memory occurs in almost all of the cognitive disorders common in older adults. Generally, psychologists refer to two categories of memory: short-term memory (STM) and long-term memory (LTM). The time interval for measuring STM is seconds, whereas for LTM it is minutes and beyond. Recently, there has been an interest in the study of remote memory. Many elderly persons demonstrate excellent long-term recall, although this recall may be rooted more in a belief than in fact. This is the nature of remote memory. It means that the stories they tell of their childhood or young adulthood are stories based on their belief systems rather than on what actually happened. This skill may be enchanting to staff and can be used effectively as a tool for reminiscence to strengthen a person's self-esteem.

Memory functions are extremely important to a person's ability to think. A deficit in STM means that a person is unable to recall some of today's events. An older adult with severe impairment of STM experiences the routine of each day as a new experience. Such a person is trapped in an endless cycle of requesting basic information about the environment from strangers, such as "Where is my room?" or "When do we eat?"

Memory impairment limits the ability of a person to form a new idea or relate one fact with another. It is nearly impossible for memory-impaired individuals to organize new information into categories. A place where one can put something (a pair of glasses) for safe keeping

may change several times a day. This makes a never-ending search for an important item an everyday event.

Screening for memory impairment is the most important part of any assessment for the elderly. The loss of STM is the first symptom of Alzheimer's disease. A stroke also may impair memory function, but in this case, the type and extent of impairment depend on the location of the damage. Other STM deficits may be due to depression. Individuals suffering from depression are inattentive to their environment. They often are preoccupied or self-absorbed. A decline in STM, then, is an important finding on assessment and should prompt further investigation.

Perception

Psychologists believe that all behavior depends on how one sees oneself, the situation one is in, and the interaction between the two. Behavior changes as individuals become aware of details in their surroundings. Learning, problem solving, remembering, and forgetting are all part of one's awareness of the environment. Effective communication with an older person depends on the nurse's ability to understand the perceptual world of that person. With such an understanding, the most bizarre behavior often becomes comprehensible.

The first phase of forming a perception is the ability to use the five senses to collect information about the environment. Frequently, in older adults, there are real impairments in the sense organs. In the previous chapter, you learned about the deficits in vision, hearing, touch, taste, and smell in older persons.

There is an emotional or feeling component to perception as well. Individuals take in information from the environment and form opinions about such information. Perceptions are normally evaluated against past experiences. An older adult may compare a meal eaten within the institutional setting with recollections of meals

FOCUSED LEARNING CHART

Memory function

Assessing memory function is the most important assessment when working with cognitively impaired adults.

In general, the more active people have been, the better their memory is as they age.

Long-Term Memory (LTM)	Short-Term Memory (STM)
Measured in minutes and beyond	Measured in seconds
Rooted in belief rather than fact	Unable to recall daily events: "Where is my room?"
	Without STM, a person is limited in forming new ideas or relating one fact to another
	Loss of STM is symptomatic of Alzheimer's disease, cerebral vascular accident, and/or depression

CRITICALLY EXAMINE THE FOLLOWING:

You are caring for an 81-year-old woman who was just admitted to the medical unit where you work. The charge nurse asked you to restrain the woman because she is screaming, "Don't hurt me! Don't hurt me!" and thrashing out at the staff. Because you are experienced in gerontological nursing, you assess the woman to determine the problem rather than restrain her because her behavior is inconvenient. Think in terms of first-stage dementia and list three reasons why this woman would legitimately be fearful. Then list what you can do about it. The first clue is in the section you just read on perception. The next clue is that the woman was just admitted and might be experiencing transitional stress. You think of a third reason and list all three with an appropriate intervention. Be prepared to share your thinking in class.

eaten with the person's own family. These recollections of past experiences are a part of forming perceptions.

Perceptual distortions also are known as hallucinations and delusional thinking. Although both may indicate a psychiatric illness in younger individuals, perceptual distortions are common in dementing illnesses. Impaired memory and a natural distrust of a strange environment exaggerate this tendency in the institutionalized older person.

Orientation

Orientation refers to a person's awareness of self in the context of a particular time and place. Tests for orientation determine whether the persons being tested know their names, where they are, and the approximate time of day. Sometimes the expression "oriented times three" is used to indicate that an individual's orientation to time, place, and person is correct. Assessment of orientation is covered on every mental status examination. This is important information because a disturbance in orientation is one of the most frequent symptoms of brain disease. Awareness of time and place requires that individuals know where they are and can remember it. In this way, individuals keep in touch with ongoing history. Orientation depends on a person's ability to link each minute with the previous minute. Disorientation with respect to time is the first major confusion to occur as a result of dementia. Loss of a sense of place is likely to follow. Finally, the person loses the ability to recognize other people and eventually cannot remember who he or she is.

Thinking

Every area of the brain is involved in the mental operation of thinking. The ancient Greeks believed there were "higher" levels and "lower" levels of thinking, a distinction that is still relevant. Higher-level thinking includes the ability to form concepts and think in an abstract manner. Asking a patient to interpret a proverb tests the patient's ability to think abstractly. If a person interprets the proverb "a stitch in time saves nine" in a way that conveys that prompt attention to a problem prevents trouble in the future, the person's ability to abstractly think is considered intact. A concrete interpretation adheres closely to the exact meaning of the phrase. Concrete thinking is a "lower" mental ability. Someone with concrete thinking may answer the question about the proverb with something like, "If I make nine stitches, the cloth will hold."

Thinking processes have a hierarchical order. The lower mental abilities are more enduring and less affected by brain injuries and disease processes. The higher levels of thinking tend to be more fragile. At first glance, interpreting proverbs may seem a bit removed from a person's ability to function in the real world. The use of good judgment, the ability to think abstractly, and the capacity to reason, however, are higher-level abilities that indicate the difference between independent and supervised living. To some extent, these abilities can be determined by proverb interpretation. In general, tests for

POINT OF INTEREST

Orientation is easily determined by asking the older adult to state his or her name, the date, and the location. If the patient answers all three questions correctly, he or she is oriented times three; two questions, the patient is oriented times two; one question, the patient is oriented times one; and if he or she is unable to answer any of the three questions, the person is disoriented.

> **CRITICALLY EXAMINE THE FOLLOWING:**
>
> Whenever you are asked to complete this type of exercise, you are asked to think on a higher level. Has it seemed that way to you? Think back to your reactions in doing the critical thinking assignments. Did you avoid doing some? Were you irritated or upset at any of the assignments? Did you enjoy the challenge of doing them? Were you bored with them or saw them as not being a challenge? Take some time and consider your reactions to these assignments. Consider how you felt when certain items were discussed in class. Did you benefit from the thinking of your classmates? Were your ideas and thinking valued by others? Take the time to write your reactions regarding the higher-level thinking experiences. Be prepared to share them in class.

abstract thinking are not included as part of the short tests of mental function.

Communicating

The only vehicle for viewing thinking processes in an individual is communication. People understand human thought when it is reflected in language. It is important to assess language problems because they are common in cerebrovascular and dementing disorders. Assessment of communication patterns, word order, and the general sense of a sentence provide a window into the dementia process. This is especially true with the patient who has experienced a stroke. Sometimes, persons who have had a stroke will have severe problems with communication. Small connecting words such as "if," "and," and "but" are missing. There are also several types of aphasia that impair an individual's ability to communicate.

Calculating

Calculating is a cognitive function that must be assessed carefully in terms of the person's intelligence and educational level. Poor performance may indicate dementia or delirium, anxiety, or depression. Serial 7s is one test that can determine a person's ability to calculate. The person is asked to subtract 7 from 100 and then to subtract 7 from that remainder, continuing five times. A nurse interviewed a moderately to severely impaired patient with Alzheimer's disease. Although the patient was completely disoriented with regard to time and place and could not recall the names of three objects even seconds after they were told to him, he performed magnificently with the serial 7 calculations. In seconds he completed the operation and then turned to the nurse, announcing proudly that mathematics was always his favorite subject. The patient had been a judge.

Problem Solving

Problem-solving skills are essential to an individual's ability to function in any environment. Even some very demented people can demonstrate aspects of problem-solving ability. Individuals in the early stages of Alzheimer's disease frequently make lists. Lists are coping devices that enable the recall of event sequences. When asked questions of orientation, some elders search for familiar cues in the environment. Examples of this behavior include the patient who was asked the date, spied a newspaper, and then winked and, smiling broadly, gave the correct answer. Another patient called to a nursing assistant passing by the door. When the nursing assistant entered the room, the patient asked her for the date and promptly relayed this information to the nurse interviewer.

An individual's environment is filled with a multitude of clues that facilitate orientation, aid a failing memory, and maintain a stable perceptual field. Use of these clues enables older adults to maintain communication with nurses, other patients, and families. Because a patient's environment is rich with problem-solving clues, room changes and unit changes should be made infrequently and only after the most careful thought.

ASSESSMENT TOOLS AND HOW TO USE THEM

Mental status examinations are the most frequently used psychological assessments. Mental status assessment includes probing of the cognitive functions as well as level of consciousness (LOC). In selecting a tool, it is important to remember that examinations with brief instruments are generally better tolerated by the elderly person. A short examination is much less tiring for an older person to sit through than a lengthy one. No brief instrument, however, is a perfect detector of cognitive impairment.

Screening tools initially may seem intimidating or cumbersome to use in clinical practice. Most tools are short and can be easily committed

This gentleman is a deacon in his church. This responsibility requires that he communicate, calculate, and problem solve. He also needs a good memory to do his job well. Interviewing people about their activities will give you important information for a psychological assessment.

to memory after using them a few times. All of the following tests are easy to learn and administer: Pfeiffer's Short Portable Mental Status Questionnaire (SPMSQ; Pfeiffer, 1975), Folstein's Mini-Mental Status Exam (MMSE; Folstein, Folstein, & McHugh, 1975), Kahn's Mental Status Questionnaire (MSQ; Kahn, Goldfarb, Pollak, & Peck, 1960), Jacobs' Cognitive Capacity Screening Exam (CCSE; Jacobs, Bernhard, Delgado, & Strain, 1977), and Kiernan's Neurobehavioral Cognitive Status Examination (NCSE; Kiernan, Mueller, Langston, & Vandyke, 1987). These scales are compared in Table 16.1 and are listed with a brief description in Box 16.1.

A very important factor to consider in the scoring of all tests is that test results are influenced by the educational level of the person being tested. An older adult with a lack of a formal education can score several points lower than an older person with greater deficits but more education. Some of the mental status tests have a method of scoring to correct for education.

There are some important reasons for an LPN to gain skills in using assessment tools. A standardized test allows you, as the caregiver, to collect pertinent information in a short period of time. The collection of this information is organized and methodical. The initial test establishes a baseline and allows for comparison of changes over time.

BOX 16.1 Brief Description of Common Screening Tools

The MMSE was developed by Folstein to be used with medical and psychiatric patients. Scores in the range of 9 to 12 indicate a high likelihood of dementia. Scores of 25 and higher are considered normal.

The SPMSQ was developed by Pfeiffer. This test is a little quicker to administer than Folstein's MMSE. Questions of orientation and memory are addressed, and there is one question concerning calculation. LOC is not assessed. An advantage over the MMSE, however, is that there are specific directions for scoring this test so as to correct for education and race. A test score of 8 to 10 indicates severe intellectual impairment; 5 to 7, moderate impairment; 3 to 4, mild impairment; 0 to 2, intact status.

The MSQ was developed by Kahn. This questionnaire has two versions: one for institutionalized elderly patients and the other for use with adults in the community. Five or more errors indicate severe impairment, 3 to 5 errors indicate some impairment, and fewer than 2 errors indicate no impairment.

The CCSE was developed by Jacobs. This mental status questionnaire was adapted specifically to diagnose diffuse organic mental syndromes on busy medical wards. A score of less than 20 indicates diminished cognitive capacity.

The NCSE was developed by Kiernan for use with behaviorally disturbed adults in acute diagnostic units. This test differs from the others in that it has two separate scores. One score is given for LOC, orientation, and attention. Another score is given for language, construction, memory, calculations, and reasoning. The two separate scores enable clinicians to differentiate areas of impairment more clearly. This examination is two pages long, with directions to the clinician on how to administer it. It can be completed in 5 minutes by nonimpaired patients and by most patients with impairments in 20 minutes.

TABLE 16.1. Mental Status Examinations

	NCSE	MSQ	SPMSQ	MMSE	CCSE
Level of consciousness (LOC)	X			X	X
Cognitive functions					
Remembering	X	X	X	X	X
Communicating	X			X	
Problem solving					
Perceiving					
Thinking	X				X
Orienting	X	X	X	X	X
Calculating	X	X	X	X	X
Corrects for education and culture		X	X		X
Number of questions	2 PG	10	10	30	30
Time required (minutes)	5–20	5	5	10	10

Source: Gurland, B. J. (1987). The assessment of cognitive function in the elderly. *Clinical Geriatric Medicine* 3, 53–63.

NCSE = Neurobehavioral Cognitive Status Exam; MSQ = Mental Status Questionnaire; SPMSQ = Short Portable Mental Status Questionnaire; MMSE = Mini-Mental Status Exam; CCSE = Cognitive Capacity Screening Exam.

Memory

Assessing memory functions is the most important assessment in working with cognitively impaired older adults. There are three steps in the memory process. Each step needs accurate assessment. The first step is reception (encoding), followed by storage (retention), and, finally, retrieval (recall). Folstein's MMSE tests memory by asking the older adult to repeat three words after the nurse three times, for example, apple, ball, and lamp. The number of trials it takes for the older person to recall the three items is noted. Immediate repetition enables the nurse to determine whether the person has heard the three words correctly. Once the older adult repeats them accurately, the nurse requests that the person remember them. In 5 minutes, the nurse asks again for the older adult to recall the three objects. Each item recalled is given a score of 1.

Orientation

All short mental status examinations include questions about orientation. Time orientation is tested by asking for the date (day, month, year, and day of the week) and the time of day. Because older adults often become quite skilled in using clues from the environment, it is important to remove newspapers or calendars that may help them find the answer. An older adult can sometimes have an accurate sense of time passing yet may not remember the exact date. The nurse may ask questions such as "How long has it been since you last saw me?" or "What was your last meal?"

Assessment of orientation in place generally begins with questions about the name or location of the place in which the person is being examined. You, as the LPN, need to determine whether patients know the kind of place they are in, for example, a nursing home or hospital. Short mental status examinations ask questions about the state, county, or country of residence. Many moderately to severely demented people are not able to recall places. It may be more functional to question an older adult regarding the location of the bedroom or the dining room, for example, "Can you tell me where your room is?"

Level of Consciousness

The determination of a person's LOC is an important assessment to make in the event of delirium or a head injury. Folstein's MMSE is one tool that screens for LOC. It is important for the nurse to know the four levels of consciousness and to be able to define each in behavioral terms. The first level is *alert,* which means that the person is awake and responding in an appropriate manner. The next level is *lethargic*. A person is lethargic when the individual can be aroused and, once aroused, responds in an appropriate manner and with an orientation that is consistent. The third LOC is *stuporous*. If a person can be aroused but responds inappropriately when aroused and then returns to sleep when the stimulus is stopped, the person is stuporous. This response may be the initial phase of a delirium. *Comatose* is the fourth level. A person who is

comatose does not respond to any stimulus except deep pain.

Delirium and the Mental Status Examination

Nurses sometimes have a difficult time recognizing delirium. Sudden onset is the most significant feature described by experts. Older individuals, however, may develop a delirium gradually over the course of 2 or 3 days. One sign is a fluctuating LOC. This can vary from mild confusion to stupor in an active delirium, which is frequently characterized by visual hallucinations. A nursing home resident was being assessed for delirium by the nurse. The resident, who was talking about snakes in her bed, suddenly stopped and turned to the nurse. "Your hands are very chapped," she said. "You should use gloves to do your housework. I always did." Then the resident returned to her delirious state.

Another feature of delirium is disorientation. One person may be mistaken for another. Sometimes an older adult imagines being at home or in another location. Other cognitive functions may become impaired. There also may be a disturbance in the sleep cycle. Many delirious elders are awake all night and then sleep during the day.

Validity and Reliability of Assessment Scales

Whenever a questionnaire is used in any clinical setting, psychologists are concerned about two questions: validity and reliability. Is the test question a valid question? For example, does the question really measure memory, or orientation, or thinking? Validity is determined by the agreement reached by a panel of individuals who are experts in the content of the particular test questions used. The more experts are involved in designing the process, the greater the validity of the test questions. Reliability is concerned with consistency. Will two nurses, each asking the same person the same questions, get the same answers? When the answer to this question is "yes," the test questions are reliable. All standard mental status questionnaires considered in this chapter are valid and reliable instruments. They have been used by a variety of experts for a number of years with consistent results.

Because rating scales are designed to collect standard information about older persons in a methodical way, nurses should review the methods of using the rating scales together. This practice ensures that information is gathered in the same way. One nurse can interview an older adult while another nurse observes. Then they can reverse roles and compare the answers they received. Some experts recommend continuing this technique with 10 patients or until 80% of the ratings are the same.

WHEN TO ASSESS

Many hospitals and nursing homes use some sort of standard mental status examination to screen for gross impairments on admission. This is an excellent practice. Although some initial confusion, agitation, or depression is often seen in older adults who are newly admitted because of transitional stress, this practice, if consistently done, helps staff to get a baseline of the person's overall cognitive function. The assessment can be repeated if the older adult demonstrates acute changes in behavior, mental status, or functional level, for example, if there is a decline in activities of daily living (ADLs). Although screening tools are not diagnostic, that is, they do not point out the exact nature of the problem, they do show, in a factual way, specific areas that have changed.

ASSESSMENT TECHNIQUES

Older adults generally remain cooperative unless they perceive the questions asked as challenging their mental competence. Catastrophic reactions such as screaming or leaving the room angry can be precipitated when a person is pushed to perform beyond the person's competency. An older adult's refusal to answer questions should be accepted. This information in itself is significant. Older persons, aware of their cognitive impairments, may become defensive when their vulnerabilities are exposed. Attention to the following factors promotes the success of the psychological assessment.

Timing

The timing of an interview is an important factor in determining success. Regular staff, especially primary nursing assistants in the nursing home setting, are especially skilled in knowing the best time to interview a resident. Allowing an older person to select a time may be the most effective way to gain cooperation.

Privacy

Privacy is very important. Questions, which to caregivers may seem routine, are often considered deeply revealing and very personal to older persons. All interviews should be conducted in the person's room or a location that ensures confidentiality.

Elimination of Interruptions

Interruptions undermine the importance of psychological assessments. They negatively affect a person's attention span, and they distract the nurse from focusing on the person being interviewed. Some interruptions are beyond your control as the nurse and occur regardless of the precautions taken. Reasonable efforts should be made to eliminate as many interruptions as possible, because they have an impact on the reliability and validity of the assessment.

Positive Introduction of the Assessment

Introducing the psychological assessment in a positive and respectful manner is useful. Describing the test as "a lot of silly questions" may prompt the response that "If they are so silly, why should I answer them?" Let the older adult know that the information gained from this assessment will help the nurses in planning and giving care.

WHAT TO DO WITH THE ASSESSMENT INFORMATION

All information obtained from the older person must be used on the individual's behalf. This information should be dated and appear in an accessible place on the chart with a notation that this document must remain on the chart. In general, assessment information is not updated unless a person demonstrates a behavioral problem or has a marked decline in functional level.

Applications in Clinical Practice

In the hospital or nursing home, psychological assessments may be used as one of the factors determining the unit assignment of a new resident on admission. They contribute to the identification of the person's strengths and potentials. When used in conjunction with the person's ability to perform ADLs, psychological assessments may point out the need for psychiatric evaluation. When a person's mental functioning appears much lower than the score of a psychological assessment might indicate, a mental illness is suspected.

Psychological assessments can be used as a basis for care planning. This is especially important when an older adult's social graces lead staff to the conclusion that the person is functioning at a higher level than is the case. Many individuals with a dementing process learn strategies to cover for losses in cognition. They may rely on list making, props in the environment, and social cues from others. Staff sometimes can make excessive demands on older persons if they are unaware of cognitive deficits.

Psychological assessments can allow a broad determination of the effects of an intervention. For example, a person with sadness, who wishes to die, may be treated with an antidepressant. Effective treatment may enhance the abilities of depressed older persons to attend to their environment, thereby improving memory and perception. On the mental status examination, such people may achieve higher scores in the area of recall. This information is useful to a consultant when a more extensive evaluation is considered necessary. It is helpful to be able to tell a consultant that an older adult has dropped four points on Folstein's MMSE because the examination was conducted 6 months earlier. It also is useful to note the specific area of decline, for instance, the area of decline is in orientation to time and place or in immediate recall.

Older adults vary greatly in symptom severity and the rate of progression. Although in the later stages of dementia, older persons present very much the same regardless of disease process, the initial symptoms may clearly demon-

> **POINT OF INTEREST**
>
> As an LPN, you should develop polished skills with one of the assessment tools. Learn it well, practice it on people many times, and then be prepared to share your skill and knowledge with the interdisciplinary team. This will make you a strong, positive asset to the place where you work.

strate one disease over another. For example, the initial symptom of Alzheimer's disease is the gradual progressive decline in the ability to learn new information. The most significant early symptom of Pick's disease is a change in personality. This is an important distinction.

Therefore, symptoms of dementia are a moving target that must be tracked. The tracking is done by frequent, well-recorded assessments. If an assessment tool has been used to establish a baseline in the early stages of the disease process, it may contribute to the diagnostic process.

OTHER ASSESSMENTS

Assessing Depression

Although recent research indicates that depression is no more prevalent in older people than it is in younger people, its manifestation is different and, therefore, difficult to identify. It is important for you, as the nurse, to gain skill in the assessment of depression because of your focus on the quality of life for all people. There is a heavy emotional cost to depression that ultimately affects the immune system. This can lead to cancer and other physical illnesses as well as infections.

Depression, therefore, predicts the onset of disability almost as powerfully as disability predicts depression. Older individuals who are depressed are in a high-risk category for institutionalization because they are less motivated to care for their personal hygiene and nutrition. This increases their vulnerability to disease. Depressed individuals are frequently withdrawn and socially isolated, so they have weak support systems. The path to a nursing home for these individuals is apt to be very short and direct.

It is a fact that people older than 65 years of age are beginning to face some significant losses: economic, vocational, family supports, and friendships. Physical disabilities, however, are frequently viewed as the beginning of the end. "If you have your health, you have everything," one grandmother reports. The loss of health signals a life of dependency for most older adults.

Generally, the most impressive feature of depression is an unpleasant mood. To psychiatrists, the term *clinical depression* refers to a cluster of specific symptoms. These symptoms are clearly defined in a diagnostic manual called the *Diagnostic and Statistical Manual* (*DSM-IV*) (1994) and must be present for a specified duration. Depression may be chronic or acute, and the symptoms may vary in intensity as well. Severe depression is thought to impair cognitive functioning at any age. Memory seems to be the function most influenced by a depressed mood, but there are many ways that memory can be affected. For example, information committed to memory when a person is depressed is likely to be biased. Other clinicians focus on the ability or lack of ability of older adults to attend to their environment as the indicator of a depression. Methods for the identification of depression in the elderly population are controversial. Use your own skills and life experience to process the responses of the older adult you

Older people experience significant losses. This woman has lost her husband, can no longer drive a car, lives alone, and has experienced the deaths of friends and family members. A concerned neighbor reported that the woman is "very" depressed. As a volunteer mental health nurse, you are asked to talk to her to determine if she is depressed and needs an intervention. What you find is a delightful woman who serves in her church and has friends and activities in her life. However, she is quiet and reserved, which you suspect is the reason someone mistook her for a person with depression. Nothing is more important in a psychological assessment than your physical presence with your knowledge and life skills.

are interviewing to try to identify expressions or behaviors of depression. Report your results to the registered nurse (RN).

Assessing Pain

Chronic pain may leave a person totally fatigued and unable to participate properly in a restorative care program. In addition, some behavioral problems in institutionalized older adults stem from ineffective pain management. A psychiatric evaluation may be requested for screaming or abusive behavior on the part of a resident of a nursing home who in fact is simply experiencing pain. A failure to identify pain as a factor affecting behavior and function may result in poor medical management.

Pain in older people is frequently either overtreated or undertreated simply because it is difficult to assess. Some older adults want every ache treated with a drug, whereas others maintain a stoic attitude: "Why bother? There is nothing that can be done, anyway." Often, older people perceive pain differently. In fact, some pain receptors may not be as acute as they were in the past. Medical journals document clinical cases describing "silent" myocardial infarctions or "painless" intra-abdominal emergencies. These cases may not, in fact, be silent or painless but may reflect an older person's normal aging situation.

Some barriers to pain assessment are cognitive impairments, delirium, and dementia. People who have a dementia process or a stroke and became aphasic may be unable to give an accurate pain history. They may not be able to describe when the pain started or at what point in the day the pain becomes most severe. Most people describe the pain in the here and now.

A person in pain is often self-absorbed and inattentive to activities in the environment. Because pain frequently leads to depression, the mental status examination score may demonstrate a decline in recall.

Delirium may be one manifestation of an attempt to treat a person's pain. An assessment for delirium should be made whenever there is a change in the LOC after the start of any new drug, particularly a pain medication. A sensitivity to medications that results in delirium makes pain management difficult.

Multiple chronic disease processes as well as acute diagnoses compound the difficulty. There even may be an acute exacerbation of a chronic problem. These multiple sources of pain make diagnosis difficult, and pain management becomes a challenge.

Myths of Pain

One of the myths regarding pain in older adults is that pain is normal. As body systems begin to wear out, one might expect an increase in pain. Pain, at any age, however, is the most common symptom of a disease process and should be investigated and treated.

Another myth is that pain and sleep are incompatible. Nurses often disbelieve a patient's complaint of pain when they bring a pain pill and find the person asleep. The wrong conclusion is drawn. It is believed that an individual really in pain could not possibly sleep. The exhaustive feature of pain, however, is seldom considered in the assessment process.

The last myth is that narcotic drugs are not safe for older people. Narcotics provide effective pain relief for some chronic conditions and terminal illnesses. These drugs should be used on a scheduled basis, for example, every 4 hours or every 6 hours. Use of a narcotic on an "as needed" basis does not provide effective pain management. Some nurses believe that narcotics dull an older person's LOC. They fear that an older adult will not be able to benefit from the support of family or friends in the time remaining before death. Effective relief of pain actually promotes interaction, and the initial drowsiness soon wears off.

Methods of Assessment

Although pain is a highly subjective experience, there are two methods for assessing it. Simple observation from a nurse who knows the person well can be very effective. A grimace or clutch of the chest provides a vivid picture of pain. Assessment questions may follow these observations. There are clinical practice guidelines for acute pain management that identify the quantifiable measures of pain that should be considered in an assessment. These measures include the intensity of the pain, the duration of the pain, the quality of the pain, and the personal meaning this pain has to the older adult. Also included is the impact on the person's functioning.

Assessment tools are available. A good tool addresses the older person's pain history and coping strategies for dealing with pain, as well as medications in the past that have been effective. It is important to ask questions that help to

describe or define the pain. Noting the intensity and duration assists in providing an objective measure to a highly subjective experience. Simply asking "How is your pain today?" may prompt the response "Well, it is there."

The simplest method of pain assessment is the use of a pain intensity scale. You, as the nurse, can draw a line indicating that the far left (L) end of the line defines no pain and the right (R) end represents the most pain the person has ever experienced. The person can point to the place on the line that reflects current pain level. Another commonly used method is to ask the older adult to rate the pain on a scale from 1 to 10, with 10 being the worst pain imaginable.

SUMMARY

Observations of a person's behavior and functional status are subjective and often inconsistently reported. It is difficult to get a clear idea of decline or progress over time without some objective measures. Psychological assessments and other assessment tools provide the means for collecting factual information about older adults.

Brief mental status examinations universally identify assessments of memory and orientation as the two features that provide the most information about an individual's cognitive functions. Assessments help establish a person's baseline functioning. They can be used to establish a diagnosis, plan care, and evaluate treatment efforts. Psychological assessments also enable the nurse to define problem areas in a more specific manner to consultants. Older adults cooperate well with assessments if the nurse is sensitive to timing, respects the person's privacy, limits interruptions, and presents the assessment tool in a positive manner. Other assessments that can provide important information in planning care are those that assess depression and pain.

CONCLUSION

Many institutionalized elderly people are all too aware of their declining abilities. These losses have a dynamic impact on their self-concept. A life once vital and central to a young family now does not seem worth the effort to maintain. A lowered self-concept and diminished self-esteem complete the picture of physical decline. The process can become circular without the intervention of a caring and knowledgeable staff.

The performance level of most individuals improves in a supportive environment. Therefore, recognition and reinforcement, both of cognitive skills and abilities and of attributes of mental health, can positively affect restorative care efforts. Nurses who consistently identify strengths in a factual way are instrumental in improving the quality of life for older adults in their care.

CASE STUDY

Ms. F. is 81 years old. She had a long career with the government that involved traveling all over the world. Although she never married, she is a devoted aunt and a vital member of her extended family. She is the youngest of three siblings. Her two older brothers live in New York and California. Despite the distance, the three communicate regularly through letters and telephone calls. Nieces and nephews are always attentive to Ms. F. She never spends a holiday alone.

The retirement years for Ms. F. became the highlight of her life. She continued her travels, sometimes with friends and at other times with a niece or nephew.

Only one problem seemed to dampen Ms. F.'s life. In her middle years, every once in a while (3 to 5 years), she became depressed, or "blue" as she describes it. Two episodes she "toughed out" on her own. Although she continued to function in her job, her appetite diminished. She woke up at 3:00 a.m. on most days and had no energy to do much of anything. In a couple of months, the blueness lifted, and she returned to the good life. These periods seemed to have no precipitating event. She saw a psychiatrist for the first time when she was 54 years old. He prescribed an antidepressant, nortriptyline (Pamelor). This medication was successful in treating the depression. After 6 months, the medication and brief therapy were stopped. She did quite well in the following years.

When she was 78 years old, Ms. F. made the decision to come to a nursing home. Her family thought she was having some minor problems with memory. Although she denied feeling depressed, she noticed a real decline in her energy level and ability to do for herself. She was placed on a unit with other residents who functioned independently. A niece came to help her decorate her room. Whatnots displayed unique treasures from a life of travel.

Based on this information, answer the following question:

1. With respect to the administration of the mental status examination, the charge nurse decided:
   a. Not to give the examination. It would be insulting to Ms. F. to be questioned in such a way.
   b. To check with Ms. F. regarding a good time to conduct some routine admission assessments, which would include the MMSE.
   c. That Ms. F. was doing so well that there was no need for such a test.
   d. To ask the social worker to conduct this examination in a few weeks after the resident had adjusted better.

Ms. F. was a trim woman and her clothing was exquisite. From the start, the other residents seemed to respect her. Although she did not become a member of one of the unit cliques, there was no one who did not accept her and welcome her company when she sat down. Her admission MMSE score was 29/30. She was unable to recall one object after 5 minutes.

A few months after admission, some of the residents began to remark to the staff that Ms. F. was ignoring some of their efforts to engage her in a conversation. She started retreating to her room a little more. In general, she seemed more withdrawn. She favored a chair off to herself rather than an available seat in a group of other residents.

Based on this information, answer the following question:

2. The charge nurse was concerned. She went to visit Ms. F. in her room. The two problems the charge nurse was assessing in this interview were:
   a. Delirium and dementia
   b. Depression and dementia
   c. Depression and hearing loss
   d. Depression and possible delirium

Ms. F. was a little vain and disclosed to the charge nurse during this interview that her hearing was not what it used to be. "I don't want to wear a hearing aid," she said. The charge nurse convinced Ms. F. that a routine audiology appointment might be useful.

She was scheduled for a clinic appointment the following week. She had a great deal of wax buildup that was interfering with her hearing. When the wax was removed, her hearing improved, but the audiologist convinced her that a hearing aid would be most beneficial and told her, "It's an attractive device and can be made to fit your glasses." The persuading force was Ms. F.'s love for classical music. Clearly, she had not been able to enjoy her music with the hearing loss. She ordered a hearing aid.

The bad weather set in, holidays came and went, and Ms. F. holed up in her room "reading the paper." As spring approached and there were a few days of good weather, Ms. F. could not be dissuaded from staying in her room. When Ms. F. was weighed routinely, staff were horrified to note a

10-lb weight loss. In reviewing the minimum data set (MDS), the staff noted that she had lost a total of 15 lb in 3 months.

Based on this information, answer the following question:

3. The charge nurse decided to conduct a mental status examination. Ms. F. agreed to being tested. The nurse noted that it took four repetitions of the objects for her to recall them. In 5 minutes she could not recall a single object. Because Ms. F. was well oriented, the nurses believed that:
a. There was some dementia.
b. She needed a battery for her hearing aid.
c. She was depressed.
d. A combination of a, b, and c.

The psychiatrist was called to assess Ms. F. He determined that she was depressed and recommended nortriptyline (Pamelor), an antidepressant. The primary physician prescribed Pamelor 25 mg every evening. After 3 weeks, the nurses reported that Ms. F. was smiling and seemed to be out of her room more. Her appetite was a little better; at least she ate a good breakfast. The primary physician conferred with the psychiatrist and increased the Pamelor to 50 mg daily. Six weeks later Ms. F. was on the porch enjoying lovely June days. She had been in the facility for a year. The charge nurse decided to repeat the mental status examination to determine whether there was marked improvement in her depression. Ms. F. was able to recall two out of the three objects. Her recall had improved. She was a little vague about the date; however, she knew the season, month, and year.

Based on this information, answer the following question:

4. The charge nurse wondered if:
a. Ms. F. was just a little confused.
b. Ms. F. might have a disturbance in orientation related to a dementia process.
c. An adjustment in the antidepressant might be appropriate.
d. She should discourage Ms. F. from subscribing to a daily newspaper because it might be too tiring for her declining abilities.

Toward the end of November, Ms. F. slipped. Although she did not fall, she injured her back when she grabbed onto the support rail in her bathroom. The nurses noticed that she held on to the furniture and walls as she walked. She had radiographs, which revealed osteoporosis. The staff and primary physician discussed with her the idea of using a walker to get around. She agreed to try this and went to physical therapy (PT) for an evaluation and a walker. Two weeks later, Ms. F. was still complaining of pain. She stayed in her bed more and did not come out for meals. Aspirin was ordered for her pain. Staff came by to visit. A few more weeks passed. Answer the following questions about this situation:

5. Some of the staff believed that:
a. The resident was exaggerating her problem to get more attention.
b. The resident was depressed because of the pain and decline in function.
c. The resident had more extensive physical problems than they realized.
d. That further assessment was needed to determine the factors behind the resident's decline.

6. The charge nurse decided that the following assessment(s) would help staff understand the resident's decline:
a. Pain history and physical assessment per physician
b. Nurse interaction focused on identifying depression, if it existed
c. MMSE
d. All of the above

The resident described the pain as severe, the worst she had ever experienced. The physician decided to hospitalize her for more tests. Hospital laboratory work showed dehydration. Magnetic resonance imaging (MRI) revealed that there was a disc pushing in on the spinal cord. The doctor ordered intravenous fluids and meperidine (Demerol) to manage the pain. When the charge nurse stopped by the hospital to see Ms. F. on the way home from work, she was shocked to find that Ms. F. did not remember her and believed it was nighttime. She had no idea where she was and had no recall from one moment to the next. It was January, and she believed it was June.

Answer the following question regarding this situation:

7. The charge nurse realized that her resident:
a. Was depressed.
b. Was in extensive pain.
c. Had not heard a word she had said.
d. Was delirious.

During her hospital stay, Ms. F. was treated for gastrointestinal problems related to aspirin use and had back surgery that resulted in some post-

operative complications. When Ms. F. returned to the nursing home, it was spring. She had a marked decline in her functional ability. She was now in a wheelchair and had been assigned to another unit. The staff from her original unit visited her to help her get adjusted. They focused on her abilities and her life of travel. They invited her to visit them and attend groups on the first floor. Ms. F. seemed very vague to them. The nurses felt sad and wondered whether Ms. F. would ever again be as bright and interested in her surroundings as she had been on their floor.

The MMSE was repeated. The nurses on the third floor realized from the MMSE that Ms. F.'s cognitive status had changed significantly. There were deficits in orientation and memory. Her ability to perform calculations, however, had not declined. In a postadmission care conference, the staff identified Ms. F.'s resident care needs. Answer the following question about this determination:

8. They believed that they must implement all the following except:
   a. To assist the resident to accept her decline
   b. To assess her ability to move about and participate in a walking program
   c. To request a psychiatric evaluation
   d. To encourage her to participate in all unit activities

The resident slowly began to respond to the staff's plan of care. She was restarted on an antidepressant that had been stopped while she was in the hospital. She responded well to a walking program. Although she had lost some of her agility, she achieved some independence with a walker. Her dementia had advanced slightly, but she could and did participate in activities. It was decided that staff would continue to do an MMSE annually to monitor her progress.

Solutions

1. b
2. c
3. c
4. b
5. d
6. d
7. d
8. a

STUDY QUESTIONS

Select the best answer to each question.

1. The health-care providers who are best qualified to conduct psychological assessments, such as Folstein's MMSE, are:

a. Psychologists

b. Nurses

c. Social workers

d. Psychiatrists

2. The social worker of a unit annually conducts an MMSE on all the residents. She informs you that Mrs. H.'s score in the area of orientation has dropped 2 points from last year. You suspect that the drop is due to:

a. Delirium

b. Arthritis

c. Progression of dementia

d. Depression

3. The activities department has alerted you to the fact that, recently, Mr. J. has not been interested in attending programs sponsored by their department. This morning, he complained to you that he believes that he is having problems with his memory. He did not eat breakfast and only picked at his lunch. He denies feeling depressed. You conduct an MMSE. There is a change in score from the admission MMSE conducted 3 months ago. His immediate recall of three objects on Folstein's MMSE has declined. You suspect:

a. Delirium

b. Progression of dementia

c. A urinary tract infection

d. Depression

4. Mrs. C. does not come out of her room for breakfast. The night shift staff report that the resident was up all night and that she has a fever. You go to Mrs. C. to determine whether you can assist her. She seems to be asleep. When you touch her arm, she opens her eyes. She does not quite recognize you, her favorite nurse. She believes that it is bedtime and her main concern is that her husband (who has been dead for 20 years) is late coming home from work. When you leave the room, she returns to "sleep." Yesterday her MMSE score was 30/30. You know immediately that she is:

a. Depressed

b. Having a massive stroke

c. Delirious

d. Confused, due to dementia

5. Important considerations when conducting psychological assessments are:

a. Timing

b. Privacy and elimination of interruptions

c. Positive introduction of the assessment

d. All of the above

17 Common Clinical Problems: Psychological

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Recognize three behaviors that may signal the presence of a psychological problem in an older adult.
2. Explain how to use nursing interventions for older adults with common psychological problems.
3. Discuss how to manage difficult behaviors of older adults.
4. Compare reality orientation, reminiscence, remotivation, resocialization, and validation techniques.
5. Select important information about psychological medications to include in teaching.

INTRODUCTION

Psychological problems are disturbances in mental or emotional health that occur as a result of external or internal stimuli. These problems are usually assessed by examining thought patterns, behaviors, and emotions. Because psychological difficulties are not as obvious as some physical problems that can be diagnosed by laboratory tests, it may be difficult to diagnose and correctly treat older adults with these problems.

Almost any psychological problem that can occur with other age groups also can occur with older adults. A few of the more common psychological problems found in clinical situations are described in this chapter. A glossary of terms used in this chapter is presented in Box 17.1.

GENERAL GUIDELINES FOR COMMUNICATING WITH OLDER ADULTS

It is helpful to review some basic principles for good communication, particularly as they relate to communicating with the older person with psychological disorders. It is important to practice the skills outlined throughout this chapter in order to develop your own style for working in an individualized way with each person in your care.

Forming Relationships with People Who Have Psychological Problems

Generally, relationships have three stages. During each stage, there are concepts with which you should be familiar. At the beginning of a relationship, people sometimes are uncomfortable. After all, they are sick and you are new to them. As time goes on and trust is established, people enter a stage of the relationship that allows for more open communication that can be therapeutic in its purpose. The last stage of a relationship involves termination or saying goodbye. Problems in relationship building can be prevented by understanding these normal stages.

Beginning a Relationship

People who have psychological problems may not be easy to get to know initially. They may have had problems starting relationships all their lives, and forming a relationship with a new nurse might be difficult. Some people with mental illnesses have trouble trusting others and find it difficult to trust a new nurse or a new roommate in a hospital or long-term care facility. There are some things that can be done to help make the beginning of a relationship more comfortable.

If the person with a psychological problem does not talk or becomes upset at first, do not take it personally. Remember that the person may be feeling uncomfortable and unsure of how you will react. You, as the nurse, can be creative in dealing with problems like this and

BOX 17.1 Glossary of Psychological Terms

Anxiety: generalized unpleasant feeling of apprehension.
Behavior modification: treatment method of changing behavior.
Bipolar affective disorder: psychological disease involving mood swings from mania to depression.
Delirium: sudden, reversible state of confusion.
Delusion: false, fixed idea or belief.
Disorientation: state of not knowing what day or time it is, or not knowing where one is.
Hallucination: false sensory impression, often seeing or hearing something that is not there.
Illusion: misperception of a real event or object.
Neurolinguistic programming: a way of communicating using neurological, behavioral, and speech patterns.
Neurotransmitter: chemical in the brain that carries electrical impulses to neurons.
Paranoia: way of thinking that systematically interprets others as being intentionally harmful.
Phobia: exaggerated fear of a particular object or group of objects.
Schizophrenia: psychological disease involving severe thought and perception disturbances.
Sensory deprivation: condition of decreased stimulation that can cause hallucinations, illusions, and disorientation.
Social support: emotional and physical assistance given by loved ones.
Somatization: extreme preoccupation with physical problems.

PRIORITY SETTING 17.1

The absolute priority, when working with any person with psychological problems, is SAFETY. As a licensed nurse, you are responsible for the safety of each person who is ill as well as the employees and visitors.

1. You know that some people with mental illness can hurt themselves. The most serious injury that can occur is suicide. The attempt at suicide can result in major injuries such as cuts at the wrist and falls. You must protect such people against their own self-destructive behavior. Suicidal people must be on a "suicide watch," which refers to additional staff caring for them in a smaller and more confined space. With the proper treatment, mainly medication, suicidal people recover and their underlying cause, depression, is managed.
2. Some people with mental illness try to hurt others. It is their effort at gaining control of their out-of-control lives. Such people could start a physical fight with someone much weaker than themselves, be verbally abusive, or go to extremes to hurt others. Once I was on a locked psychiatric unit with 12 students. A former patient came to visit a friend, pulled a gun, and started shooting it at random. It was horrifying. No one was wounded, and the former patient was "taken down" by the security staff and two nurses. This is an extreme example of danger to others.

Because you are licensed, you are responsible for what happens on the unit. Be ever diligent; listen to the CNAs as they work closely with the patients; get to know the patients and develop a relationship of trust with them; then do your best to provide an environment of safety.

need to respond in a natural way. Some approaches to consider are using humor to diffuse tension or finding an interest of the person's, such as fly tying or crocheting, and asking him or her about it.

Important points to keep in mind are the need to establish trust and not to reject the person. You may need to try saying to the individual, "It seems like you'd rather not talk right now. I'll come back in an hour and sit here (or at the desk, or at a table) just in case you want to talk to me then."

Developing a Relationship

Once you have developed a trusting relationship with an older adult, you are ready to be an instrument in the work of healing for a person with psychological problems. With the development of trust, the older person is able to share with you such emotions as fear, anger, and the symptoms of more serious illnesses such as delusions or hallucinations. Your responsibility is to listen and guide the discussion.

If the older person has a serious disease, most of the verbal therapy is done in group or private sessions with nurse practitioners or psychologists. Then your responsibility is to listen, be genuine, and report anything unusual to the registered nurse (RN).

Ending a Relationship

Nurses begin and end relationships with many people every day. Sometimes this happens in small ways, like taking a weekend off or going away for a conference or vacation. Sometimes it is more permanent, like discharging a person to another facility or to the home, changing jobs, or saying goodbye to a person who is dying. During this phase of a relationship, people in general try to avoid the termination process. This often is done when the patient ignores you and other staff members or acts out.

If a nurse is going away for a short period of time, the older adult may start demanding more attention by ringing the call light more frequently, by becoming angry or irritated by small things, or by not responding or talking. To prevent this from happening, it is best if the person knows as soon as possible when to expect the separation. Provide opportunities to talk about it openly with you. If a permanent separation is approaching, some kind of formal farewell, like a goodbye party, might be helpful. Taking pictures with patients and staff also can help ease the difficulty of a separation. If an older person is being discharged home, do not always assume it is a joyous occasion. Sometimes the situation at home is worse than being in the nursing home or hospital. Even if a person is looking forward to going home, mixed feelings may exist about having to adjust to another new

situation. Remember the difficulty of transitional stress.

It is not unusual for someone who is about ready to go home to suddenly become worse. If this happens, it may be a clue to you that the person is having problems with ending his or her present relationships. If you, as the nurse, talk about this openly by sharing feelings like "Things just aren't going to be the same around here without you, Mr. M.," the person may be more willing to discuss personal feelings.

Verbal Communication

Communication skills described in general nursing books also can be used successfully with older adults. There are some skills that are important to emphasize when working with elderly people who have psychological problems. The following discussion includes validation techniques, which are especially useful with the disoriented. There will be more information about validation therapy (VT) later in the chapter.

Open Questions

Verbal communication can be helpful by using open questions instead of closed questions. A closed question is a question that can be answered with a simple "yes" or "no." An open question tends to encourage the person to talk more. Open questions are asked using such words as "who," "what," "where," "when," and "how." "Why" questions usually are not very helpful, especially with someone who is disoriented. Some people with psychological problems may not be able to logically or rationally answer a "why" question. If a resident in a nursing home says she is looking for her mother, you may validate her by asking open questions like "What does your mother look like? What did you like to talk about with your mother? What did you and your mother do together?" If you were to ask "why" do you want your mother, the resident often would not be able to tell you.

Giving Instructions

When giving directions, it is best to do so slowly, one step at a time. Individuals who are disoriented may not be able to perform any self-care activities unless they are prompted by very simple cues. Telling people who are disoriented to brush their teeth may not get any results. But if you tell them to pick up the toothbrush, then pick up the toothpaste, then put the toothpaste on the brush, then put the brush in the mouth, and then brush up and down, they may be able to do more than you originally thought.

Guided Choices

Some people may not respond to open questions as well as they do to guided choices. When asked "What would you like to do today?" someone with a psychological problem may not know how to respond. However, when given a choice between two activities, with choices given one at a time, the person may be able to make a choice. An example of guided choices is: "Would you like to go to singing time today? Would you rather go for a walk outside?"

Empathy and Genuineness

When a nurse shows the desire to understand someone, it promotes more meaningful communication. Empathy can be expressed by maintaining eye contact, using a caring tone of voice, listening closely to what someone says, and making statements such as "This must be difficult for you" or "It sounds like you are having a rough time right now."

The opposite of empathy is patronizing a person. Using a tone of voice as if talking to a child is an example of being patronizing. This type of communication keeps the nurse from using empathy and is not helpful in communicating with older adults. Referring to an older person as "honey" or "dearie" is also patronizing and, therefore, a hindrance to effective communication. Another example of patronizing behavior is referring to an older person in a report to another nurse as a "real cutie" or a "sweetheart."

It is important that the nurse be genuine when showing empathy. Being genuine means that nurses must truly represent themselves. Finding things you sincerely want to say to a person is more important than saying the right thing from a book.

Listening

Listening to someone includes listening to feelings, words, and behaviors. Sometimes people with emotional problems may forget or confuse the facts or use words that do not make sense. When this happens, it is especially important to listen to feelings instead of trying to get the facts straight. If a resident is incomprehensible but is speaking loudly and has tearful eyes, you might respond by saying, "This is extremely frustrating for you."

Another aspect of listening is to make sure the older adult can hear you. A review of the basic principles may help you. Start by being directly in front of the person. Stand so there is not a bright light (a window on a sunny day) behind you so the person can read your lips as well as listen to you. Speak in a normal tone; do not shout even if the person cannot hear you. If you suspect the person is having difficulty hearing you, move closer to the person. Ask permission to move close to one of the person's ears and repeat what you were saying, in a normal tone. If the person seems comfortable with touch, place your hand on a shoulder and express nonverbal acceptance and caring with touch. Remember to smile and do not act rushed even if you are. You may find other successful methods for promoting the older adult's way of listening. If so, use them and share them with others.

Values and Culture

There are many different motivations for behavior during a conversation. Two that can enhance or interfere with effective communication are the values and culture of the nurse and the older adult. What one person sees as normal may be seen as unacceptable or offensive by a person who has different values or comes from a different cultural background. For example, the nurse who has been educated to value touch as a way of communicating concern and an older adult who perceives touch, without permission, as an invasion of privacy will have problems with the communication process.

Do you recognize the cultural background of this man by looking at him? It is important to gather information quickly on cultures unfamiliar to you so you can give caring, holistic health care. This man is from Sudan and has suffered horrific family deaths and persecution from the terrorists there.

Nurses know that older adults, as with other age groups, come from a wide variety of backgrounds. A Hispanic resident may stand very close while talking to staff members. A staff member who is not aware of this cultural difference may interpret such behavior as being intrusive. An older Japanese person who values modesty may have difficulty talking openly about bowel and bladder problems. Some Native Americans want their Shaman, or medicine man, to perform a sacred "sing" to help them heal. This ritual involves music, dance, and numerous family members and friends. In order to have meaningful communication with older adults, all caregivers need to understand and respect the variety of differences that can occur because of personal values and cultural behaviors. Review Chapter 7 if you feel you need more information on cultural awareness.

Being patient also is very important. Some nurses have to be available to the older person to whom they are assigned for several days before seeing a positive response. When the results do come and the nurse is able to communicate successfully with the older person, it is a very rewarding experience.

Nonverbal Communication

Psychologists say that nonverbal communication, such as tears or the inability to smile, is the most honest communication a person can make. In order to be an effective listener, you need to both watch and listen to what is being said. Using direct eye contact and a caring tone of voice can help the communication process. Positioning the body at eye level also helps.

Touch

Touching is an important part of communicating with people. Many older people miss human contact and enjoy being touched. However, a person with psychological problems may become frightened, withdrawn, or agitated if touched. When the nurse touches someone who has an emotional problem, it is a good idea to ask the person first if it would be all right. Saying "Would it be okay if I gave you a hug?" might be a way of asking for permission. Carefully note the response of the person to both the question and the actual touch. Some people who are very withdrawn may respond only to touch.

Touch can be used to stimulate sensory memories as well. Different people respond to touch in different ways. A list of common responses to touch is found in Table 17.1. A per-

TABLE 17.1. Common Responses of Disoriented Older Adults to Touch

Remind Client of	Touch Technique
Mother	Palm of hand in a light circular motion on the upper cheek
Father	Fingertips, in a circular motion, medium pressure, on the back of the head
Spouse/lover	Hand under the earlobe, curving along the chin, with both hands, a soft stroking motion downward along the jaw
Child	Cupped fingers on the back of the neck, with both hands, in a small circular motion
Brother/sister or good friend	Full hand on the shoulders and upper back by the shoulder blades; use full pressure in a rubbing movement
Animals/pets	Fingertips on the inside of the calf

Source: Feil, N. (1989). *Validation: The Feil Method*. Cleveland, OH: Edward Feil Productions, pp. 47–48, with permission.

son who talks about his mother or says "Ma, ma, ma" repeatedly may respond well to stroking on the upper cheek. This stimulates the rooting reflex and can bring back memories of a loving mother. Stroking the upper arm from the shoulder to the elbow is perceived by many people as a universal symbol of friendship. It feels comforting and safe to have someone touch in that way. If a patient is agitated, you may want to try stroking their upper arm while you talk quietly and gently to the person. The results may surprise you.

Matching and Mirroring

Research has determined that it helps the communication process if a person can match or mirror another's behavior. Mirroring is doing exactly what the person is doing as if the person were looking into a mirror. Matching is using the same pattern or intensity of tone the person is using. This must be done in a respectful way and not as a way of making fun of the individual. If the nurse feels uncomfortable doing this, it is not genuine and does not help communication.

Matching and mirroring are nonverbal ways of helping someone know that you hear what he or she is saying. Matching of emotions can be done by labeling the emotion out loud and using the same intensity used by the older person. Mrs. C. may pound her fist on the arm of her wheelchair and say "I hate them, I hate them, I hate them." Using matching and mirroring, the nurse would pound on the table with the same rhythm she is using and say "You're angry, you're angry, you're angry," using the same intensity of emotion.

Universal Symbols

A universal symbol is an object in the present that represents something important from the past. Sometimes these symbols increase in importance for people who develop disorientation as they grow older. The symbol can be something that has meaning to the older person, such as a reminder of a hobby or life's work, or it can be a different type of symbol. A few typical symbols are listed in Table 17.2. An apron can be made with a large pocket in the front that can contain significant symbols. A farmer may fondle farm tools placed in the pocket of an apron and by doing this revive a memory of a time in life he

POINT OF INTEREST

In all likelihood, you will not eagerly want to use the touch techniques just described. This is a test of courage of sorts. These touch techniques have a powerful impact on people with dementing illnesses. You need to have the courage to step into the situation and give the techniques a try. What if you use the rooting reflex touch on a resident and the person reacts loudly and with fear or anger? Don't walk away and say that technique never works. Instead, critically examine what has happened and consider what the mother of the older person did to cause such a strongly negative reaction so many years later. You have learned something important about the person by using this technique. It is that the mother was not a positive influence in the older person's life and the issues surrounding the mother may need to be resolved for the older adult.

TABLE 17.2. Universal Symbols and What They Can Mean

Symbol	Possible Meaning
Jewelry, clothing	Worth, identity
Shoe	Container, womb, male or female sex symbol
Purse	Female sex symbol, vagina, identity
Cane or fist	Penis, potency, power
Soft furniture	Safety, mother, home
Hard furniture	Father, God
Napkin, tissue	Earth, belonging, baby
Flat object	Identity
Food	Love, mother
Drink from a glass	Male power, potency
Any receptacle	Womb
Picking the nose	Sexual pleasure
Playing with feces	Early childhood pleasures

Source: Feil, N. (1989). *Validation: The Feil Method.* Cleveland, OH: Edward Feil Productions, p. 73, with permission.

enjoyed. As he touches the tools, the nurse can encourage communication using these symbols of the person's previous life.

Problem Behaviors

If a person with a psychological problem begins to display any unusual behaviors, it may be due to a number of different causes. Recent changes in relationships may contribute to increased wandering, shouting, and aggressive or withdrawn behaviors. These behaviors are not uncommon after a room or roommate change or when the person is becoming accustomed to new staff members. These behavioral changes also may indicate that a medication change needs close monitoring or that symptoms of the person's illness are becoming more acute.

When you are caring for a person exhibiting difficult behavior, you need to take special precautions. Be alert to any situation that would place you, the older adult, or other patients in danger. Report anything suspicious to the RN, and stay calm.

All persons with psychological problems do not act in a dangerous way. Some sit quietly and never talk or move. This person needs your attention and expertise as well. Talk gently and kindly to the person. Sit with this quiet individual even if there is no conversation. Touch the person if it seems acceptable. All of these simple acts indicate acceptance of the person and are important for healing.

What should you do if an older adult is "yelling" at you? First, do not respond with anger. Stay calm. Be empathetic and kind. Listen to what is being said in order to identify what the problem really is. Get help if you need it. Be alert to what is going on throughout the unit as well as with the individuals in your care.

Some older adults with psychological disorders suffer from hallucinations, delusions, and illusions. These are symptoms of serious mental illness. People exhibiting these symptoms may think that they are Jesus Christ, or they may see bugs crawling all over their arms, or they may think you are a princess and want to wait on you. When dealing with such problems, the first rule is to stay calm. The next most important thing is to tell the truth. Do not play into the symptom by saying "Yes, I am princess Laura," or something of that nature. Be caring, honest, and genuine with the person. Remember, it never is wrong to get help if you feel uncomfortable or in danger.

AGITATION

Agitation can occur as a result of physiological or psychological problems. Some people become agitated because of physical causes that result in delirium. Common psychological problems that can cause agitation are the manic phase of bipolar affective disorder, stress or anxiety, flashbacks from traumatic experiences, post-abuse reactions, or dementia. When people become agitated, they also may become violent. Such violence can be directed toward themselves or others. Preventing agitation, and managing it once it occurs, can be accomplished by following a few simple principles. For example:

- Watch for signs of agitation. Some people show signs of increasing irritability before a severe problem occurs. Others may have sudden, explosive outbursts. Notice if someone is talking very loudly, pacing more or faster, or making threatening comments to staff or others. Before an actual outburst occurs, try to keep the person talking to you by using some of the communication skills discussed in this chapter. With many people who are agitated, simply matching their breathing patterns or tone of voice is calming. With most people who are agitated, it is best to step back about 4 to 6 feet while talking with them. With disoriented elderly people, the reverse may be

true, especially if a sensory deficit is present. It may be more calming to move closer to maintain sustained eye contact and touch. This must be done cautiously to protect your own safety and that of others. If there is the possibility that other patients or visitors may be harmed, move them out of the way.
- If a person becomes physically aggressive, it is important to remember that the thumb is the weakest point of the hand. If a person has a hold on you, the way to remove yourself is by rotating away from the thumb of the person's hand. For further information on intervention techniques, most psychiatric facilities provide training sessions that allow you to practice dealing with these behaviors in a way that minimizes harm to yourself and protects the agitated person.

Dealing with Psychological Problems Caused by Stress

Here are some general guidelines for dealing with older adults with psychological problems who are experiencing stressful situations. Making an extra effort to assign the same staff members to an older person may help to prevent emotional distress. This is true both in the hospital and in the nursing home. A hospitalized person may be assigned nine different nurses during a 3-day stay. The sheer number of names to remember is difficult, but it is especially challenging for the older adult with emotional problems.

In addition to the "normal" stress of being admitted to a hospital or nursing home, the person with psychological problems has to deal with whatever illness caused his or her admission and the symptoms of his or her psychological illness. An example is a person who has hallucinations. Hallucinations are real to the person experiencing the event, and they add a tremendous level of confusion to the daily life of the person experiencing them. Hallucinations interfere with one's ability to accurately perceive information. Your instructions or even a greeting may be misinterpreted; medications may look like spiders; or walls and doorways may keep moving. The approach to such problems includes keeping the same caregiver with the person throughout his or her stay. The nurse will begin to understand the behaviors of the older adult and be able to work within the limitations of the mental illness of the person.

Reminiscence is an excellent tool to use to strengthen an older person's self-esteem.

It also helps when the older person's familiar belongings can be kept in the room. This promotes self-worth and helps to prevent disorientation. Small objects and pictures can be placed near the older person during a hospitalization to prevent the disorientation that can accompany stressful changes during an illness. Playing taped music of familiar songs generally is better than television viewing in preventing sensory overload. These are just a few examples of simple nursing interventions that can be used to prevent psychological problems caused by stress in older adults.

CRITICALLY EXAMINE THE FOLLOWING:

A 78-year-old woman, who is legally blind, attempts to hit a staff member when she is being returned to bed.

Possible Solutions:

1. Call resident by name.
2. Move close to her face and touch her if acceptable.
3. Match her voice tone and breathing while talking to her.

CRITICALLY EXAMINE THE FOLLOWING:

Mrs. C. starts yelling and shouting, "Call the police, call the police." while she is throwing items at her roommate.

Possible Solutions:

1. Maintain eye contact, speak in a calm voice, and call Mrs. C. by name.
2. Tell her to talk to you and ask, "Are you frightened of something?"
3. Have another employee remove the roommate to safety.

Violent Behavior

If older adults start to act violently, the nurse must remember to protect these persons from their own behavior at all times. The nurse needs to call for help and, as a member of a team, decide what the intervention should be. Do not raise your voice; stay calm. They are the basic rules for handling someone who is violent.

Some violent behavior can be life threatening. I remember the day I was on a psychiatric unit, and a former patient came to visit and brought a gun with him. He started shouting and shooting at random. That was an extreme act of violent behavior. Fortunately, he was a poor shot. But the absolute fear was overwhelming for the patients and almost so for the staff. The charge nurse began an interaction with the former patient, once he was through shooting, and the rest of us slowly gathered the other patients and took them to safety. There is no formula for what to do in every possible situation. Simply stay calm and safeguard the patients and yourself.

Sexual Acting Out

Acting out feelings of anxiety may take many forms. Sometimes older adults with dementia lose social controls and express sexual feelings openly. Some people, such as those in the early stages of Alzheimer's disease, have an increased desire for sexual activity. People with other types of psychological problems, such as bipolar affective disorder, demonstrate sexual feelings in ways that are not socially appropriate. Dealing with these behaviors is almost always difficult, no matter how experienced the nurse is. Always consider if the acting out is an expression of the need for affection and touch.

CRITICALLY EXAMINE THE FOLLOWING:

Mr. J. walks into the visitor's area, unzips his trousers, and begins to masturbate.

Possible Solutions:

1. Gently approach him and get his attention by moving in close and speaking to him. Say his name.
2. Quietly lead him to his room; make sure that he is safe and then give him privacy to do whatever he wishes sexually. Ask his roommate to go to the dayroom with you if necessary.
3. Give affection and attention when he is not sexually acting out.

Notice any factors that seem to trigger the behavior in order to intervene before the behavior occurs.

SPECIALIZED COMMUNICATING SKILLS

The hallmark of nursing care for persons with psychological problems is the ability to communicate effectively. In addition to the skills just described in this chapter, there are other communication skills that can be used to make it easier to talk to older people with psychological problems. Some standard communication skills and concepts from neurolinguistic programming (Bandler, 1985) and validation (Feil, 1993) are described in this section.

Neurolinguistic programming uses observation of a person's words and behaviors to help establish the best way of relating to that person. Validation, a communication approach for relating to disoriented older adults, helps disoriented persons express themselves. Sometimes communication with someone who is disoriented is blocked by the listener's need to have the disoriented person think or talk in a "logical" way. When the listener is able to put away the need to communicate in a normal way, there is the possibility of communicating in other, more effective ways. When this happens, the listener is able to understand and validate the disoriented person's experiences.

Preferred Sense Words

All people relate to their surroundings through their senses. Most people respond more through

TABLE 17.3. Commonly Used Preferred Sense Words

Visual	Auditory	Kinesthetic
See	Listen	Feel
View	Hear	Grasp
Picture	Sound	Move
Look	Loud	Touch

one sense than through others. How a person talks will give an idea of that person's preferred sense. If Mrs. J. says, "I see what you mean. Look at this," she probably is a person who responds best to sight or visual words. Some people respond best to hearing or auditory words, and others respond best to words about feelings or movement (kinesthetic words). A list of commonly used visual, auditory, and kinesthetic words is included in Table 17.3. The nurse can use the person's preferred sense to establish rapport. For example, if an older adult says, "No one listens to me anymore," a response like "What would you like for me to listen to, Mr. J.?" will receive a better response than "What would you like me to see, Mr. J.?"

Vague Pronouns

If a person is not able to fill in the details with enough facts to be understood, try using vague or ambiguous pronouns to help foster communication. Sometimes people refer to all women as "she" and all men as "he." If the nurse becomes too concerned about accurate details, the opportunity to communicate may be lost. Instead of worrying about the facts, such as who "he" or "she" is, try to focus on the feelings. If an older person says "She's all alone. She can't stay there," you can respond "You're worried about her. She's important to you." That type of sensitive response generally will elicit more communication.

Speaking Slowly

Many people who have emotional problems have slowed thought processes. When this problem is combined with normal aging changes, it is very important for the nurse to use slightly slower speech and wait a little longer for the person to respond. Asking questions one at a time, instead of running several questions together, can also make it easier to talk to an older person with an emotional problem.

Asking the Extreme

When someone who is disoriented is upset about something he or she thinks happened, ask questions about the extremes of the situation. What is the worst? What is the best? Imagine the opposite. When is it better? When does it not happen? Suppose every night an elderly woman thinks some men are coming to attack her. The nurse might ask, "When do they usually come? When are they not there? What helps you feel safe? What doesn't help you very much?" Often by looking at the extreme of a situation, the person will recognize what is happening in the "here and now."

GRIEVING AND DEPRESSION

Surviving losses is part of the aging process. An older person may lose relationships with people through death, retirement, or relocation, or he or she may lose the ability to maintain contacts with friends and family because of physical problems. An older adult also may suffer the loss of valued social roles, a home, financial security, vision, hearing, or other body functions. The grief process that occurs with the loss of a loved one is one of the most powerful losses a person can experience.

Dealing with Grief

It is helpful to keep in mind the stages of the grieving process—denial, anger, bargaining, depression, and acceptance—when dealing with losses (refer to Chapter 9). These stages do not always occur with every person. Some people who experience losses may become angry but not go through the other stages. As a nurse, it is important to accept each person's response to grief and not have a preconceived idea of how a person should respond.

An older adult can be helped to talk about grief by asking open-ended questions such as "What did you do at your former job? When did you start working there? How did you get started working there?" if the person is grieving over the loss of a job. Asking open-ended questions about feelings also can help another to express grief. Sometimes it can be uncomfortable to hear a person talk about negative emotions like anger and sadness. Encouraging someone to express feelings and allowing expressions of anger or crying can help that person deal with feelings effectively. Saying something like, "How did you feel about that?" or "What upset you the most

about that?" can encourage someone to talk about feelings. Telling someone who is sad and grieving "Don't cry now, it will be all right" only gives false reassurance and tells the person to keep such powerful emotions inside. If emotions are not expressed, they tend to be expressed later in dysfunctional ways such as extreme anger, agitation, or withdrawal.

Depression

Because depression is a part of grieving and loss, it is a serious problem among the elderly population. There may be other factors that contribute to depression as well. Most of the current theories about depression have a strong emphasis on neurobiological causes and take into account the fact that depression tends to run in families. Most researchers conclude that depression is linked to the amount of the neurotransmitters serotonin and norepinephrine present in the nerve synapses. Lower serotonin and norepinephrine levels seem to be associated with depression. Factors within the body can deplete these substances, but external factors such as stress or decreased exposure to light also can influence the amounts of neurotransmitters available to a person.

As health-care providers, nurses also know that regular exercise can help maintain a higher level of endorphins in a person's body. Endorphins are naturally produced morphine-like substances that help people feel better. If the ability to exercise is impaired, then the body and mind are affected, and depression may result. Getting exposure to sunlight also can affect some people by changing their mood. For the homebound elderly person, this may be a problem. A poor diet also may contribute to the development of depression. Many older people have poor nutritional intake due to a variety of psychological and physical factors such as poor denture fit, cost of nutritious foods, changes in taste sensations, and eating alone. When the effects of the losses of aging are combined with those from physical risk factors, it is clear why many elderly people are depressed. The good news is that most people who have depression can be helped by treatment. Medications that are used to treat depression are generally effective.

The tricyclic antidepressants were widely prescribed in the past and are still effective for many people. Major problems with using tricyclic agents are side effects related to the cardiovascular system and urinary retention. Many elderly persons have problems with heart disease and hypertension, and men may have prostatic hypertrophy. These problems can be contraindications for the use of tricyclic drugs. With the advent of serotonin-selective reuptake inhibitors (SSRIs) such as fluoxetine (Prozac), sertraline HCl (Zoloft), and paroxetine HCl (Paxil), safer treatment options are available for people who have depression and other physical problems. Another antidepressant used very effectively with many elderly people is bupropion (Wellbutrin). Wellbutrin must be monitored closely if there are any eating disturbances or if there is a concern over weight loss.

Medications are an important part of treating depression but are most successful when used in conjunction with other types of therapy. Individual therapy with a counselor educated to work with older adults can help the person develop coping skills for dealing with depression.

CRITICALLY EXAMINE THE FOLLOWING:

Mr. N. usually walks well, but since starting on an antidepressant, he has fallen three times in the past week.

Possible Solutions:

1. Check lying, sitting, and standing blood pressure.
2. If he has orthostatic hypotension, teach him to sit on the side of the bed for a few minutes before standing up slowly.
3. Talk to his physician to determine whether another drug could be used.

Depression and Confusion in the Elderly Patient

Assessing someone who is depressed is complicated by factors that occur as a result of normal aging. The previous chapter describes how to assess someone with depression and how to use standard measures of depression. Some of the behaviors seen in those with depression may be very similar to behaviors seen with other problems common in older people. Individuals who are depressed may not care about their surroundings and begin to be disoriented and confused as they draw inward. It can be very difficult to know whether the mental slowing and memory loss attributed to depression are actually caused by the depression or represent changes commonly found in the early stages of dementia. Many elderly people who have depression are thought to

have dementia and are not treated for their depression (see Table 17.4).

Depression and Suicide

Assessing for the risk of suicide is essential for someone who is depressed. The suicide rate among older adults is high. It may not seem likely that an older person would have thoughts about suicide, but it happens too frequently. If an older person says something like "I just don't want to live anymore," the tendency may be to discount the person and say "Oh, you don't mean that" or "You'll feel better tomorrow, you're just having a bad day." If a person expresses a wish to die, makes funeral plans, has a major change in life, or begins to give away cherished possessions, be aware that these can be signs that the person may be planning suicide.

Asking people whether they are having thoughts about killing themselves is not "putting the thought into their heads." Many people are relieved to talk to someone about suicide if asked in a calm, matter-of-fact manner. Finding out whether the person has a plan and what it is are essential pieces of information. If a homebound older adult describes a hoard of potassium supplements or cardiac medications that are readily available, and if the person's conversation indicates a plan to take the medication after the nurse leaves, that is a situation requiring immediate action. Persons who say they do not want to live but have not thought about how they would end their lives are at a much lower risk for an immediate suicide attempt than those who have a plan. Many incidents of so-called noncompliance with medications are actually intentional attempts to overdose. If an older adult is having thoughts about suicide, listen carefully, intervene immediately if necessary, and refer the person for treatment.

CRITICALLY EXAMINE THE FOLLOWING:

A 72-year-old man finds no meaning in life and feels sad, especially in the winter. He has recently been told he must take insulin for diabetes and cries when talking about it.

Possible Solutions:

1. Explore feelings by asking when his sadness started, when it is better, and when it is worse.
2. Plan ways to decrease isolation in winter, such as attending church and a senior lunch program when weather permits. Ensure telephone contact with support system when the weather is bad.
3. Refer to diabetes nurse educator and a diabetes support group.

Failure to Thrive

The term *failure to thrive* is most often applied to young children who do not grow and develop as expected. Some elders who are depressed also may have a failure to thrive or a giving-up complex. This may be the case when the older person no longer makes an effort to continue with life, for instance, by refusing to eat, refusing medications, or choosing to resist or refuse treatment for health problems. If there is not an intervention that involves the interdisciplinary team and the family, the older adult may well die in this situation.

DELIRIUM AND DEMENTIA

Because depression can cause some confusion and disorientation, it can be difficult to determine whether the older person has a problem with delirium, dementia, or depression (Table 17.4). Many factors influence a person's ability to think clearly.

Emotional stress and change can cause anyone to have difficulty remembering scheduled appointments or to be distracted easily from activities of daily living such as turning off the burner when cooking. Sometimes physical factors such as illness, insufficient oxygen, or high or low blood sugar levels may cause a person to behave in a very bizarre way. The person who has a problem with disorientation can be found in any setting. When a person becomes disoriented, the caregivers may become resigned to the problem and consider this to be a normal part of the aging process. That is not a correct assumption. Clarification of the differences between delirium and dementia can provide guidance for effective intervention in both situations.

Delirium

The psychological problem of delirium refers to a situation in which an older person has a fairly rapid change in behavior and thinking ability. Mental status changes that occur with this acute problem usually affect individuals' abilities to recall where they are, what day or time it is, or even what their own names are. Delirium may

TABLE 17.4. Differences Between Delirium, Dementia, and Depression

	Delirium	Dementia	Depression
Onset	Rapid	Slow	Rapid
Duration	Short	Long	Short or long
Night symptom	May worsen	Frequently worsen	Usually do not worsen
Cognitive functions	Variable	Stable	Variable
Physical causes	Common	None	Possible
Recent changes	Common	None or minimal	Common
Suicidal ideation	Rare	Rare	Common
Low self-esteem	Rare	Rare	Common
History of psychiatric symptoms	Not usually	Rare	Common
Mood	Labile	Labile	Depressed
Behavior	Labile	Labile	Slowed thought and motor processes

cause agitation or rapidly changing moods. Someone who is delirious commonly has an anxious facial expression. Short-term memory may or may not be intact. With delirium, the older adult pays little attention to surroundings or may respond slowly to new surroundings.

The person with delirium usually talks in a rambling way that does not make sense. The individual may have difficulty staying awake or have increased activity and be awake all the time.

CRITICALLY EXAMINE THE FOLLOWING:

A 75-year-old man who has just had surgery develops delirium, is agitated, and tries to pull out his nasogastric tube.

Possible Solutions:

1. Check for physical causes.
2. Ask a family member or a volunteer to sit with him to prevent removal of the tube.

An 82-year-old woman, who has just received meperidine, thinks the nurse who enters the room with a stethoscope is going to hang her with a rope.

Possible Solutions:

1. Stop meperidine use and notify the physician.
2. If possible, remove the stethoscope and return later when she is less agitated to take her apical pulse.
3. If she is not too agitated and is able to listen, speak to her in a quiet and caring way. Do all you can to help her overcome her agitation.

Sensory and perceptual disorders such as hallucinations and delusions may be present. such as the perception that the nurse holding a syringe has a knife or hearing a baby cry that is not there. Changes in thought content and process also may be present. Fixed ideas or beliefs may be evident, as well as disjointed or flighty thoughts.

Delirium can result from a variety of physiological causes and can be reversed. Malnutrition, electrolyte imbalance, infection, acid–base imbalance, change in blood sugar, hypoxia, drug reactions, dehydration, and head trauma are a few of the common causes of delirium. It is important to determine what is causing the delirium because the sooner the problem can be treated, the sooner the delirium will resolve.

When an older adult has a period of delirium, it can be very upsetting for the family and nursing staff. Explaining what is happening to all of those involved can help reduce stress and make it easier for everyone to handle the problem behaviors that occur.

Dementia

The symptom of dementia is usually defined as the loss of intellectual abilities to the extent that it interferes with normal activities of daily living. Dementia is characterized by problems with cognitive ability, personality changes, memory impairment, decreased intellectual functioning, and changed judgment and mood.

Dementia usually occurs gradually, over a period of months or years, and is the result of deterioration of the brain. This damage can be caused by neurological diseases such as Pick's or Huntington's disease or can be the result of vas-

cular problems such as multi-infarct dementia. Advanced AIDS also has an associated dementia. The most common type of dementia is associated with Alzheimer's disease (AD). It is estimated that in the future, dementia will outweigh heart disease and cancer as a major health problem. This estimate is based on the growing number of elderly people in our society and the strong correlation between aging and AD.

Because dementia is such a significant concern, new approaches to dealing with this problem are being examined. Validation therapy (VT) is a way of communicating with people who have dementia (Feil, 1993). Validation means respecting the feelings of the person and confirming that, from the individual's perspective, the experience is true.

This therapy is being used in many countries for people who are disoriented to decrease stress, to promote self-esteem and communication, to reduce chemical and physical restraint usage, and to make it possible to sustain independent living for a longer period of time.

A brief introduction to VT follows. More information on communication strategies is given later in this chapter. For those with a special interest in validation, additional information is available by doing a topic search on the Internet.

Stages of Disorientation

Naomi Feil (1993) has described four stages of disorientation that occur with people who are "old-old" (older than 80 years of age). These changes occur in people who have had fairly normal lives until they reach their 80s, when they begin to show signs of disorientation.

Malorientation. Malorientation is the first stage of disorientation. People who are maloriented may initially appear as if nothing is wrong with them. These people may be oriented as to where they are and who the president of the United States is but are beginning to forget information important for maintaining normal activities of daily living. They may try to cover up their memory loss by making up excuses. They do not like to be around people who are disoriented because they are threatened by their own memory loss. They deny their feelings and blame other people for their problems.

People who are maloriented respond best to open questions about facts, not feelings. It is important to hold on to acceptable social roles and rules for people who are maloriented. Encouraging someone who has been a teacher to lead the Pledge of Allegiance may be a way of helping maintain dignity and promote self-esteem. Often, the technique of using commonly preferred sense words assists this person to relate to the caregiver. It is best to listen to the maloriented person until you identify what the person's preferred sense is, and then address the person with words that represent that sense. For example, someone who often says "Oh, yes, I see what you mean" probably is a visual person and may respond to visual words better than to other choices (see Table 17.3).

Time Confusion. As people become more disoriented, they withdraw more from the real world and retreat into their own inner world. During this stage, people lose a sense of real time and respond to an inner sense of time. Someone may think about the mother (who is dead) and, because past time has fused with present time, talk about her as if she was present.

Because the nurse feels a need to orient the time-confused person, he or she might say something like "Your mother is dead; you can't go to see her." This only agitates and distresses the individual, who has no real need to stay in a painful present reality. Using the validation approach, the nurse would move close, use touch, and say "You miss your mother. What color eyes did she have? Blue or brown?" This is an effort to stimulate pleasant thoughts and memories for the person. There are several different methods of touching a person with dementia that are designed to evoke feelings about a loved one. Refer to Table 17.1 to review common forms of touch.

Repetitive Motion. If people with dementia continue to retreat from present reality, they may enter the stage of repetitive motion. During this stage, movements or sounds are repeated constantly. Usually, speech is limited to single-syllable words, and eye contact is made only after someone touches and talks to the person. The use of touch with these people is very important. Individuals with repetitive motions are often ignored emotionally, with caregivers providing physical care only. Validation techniques of sustained eye contact, stroking, and touching can help reach people in this stage of disorientation and prevent the final stage, which is that of vegetation. When persons are in the repetitive motion stage, they often communicate through universal symbols. These people use objects to represent thoughts. A common example is carefully folding and holding or caressing a napkin, which could represent a baby. Other examples are given in Table 17.2.

FOCUSED LEARNING CHART

Stages of disorientation in persons with dementia

Malorientation	Time Confusion	Repetitive Motion	Vegetation
1st Stage	2nd Stage	3rd Stage	4th Stage
Appear normal	Ambulatory, but confused	Generally non-ambulatory	Bedridden
Forgetful regarding day-to-day information	Withdrawn from real world and retreat to own inner world	Retreat from present reality	Vegetative state
Make excuses to cover up memory loss	Respond to inner sense of time (childhood, newly married)	Use objects to represent thoughts; make sounds, not words, or just single-syllable words	No words or eye contact and very little movement
Ask open questions about facts, not feelings; use commonly preferred sense words (Table 17.3)		Use touch (Table 17.1) and universal symbols (Table 17.2)	Use touch and familiar music to comfort

Vegetation. The final stage of disorientation and withdrawal is vegetation. In this stage, very little movement or sound is noted. Eye contact is very rare. Using touch and familiar music can help reach a person in this stage.

Alzheimer's Disease

The most common type of dementia is AD. The disease was first described in 1906 by a neurologist, who observed neurofibrillary tangles in an autopsy of the brain. Although there have been many advances regarding AD over the years, the only way to conclusively diagnose AD is at autopsy. This means that AD is usually diagnosed by first ruling out any other causes of delirium or dementia. When symptoms of dementia are present and no other organic disease causing behavioral and mental changes can be found, a diagnosis of AD can be made.

AD is commonly found in persons older than 80 years of age but can be found in persons as young as 30 years of age. Recent research findings indicate a strong correlation for increased incidence of AD as people age. There also seems to be a significant correlation between both Down's syndrome and head trauma in relation to AD.

At least half a dozen drugs are being investigated for use in the management of dementia. At present, the medication tacrine (Cognex) is being used with mixed success in the treatment of mild-to-moderate AD. Because of the effects of this drug on the liver, it is necessary to make frequent checks of liver enzymes.

PARANOIA

Some people with emotional problems fear that other people are trying to hurt them. Such paranoid ideas are an indication of problems the person may have with trusting others. This can occur with dementia, schizophrenia, or other psycho-

CRITICALLY EXAMINE THE FOLLOWING:

A 70-year-old man thinks that the nurses are poisoning him.

Possible Solutions:

1. Ask him if he feels this way all the time, or whether there are times when it is worse than others.
2. Ask him what would have to happen for him to feel safe eating the food here.
3. If necessary, bring in food from home or have the person open canned food for himself.

logical problems. Many times, people who are paranoid seem very convincing and logical. Developing trust is the most important thing to accomplish with someone who is paranoid. This can be best done by being consistent and reliable in all you do with the person. Do not make promises you cannot keep. If you say you will do something, following up with the paranoid person is especially important. It is particularly important to avoid putting medicines in food or drink without the paranoid person's knowledge.

DEVELOPMENTAL DISABILITIES

Historically, people who had developmental disabilities did not live to an old age. With advances in health care, more individuals who have developmental disabilities, such as Down's syndrome, are living longer. There is evidence that as individuals with Down's syndrome grow older, they are at high risk of developing AD.

Individuals with developmental disabilities may have some of the problem behaviors that have been identified in this chapter. Principles for setting limits on behavior include the following:

- Recognize the person's feelings and encourage expression of them.
- State the limit clearly.
- Point out ways that behavior can be expressed within the limits and what is outside the limits.
- Allow the person to express anger at having limits placed on him or her.

SUBSTANCE ABUSE

Staff working with people who have chemical dependency problems recognize that there are a growing number of older adults with substance abuse problems. Because many older people are treated for a wide variety of physical problems, sometimes they receive prescription drugs from several different sources. The availability of prescription drugs contributes to the problem of drug abuse among older persons.

Alcoholism is another problem for many elders. Many of the same reasons people use substances to self-medicate (depression, losses, loneliness) in other stages of life are even more of a problem for the elderly population. Because many of the memory lapses found with substance abuse are similar to those in the early stages of dementia, substance abuse may not be discovered until it is advanced. Sometimes, families have difficulty confronting older family members about substance abuse problems. The denial of a problem, which is characteristic of most substance abuse problems, is especially difficult to deal with when working with older adults. This then creates a problem with the treatment process. If a substance abuse problem is suspected, it is best to contact trained professionals to assist with interventions.

EATING DISORDERS

Often, the reason for seeking health care is a problem with eating. Problems with eating can be due to physical factors, such as loss of taste sensation or poor denture fit, but many times, eating difficulties are due to psychological problems. Anorexia can be a symptom of a psychological problem, such as depression, or it can be a problem in itself.

Compulsive resistance to eating or anorexia historically has been most commonly found in young women. More and more clinicians are now describing similar symptoms in the elderly popu-

CRITICALLY EXAMINE THE FOLLOWING:

A 67-year-old resident is throwing food at his roommate.

Possible Solutions:

1. Explain to him that throwing food exceeds the limits set for personal behavior.
2. Tell him that it is okay to be angry but that it is not okay for him to throw food.
3. Tell him that if he is angry he can tell someone.

lation. Eating or not eating can be used as a way of exhibiting controlling or resisting behaviors, especially in stressful situations. Compulsive overeating also can occur in the elderly population, as can the bingeing and purging found in bulimia. Some elderly patients with psychological problems have phobias related to certain foods. Others may become paranoid about food that they believed to be poisoned or contaminated.

Regardless of the specific problem, treating someone who has an eating disorder may require tremendous amounts of creativity. Sometimes, the only effective treatment is using a feeding tube until adequate weight gain is achieved. Behavior modification techniques, such as giving privileges for weight gain and withdrawing privileges for weight loss, may need to be planned by the health-care team or a psychiatric nurse specialist.

GROUPS FOR THE ELDERLY

Many older adults with psychological problems can benefit from group interactions. Discussed below are some types of group therapy that have been used successfully with older persons.

Reminiscence

Based on memories of similar events or experiences, many older adults form bonds in groups. Stimulating memories of childhood or early adulthood can serve to improve feelings of self-worth and provide an opportunity to review their lives. Memories may stimulate laughter and happiness or other emotions and serve as a way of coping with present circumstances. Groups can be conducted around an important event, such as Pearl Harbor Day. Common, shared experiences, such as early school days, can be recalled to promote socialization and provide mental stimulation. Reminiscence also can be used individually as a means of helping people process any unfinished business in their lives.

A very structured form of reminiscence is the life review process. This process provides an opportunity for evaluation and integration of life experiences. People in the more advanced stages of disorientation are not able to benefit from this type of therapy.

Remotivation

To improve interest in and quality of life, remotivation techniques can be used. The emphasis with remotivation is the use of real objects to stimulate senses and provide new motivation in life and the surrounding world. Pictures, plants, animals, or sounds can be used to encourage group interaction. Holidays, birthdays, or hobbies can be used to focus on remotivation for participating in the here and now. The focus is on factual information as opposed to exploration of feelings. These groups work best with those who have depression or early stages of disorientation.

Resocialization

Encouraging residents to assume social roles can stimulate feelings of increased self-esteem. The focus for this group is on social roles and not on problem solving. Discussion may occur about previous social gatherings and how people behaved during these events. The emphasis is on the present and discussion of factual information.

Many older adults with psychological problems can benefit from group interactions. Group members are assigned roles, such as the greeter, or to serve each other refreshments. Feelings are not the focus of resocialization groups, which can be helpful for the mildly disoriented.

Reality Orientation

Helping residents become oriented to present reality is the goal of reality orientation. Constant reminders about the present, that is, where they are and what day it is, are given. Current events on the television or in the newspaper can be used as topics to stimulate discussions. The season of the year, holidays, and the weather are other topics to promote orientation to reality. These groups are focused on keeping people oriented to present reality and are not usually very effective with people who have more than mild disorientation.

Validation

Validation groups combine some of the other types of techniques with group problem solving and a focus on support. Members are assigned roles, sing familiar songs, serve each other refreshments, and reminisce about the past. Movement is encouraged during group activities. The group is presented with a problem to solve. Resolving losses and expressing feelings are emphasized. Validation groups are most effective for people who have moderate disorientation.

This group of older adults is being led in a resocialization group. Many older adults with psychological problems will benefit from group interaction.

PSYCHOTROPIC MEDICATIONS

As with all medications, adaptation is necessary when using psychotropic medications with an older adult. Teaching the older person and his or her family about the reason for the medication, side effects, toxic effects, and what to do if a dose is missed are very important when psychotropic drugs are used.

Many psychotropic drugs require a period of time—sometimes several weeks—before a therapeutic effect is achieved. This waiting period may be longer for some older people. They may show more signs of toxicity at lower doses than usual because an impaired ability to excrete the drug results in a buildup in the bloodstream. Another possibility is that they may be more difficult to treat, because there are side effects due to the difference in distribution and excretion of drugs in the aging body.

Psychotropic medications work in the brain in a variety of ways. Most medications work by helping to change the level of neurotransmitters or chemicals in the brain. It is hoped that re-establishing a more normal balance will help the person have fewer psychological problems. Because these drugs work on the brain, it is important to use them only for psychological problems and not just because the resident has behaviors that irritate other people. Before any drugs are used to sedate a person with problem behaviors, all other types of nursing interventions must be used along with documentation of the interventions.

Because of physical health problems, some medications used to treat mental health problems may be contraindicated or may require careful administration in the older person. For example, an elderly man who has prostate disease may, if given a tricyclic antidepressant, have extreme difficulty voiding.

A common side effect of many psychotropic drugs is constipation. When combined with normal aging changes, the constipation resulting from psychotropic medications can become a troublesome problem for the elderly person.

Orthostatic hypotension is a problem that results from many psychotropic drugs. Simple teaching techniques can help manage some of the postural blood pressure changes; however, many times these changes are severe enough to require that the medication be discontinued.

PHYSICAL AND MENTAL HEALTH

Because there is such a strong relationship between physical and mental health, many professionals believe that all diseases have both physical and emotional aspects. Some older people grew up in a time when it was frowned on to admit that mental illness existed, but it was more socially acceptable to have a physical problem. One grandmother described a time early in her marriage when she became so upset with her husband that she became "sick" and took to her bed for a week.

This expression of emotional problems through physical complaints is called somatization. Many times, if a stressful situation is encountered, the person who uses somatization may develop a backache, headache, or stomachache to avoid dealing with problems. This does not mean the ache is "all in the head," but it may mean the person finds it easier or more acceptable to have a physical pain than an emotional one. For someone who has done this for 80 or 90 years of life, it may be difficult, if not impossible, to change their way of coping. The nurse can help the patient learn to meet needs more directly by encouraging the person to talk about feelings openly.

PATIENT RIGHTS AND LEGAL RESPONSIBILITIES

The current standard of care in nursing homes and in mental health centers is that the older person has the right to the least restrictive form of treatment. Federal and state regulating agencies such as the Health Care Financing Administration (HCFA) have specific regulations protecting these rights. In most states, treatment can be administered involuntarily only if a danger exists to the individual or to others. The length of time allowed for this type of treatment varies from state to state but is usually only a few days. If a longer treatment schedule is required and the older person is unwilling to consent, then an application for guardianship may be made. This takes away the person's rights to make personal decisions and assigns those rights to a guardian. This is a procedure that may be necessary for people with some types of mental illness, including dementia.

When agitated behaviors become severe, the nurse has to make a decision about how to handle the problem. Points that must be considered are the patient's right to the least-restrictive treatment environment and the legal issues related to the use of chemical and physical restraints. If an older adult has an episode in which increased symptoms of bipolar affective disorder or schizophrenia are exhibited, an antipsychotic drug is likely to be more effective than for someone with dementia or delirium. Before giving a chemical restraint, it is necessary to try talking to the person as well as using behavioral interventions. When all else fails, physical restraints may be necessary on rare occasions. If using physical restraints, remember the safety precautions:

1. Use the least-restrictive device.
2. Check on the person often.
3. Remove the restraints every 2 hours for a brief period of time.

CONCLUSION

The care of elderly people in all arenas of nursing is an opportunity to practice the art of nursing on its highest level. The skills and understanding that are needed to give meaningful care to the elderly patient with psychological problems are complex and require a personal and professional commitment to the needs of people as they age.

CASE STUDY

Mr. A. is an 80-year-old retired farmer. He lived with his wife on the farm until 1 year ago, when he became too ill for his wife to manage his care alone. At that time, he became a resident of a nursing home in a nearby town. He has been forgetful for several years and now wanders the halls looking for his pickup truck. During the winter, he walked away from the nursing home and wandered for several hours. This resulted in frostbite on several fingers and toes. He becomes agitated when he is told that he cannot go back to his home. What actions can be taken to assist Mr. A.?

Solution

Working with the entire nursing staff, a plan is developed for using validation therapy with Mr. A. When he asks about his truck or home, the staff ask him questions such as, "What color is your truck?"; "What did you do with your truck?"; "Where did you go?"; "With whom?" Coveralls with a front pocket are obtained, and a small hammer and screwdriver are placed in his pocket. His toolbox is brought into his room. The staff have put him in charge of a small garden outside the nursing home. Individual sessions of validation are scheduled 20 minutes a day, three times a week, by the activities staff.

Over a 6-week period, the staff notices that Mr. A. spends quiet, productive time in the garden area. He carries his toolbox with him most of the time but does not use its contents. He no longer leaves the building except to work in his garden. He is still forgetful.

STUDY QUESTIONS

Select the best answer to each question.

1. The best intervention for an elderly resident of a nursing home who suffers from paranoia is:

a. To encourage him to lead a large group singing

b. To plan one-on-one activities with staff and other residents

c. To invite the resident to sit on the residents' council of the nursing home

d. To have the resident join a weekly bingo group

2. An elderly homebound person taking medication for a psychological problem needs to know which of the following?

a. If dizziness occurs, notify the nurse.

b. It may take several weeks to get the desired effect.

c. Report any changes in vision.

d. All of the above.

3. Validation techniques are best described as:

a. A way of helping someone resolve past experiences

b. Helping someone find new meaning in growing older

c. A reminder of a painful present reality

d. Bringing someone from the past into the present world

4. When a hospitalized older adult suddenly becomes disoriented, the best intervention is which of the following?

a. Ignore the person's feelings because they are a normal part of aging.

b. Tell the person to cheer up because things are not so bad.

c. Do not allow the person to talk about being sad because that makes it worse.

d. Encourage the person to discuss feelings openly because it helps to talk about problems.

5. When teaching older adults or their families about the use of psychotropic drugs, one of the most important concepts to teach is:

a. The meaning of the different colors of the medications

b. The stress psychotropic drugs put on the kidneys

c. To anticipate the chronic light-headedness that most people experience

d. Not to expect the full effect of the drug for several weeks

18 Rehabilitation and Restorative Care

Kathleen R. Culliton

Learning Objectives

After completing this chapter, the student will be able to:

1. Define rehabilitation and restorative nursing in a holistic framework.
2. Identify the clinical implications of restorative care in walking programs, continence training, and feeding and self-help programs.

INTRODUCTION

Nurses strive to promote the health of older adults. Generally, nursing care involves assisting older persons in overcoming the symptoms of an acute health problem or the worsening of a chronic condition. Nurses use medications, treatments, and referrals to help the individual overcome physical, psychological, social, and spiritual illness. In the acute-care setting, nurses assist older adults through the crisis of illness and discharge them back into the community to their homes or a supportive living environment. The goal of nursing care is to assist older adults back to the highest level of health possible and to allow them to live in their homes or whatever environment will provide them with optimal safety. Assessment of their general health and ability to meet their personal needs are considerations during the discharge process. There are times when older adults are no longer physically or emotionally able to safely return to their homes. You, as the licensed practical nurse, play a significant role for institutionalized older adults who need restorative care.

The purpose of this chapter is to present an overview of gerontological nursing concepts based on rehabilitative and restorative care. Both rehabilitative and restorative nursing care surpass the traditional custodial approach that has prevailed in the care of older adults before the initiation of the 1990 Omnibus Budget Reconciliation Act (OBRA) regulations. Data collection for residents in nursing homes is done on the minimum data set (MDS) (see Chapter 3) and emphasizes restorative care of older adults as a major priority of care.

Demographically, America is graying. Along with the aging process comes increased disability for many older persons. It has been statistically projected that 40% of all disabled persons in America presently are 65 years old or older. As the aging population increases, nurses are called on to provide rehabilitative and restorative care to more and more older people as they enter health-care facilities.

PRIORITY SETTING 18.1

When dealing with rehabilitation and restorative care, there are three basic priorities for you to follow:

1. Get to know the person admitted to the unit and the person's family and significant others. To make the rehabilitation and restorative program meaningful for the person receiving treatment, you need to know that person's personal goals and dreams. Because people are not brought to a rehabilitation and restorative care unit in a life-and-death crisis, you have time to fulfill this priority. Take the time to identify the person's goals and share them with the rest of the IDT team.
2. Use your knowledge and skills as a nurse to prevent disabling consequences (i.e., foot drop, contractures, pressure ulcers, depression) while carrying out the rehabilitative and restorative programs.
3. It is assumed that you will carefully follow all physicians' orders. The third priority goes beyond doing what is legally and morally required of you, such as following orders. It is to support the people in your care as they go through the challenges of a rehabilitative and/or restoration program. It is difficult and demanding. Your support can make a significant difference in the outcome for each individual.

UNDERSTANDING REHABILITATION AND RESTORATIVE CONCEPTS

Rehabilitation is the process of teaching and training individuals to achieve their highest level of independent function. People are most familiar with rehabilitation programs for spinal cord injuries. For older adults, the rehabilitation often is for treatment of a cerebral vascular accident (CVA, or stroke) or deformity from arthritis and the surgery that often accompanies severe arthritis. Rehabilitative care is a multidisciplinary care model. Physical therapists, occupational therapists, speech therapists, dieticians, respiratory therapists, recreation therapists, social workers, psychologists, nurses, and rehabilitation physicians are members of rehabilitation care teams.

Rehabilitation is initiated after an extensive assessment of an individual's physical, emotional, spiritual, and functional assets and liabilities. Assessment information is reviewed, along with the resources available to assist the individual to develop a rehabilitative plan. Often, an individual does not need all available services. Then the

team is restructured to include the necessary health-care team members. This team works with individuals and their families to develop rehabilitative goals and to decide the best way to work toward the goals.

Selecting a short-term or long-term living environment is one of the first choices that a rehabilitation team must make. Every care environment has the potential to be a place for rehabilitation. The limiting factors often are not enough family support, environmental safety, insurance reimbursement, and access to the rehabilitation team. An older adult with a total hip replacement may want to go home, but home has an upstairs bathroom and there is no one available to prepare meals. These factors present a problem. A young man may be recovering well from knee surgery and want to have intensive inpatient therapy, but his insurance company does not approve the cost. An elderly woman may want to go to her rural community hospital for rehabilitation after a stroke, but the services that she needs are not available in that community. The rehabilitation team works to help the person access support services and find the most appropriate environment for the rehabilitation process.

Restorative nursing care is related to rehabilitation. It has the same goal—to assist older people with reaching their highest functional ability. The major difference is the intense involvement of the whole health-care team. Because of the direct involvement of therapies and other health-care professionals, rehabilitation is an expensive service. Restorative care is initiated after an older person has reached the rehabilitative goal or has not demonstrated any further improvement. The whole health-care team is involved in designing restorative care plans but is not directly involved in the implementation. For example, an older person who is in a rehabilitation program after a stroke would have the benefit of a physical therapist to learn exercise, safe walking, and transferring techniques. The older adult continues to need assistance with exercises and walking, but a nurse or a nursing assistant encourages the person to do as much as possible independently and assists him or her only if necessary.

Rehabilitation provides individuals with intensive short-term strengthening and retraining, whereas restorative care continues the process over time. It is unfortunate when older adults have a major health crisis and go through intensive therapy and training only to move to an environment where everything is done for them and the benefits of the therapy are lost. Examples of restorative programs are ambulation, personal care, feeding, and toileting. The challenge for the nursing team is to continue to promote high levels of independent function. It is faster to transfer a person into a wheelchair and push the person to the dining room for breakfast, but that is not promoting independence.

Unfortunately, this same concept of needing to hurry is associated with high incidences of incontinence. It is often perceived as faster to change an older adult's briefs and bedclothes than to anticipate the need for voiding and walking the person to the bathroom. With rehabilitative and restorative nursing care, "faster" is not the goal.

The same principle applies to eating and personal care. Have you ever watched someone struggle to put a shirt on a paralyzed arm? Watching that struggle is uncomfortable because nurses know they could help that person get the shirt on faster and without as much stress and strain. It is very difficult to watch someone try to eat independently and to see the stress and frustration that can occur. Yet that older person deserves the right to feel the satisfaction of accomplishing a task or meeting a personal goal.

The concepts of rehabilitation and restorative care are critical to promoting an older adult's optimal level of function. The focus of rehabilitative and restorative care is to maximize the abilities and functions of older adults to ensure the highest level of independence and quality of life. Rehabilitation and restorative care are not isolated treatments with limited application. They embody a broad set of principles to incorporate into every facet of nursing care in all settings.

Within the context of the interdisciplinary team (IDT) effort and after clinical conferences with the team to determine what plan is to be designed, licensed practical nurses, working cooperatively with the registered nurse (RN), prepare the goals and the nursing-care plan. In this capacity, the nurse's role becomes one of practitioner, educator, counselor, case manager, researcher, and consultant.

NURSING ROLES

Bedside Caregiver

As caregivers, LPNs provide direct care to older adults until the skills necessary for self-care have

been developed by the individual. Nurses need to give older adults positive reinforcement, encouragement, hope, and an opportunity to develop and use both their physical and social skills.

Educator

When serving in the role of educator, nurses provide older people and their families with information related to the disability and its treatment and management. Included in the education plan should be health measures to obtain and retain function and to prevent further disability. The nurse must realize that effective outcomes are more likely to occur when older adults and their families are included in the process of determining the goals of rehabilitation and restoration of function and treatment. It is important for older adults and the family or other caregivers to recognize that they are responsible for the decisions made and actions that result from those decisions. That is a predominant principle of rehabilitative and restorative care.

Counselor

As counselors, nurses assist elderly people with describing, analyzing, and responding to the current situation that makes rehabilitation or restorative care necessary. Counseling is the process of helping people solve and effectively cope with their problems. Counseling disabled people and their families is an ongoing process that requires supportive behaviors from the entire IDT. LPNs, after establishing trust and rapport with the older adult and the family, need to focus on assisting them in dealing with their grief over the losses imposed by the older person's current disability. The opportunity to express personal feelings assists the elderly person in developing coping skills related to the event of trauma that made rehabilitation and restoration therapy necessary. The LPN should counsel disabled elderly persons and their families to respond to the feelings of loss, frustration, and anger that they generally feel. It is important to express and deal with such feelings as a family.

Advocate

When assuming the role of advocate, LPNs use their influence and power as health professionals to bring about necessary changes for both the older person and the family's well-being. That allows the rehabilitation and restorative care to have maximum effect. Such interventions aid the older adult and the family members in obtaining necessary community-based services. Such services assist in maintaining older disabled adults as fully functioning, independent individuals within the constraints of the limitations imposed by the disability. Such interventions may include the use of assistive or adaptive devices like crutches, a walker, a plate guard, and a padded spoon.

Case Manager

Generally, an RN is the case manager for disabled persons. However, in some situations, the LPN is asked to serve in that role. The case manager role places the nurse as a central figure working with the total health-care team throughout the entire episode of illness. The major focus for a case manager is to resolve actual problems and prevent potential problems for the aging person. The treatment plan, once agreed on by the IDT, is under the supervision of the licensed nurses (RNs and LPNs) working in conjunction with each older adult and family. Once the plan is agreed on, a contract is entered into by the individual, family members, and the nurse so that the plan can be implemented with clear communication with each person involved. This management may take place in a hospital or nursing home and continue into the community where home-based care is provided.

Researcher

Many LPNs work in conjunction with RNs and a qualified nurse researcher to gather data on the rehabilitation and restorative care of older adults. Many questions remain unanswered regarding rehabilitative and restorative care of older adults in a number of areas. Each area provides a rich

POINT OF INTEREST

Refer back to the chapter on end-of-life issues (Chapter 9). Review Kubler-Ross's five stages of grief again. The older adult and the family will be going through these stages because of the loss that has brought them to the IDT for rehabilitation and restorative care.

arena for research. Some of the research interests are given in the following list:

- The management of behavioral symptoms
- Feelings about placing disabled family members outside the home and into an institution for care on a permanent basis
- Barriers that prevent the use of respite and day-care services
- Accurate measures of caregiver burden
- Effective coping strategies used by caregivers
- Types of educational and support programs needed to assist caregivers
- Services needed to individualize care at different stages of an illness or injury

All of these clinical questions need to be raised when older individuals suffer a traumatic episode and require nursing care. The nurse is responsible for raising questions regarding the specific needs of older individuals and seeking systematic answers through research. A research approach helps build a body of knowledge regarding rehabilitation and restorative care.

GOALS OF REHABILITATION AND RESTORATIVE CARE

A goal is defined as a written statement of desired behavioral outcomes from which steps or strategies may be designed to achieve that desired end. Goals provide direction. They are the measuring tool for an effective plan of care. For example, "I will buy a car today" is a statement of the desired outcome. A defined series of steps needs to be taken before the accomplishment of that goal. Some of the steps are establishing a means to pay for the car, deciding what type of car to buy, finding out the selling price of cars at various car dealers, checking on insurance, and buying the car.

From the time of injury or disability, the efforts of all health-care professionals involved in the older adult's care are to be focused on the ultimate goal: the highest level of personal independence possible within the limitations imposed by the injury. In setting goals, LPNs assess the older person to determine what assets of mind, body, and spirit are present that will aid in the accomplishment of the goal. For instance, can the person ambulate sufficiently to make trips to the bathroom, dining room, and physical therapy department? The LPN might ask a number of questions:

- Is the person able to communicate needs verbally?
- Can the person feed himself or herself?
- What are the goals of the older adult?

The information derived from the assessment is important in determining realistic and achievable goals for each individual. For lifelong quality of living, the components of a successful rehabilitation and restorative program must include the following goals, which should be individualized toward increasing the function and performance of the individual. These goals are:

- Independence and self-care
- Mobility
- Involvement in activities—social, civic, family, church, and recreation
- Fulfillment of life's goals
- Holistic approach to living with a disability

You must be knowledgeable in evaluating the current holistic status of the older adult. For older adults, major changes in three areas are critical to the success of a rehabilitation and restorative care program. Changes must be noted in physical, functional, and psychological status. Each of these areas can greatly affect the ability of the older adult to carry out the goals identified in the plan of care.

Physical Changes Affecting Restorative Care

A number of physical changes may be present when an older adult sustains an injury or trauma necessitating rehabilitation. Existing health problems must be considered in planning rehabilitative and restorative care:

- Musculoskeletal changes due to old fractures, osteoporosis, arthritis, osteoarthritis, muscular dystrophy, or loss of strength in arms and legs

POINT OF INTEREST

When LPNs are asked to be involved in research, they are asked to gather data for the principal investigator (PI). This is an opportunity you should take. You will learn from the PI, will be able to spend time with older adults while gathering data, and will have pride in the finished research project.

FOCUSED LEARNING CHART

Holistic functional assessment

Psychological	Physiological	Sociological
Memory	ADLs	Interaction with others
Judgment	IADLs	Family support
Thinking ability	Current health status	Involvement in the community

can create mobility difficulties. Such situations can occur because of muscle atrophy, decreased bone mass, loss of subcutaneous fat, and decreased flexibility of the joints and limbs.

- Cardiovascular changes due to diminished cardiac output, irregular heart rate, and increased blood pressure readings can result in diminished circulation that does not bring sufficient oxygen to the body. Such conditions often cause a lack of activity because of fatigue. Cardiac changes may be the result of thickening of heart valves, thickening of blood vessels, or delayed response to stress.
- Respiratory changes related to diminished respiratory rates can create ventilation challenges for the older person and may be caused by long-standing asthma, obstructive lung disease, emphysema, tuberculosis, upper respiratory illnesses, limited rib cage expansion, atrophy of respiratory muscles, decreased arterial oxygen tension, decreased vital capacity, and diminished cough.
- Renal and digestive tract changes create elimination difficulties that may impair the proper implementation of a restorative program. These changes may include decreased peristalsis of the intestinal tract that results in constipation or diarrhea, decreased intestinal enzyme levels that reduce the ability to properly digest foods, diminished glomerular filtration in the kidney, and decreased bladder capacity resulting in incontinence or retention of residual urine. The latter may create edematous lower limbs that make it difficult for the older person to ambulate in a comfortable manner.
- Consciousness and mental status changes may result in short-term memory loss, slower thought processing, and decreased pain threshold.
- Perceptual changes may be demonstrated by loss of visual acuity, diminished hearing, decreased sense of taste, lower sensitivity to touch, and decreased proprioception (spatial sensitivity or awareness of where things are in the available space).

Functional Changes Affecting Rehabilitative and Restorative Care

Changes in function in older adults may result from the impact of social and environmental situations. These changes can include the following:

- Inability to negotiate stairs in the home
- Functional implications of acute or chronic disease processes
- Physical factors such as limited range of motion, strength, and endurance
- Inability to consume sufficient nutrients to maintain optimum health
- Inability to cook food, clean a home, or complete the laundry and other critical chores

These functional changes need to be assessed by a nurse so that the realistic goals can be established.

Psychological Changes Affecting Rehabilitative and Restorative Care

The psychological status of an older adult is a critical component of any rehabilitation and restorative care program. When the older person

enjoys psychological well-being, there is a strong motivation to work toward the highest possible level of function. When older people feel needed and wanted by family, friends, and associates, they generally possess self-esteem and a positive self-image: two critical factors in developing a high degree of motivation to proceed with the restorative care program.

DEVELOPING GOALS FOR REHABILITATIVE AND RESTORATIVE CARE

When developing goals for rehabilitative and restorative care, LPNs need to complete a full nursing assessment under the guidance of a registered nurse. The nursing assessment should include a database with the following elements:

- Nursing history that includes the older adult's past medical conditions, psychological impairments, hospitalizations, and previous injuries (see Chapter 14)
- Physical assessment of all bodily systems (see Chapter 14)
- Functional assessment to check for functional ability and mobility (see Chapter 14)
- Mental status and psychological parameters that may be present; for example, depression or anxiety (see Chapter 16)
- A spiritual assessment to determine any spiritual needs or deficits that may be a deterrent to good rehabilitation progress

Following the assessment, the LPN and RN work together as a team to analyze the data and prioritize rehabilitative and restorative goals for the older person. The following principles of holistic nursing care should be the guidelines for identifying such goals:

- When the older adult enters the hospital or nursing facility, rehabilitation must begin immediately.
- Proper body alignment is to be maintained at all times.
- Pressure ulcers are to be prevented on all body parts.
- Rehabilitation is to be implemented concurrently with the illness, whether chronic or acute, temporary or permanent, or disabling or nondisabling.
- All joints must be kept free through proper exercise/range of motion.
- Convalescence is a gradual process and may extend over a considerable period of time for the older person.
- Nurses must understand the person's self-concept and feelings of dependency and isolation, if they exist.
- The time period for rehabilitation depends on the person's psychological acceptance of the condition as well as his or her physical condition.
- People born with disabilities usually have less difficulty accepting their condition than those who acquire disabilities later in life.
- More severe emotional reactions are produced when accidents are traumatic.
- Loss and its meaning vary with every person.
- Any personality problems that may be exhibited are generally the result of the person's personality characteristics before disability.
- The usual initial reactions to physical injury are shock, fear, disbelief, and anxiety.
- Periods of grief are produced when loss of any physical ability is experienced.
- Depression, anger, and denial may be present.
- Values are examined and limitations put in perspective over time.
- Time is essential for acceptance.
- The family needs emotional support and comfort during the acute phase of the trauma or illness.
- All information possible should be given to the family and older adult, including information about resources for rehabilitation services and economic assistance.
- The nurse or social worker should be familiar with community agencies that can help.

IMPLEMENTATION OF GOALS IN REHABILITATIVE AND RESTORATIVE CARE

Goal 1: Maintenance of Joint Function

The implementation of planned care for older people requires that a holistic approach be adopted. The major concern in implementing care is the prevention of deformities through passive exercises that keep joints movable, promote venous return and lymphatic flow, and help prevent excessive demineralization of bones. This goal and care are dependent on the physician's orders that identify the extent of the exercise program to be implemented. By means of a thorough assessment of the physical condition of the older adult and the specific illness and prognosis for

CRITICALLY EXAMINE THE FOLLOWING:

You are working with the RN to do a holistic assessment on an 80-year-old car/pedestrian victim. Sister Agnes, a Catholic nun, was walking to prayers when she was hit by a speeding car. She has multiple fractures that will keep her in bed for days. She is in pain, and the RN is working to resolve her discomfort. The RN asked you to do a spiritual assessment on Sister Agnes. How will you proceed?

Spirituality discussions make some people uncomfortable. If that is true for you, please work on your skills in this area to overcome such feelings. When considering this discussion with Sister Agnes, you already know two significant things about her that will influence your interview. First, because she is a nun, you can feel reassured that she is a spiritual person and will welcome the discussion. The second thing you know is counterproductive to the first. She is in pain and will not feel like having a lengthy discussion. What two questions could you ask her that would give you the basic information you need without causing her undue distress because of the pain?

I do not generally give the answers in this section, but I will share my thoughts with you in this situation. You may have different answers that are just as effective as mine. My responses are not the only ones that could be used. Thoughtfully write your questions and come to class prepared to share them.

1. Do you believe in a higher power or God? Note: For a Muslim, the higher power would be Allah; for an agnostic, it would simply be a higher power. For Sister Agnes, her response probably would be that she believes in God.
2. What can I do for you or with you, while you are here, to assist you in meeting your spiritual needs? Note: Some people may want you to pray with them, others may want religious artifacts in the room or a visit from their spiritual leader. Other people will want nothing.

A holistic assessment includes asking about the older adult's spirituality. Religion takes a significant role in the lives of most older people. Therefore, you need to know about their spiritual needs and strive to meet them.

recovery, nurses assume responsibility for the passive exercise program. Such a program may include range-of-motion activities, in which each joint is put through the normal activities of which it is capable—that is, supine, prone, lateral, medial, anterior, and posterior positions. This approach maintains the wellness capability of the joints and reduces the complication of contractures, strictures, and the limitation of activity. By implementing passive range of motion, nurses are assisting the injured person to resume independence of function and perform at optimal levels.

Goal 2: Active Exercise

Active exercise is designed to improve function and performance. It entails transferring from bed to chair, walking and ambulating with assistive devices, proper use of crutches, knowledge of how to maneuver the wheelchair, hand–eye coordination, and the use of assistive devices that promote independent living in a normal manner. In each of these activities, nurses, in the role of teachers, help motivate the person to be as active in personal care as possible. Always follow the physician's orders for active exercise. A physical therapist (PT) is an excellent resource for these activities as well.

Goal 3: Bladder Continence

In some situations, it is necessary for the LPN to initiate bladder-training programs. Achievement of continence avoids the use of indwelling catheters. Bladder training aids in reducing the chance for urinary tract infections and increases self-esteem. Retraining is based on the development of clear patterns of communication between staff, the older adult, and the family regarding the schedule for toileting (usually every 2 hours). It is necessary for the bladder to be emptied at set times throughout the day. Limiting fluids after 6:00 p.m. so that the bladder can retain urine throughout the night is another strategy. At times, periodic catheterization may be employed to develop reflex emptying when the sensation for voiding is diminished or absent.

Goal 4: Bowel Continence

In addition to bladder training, it is important to employ bowel-training techniques if they are needed. Bowel training requires the establishment of a routine for emptying the bowel daily. This occurs most normally in the morning approximately 20 minutes after breakfast. The intake of breakfast stimulates the duodenocolic reflex, which assists in bowel elimination. A diet consisting of whole-grain breads, cereals, fresh fruits, and whole bran, along with increased fluid intake is helpful in providing both the bulk and fluid needed for effective bowel training. This approach also reduces the complication of constipation in the older adult. If constipation does occur, it may be necessary to provide medication to soften the stool and allow the bowel contents to move into the lower colon area for elimination. It also is helpful in bowel-training programs to request that the older adult assume the squatting position (use the toilet instead of the bedpan) to facilitate bowel elimination. This is not always possible. Rectal suppositories are useful when initiating a bowel-training program. Enemas are rarely used as part of a bowel-training program.

CRITICALLY EXAMINE THE FOLLOWING:

You work in a long-term-care, rehabilitation facility. Recently, the adult children of a patient have come to the nurse manager to make a complaint. Every time one of the children comes to visit their mother, she is holding hands and talking in a quiet and intimate manner with a gentleman resident. The children want the time together stopped. The nurse manager has asked you to look into the situation. What are you going to do?

Is there additional information you need to gather? If so, what is it? How important is sexual expression for older adults? Is it being expressed appropriately in this situation? Please carefully ponder your response and be prepared to share your thinking in class.

Goal 5: Appropriate Sexual Expression

When implementing a holistic plan of care, the LPN must be aware of the older adult's sexual needs. This means building in time during the rehabilitation and restorative care process for partners to have privacy. It also can include offering the sense of touch by holding hands with the elderly in appropriate ways and, when given permission, for squeezing the shoulder or forearm with a firm but gentle touch.

Goal 6: Psychosocial and Spiritual Well-Being

It is extremely important to include interventions that address the psychosocial and spiritual

needs of older adults. Communication, increased self-concept and self-esteem, treating the person with dignity and respect, as well as meeting spiritual needs are essential to holistic nursing care. Examples could include uninterrupted time to pray, arrangements for visits from the local clergy, and allowing religious artifacts in the room.

In implementing rehabilitation and restorative care, nurses follow the plan of care outlined by the IDT. Such information comes from the database (MDS) of information collected during the admission assessment and periodically throughout the course of the care. The nurse must be alert to changes that need to be made in the plan of care as the older person either improves, stays the same, or declines in physical abilities.

A Final Thought About Implementing Goals

The implementation of care measures should focus on the older adult's previous coping skills. It is important that older adults become partners in the care regimen by sharing knowledge and adaptability. The goals are established by the older person, the family, and the nurse, as a member of the IDT, based on the assessment data. When the goal is stated in specific, measurable terms, then evaluation of the progress and outcome of care is easily measured. The terms of the goal are to be put in the framework of self-care and self-responsibility.

ASSESSMENT OF GOALS

Goals are assessed at intervals—sometimes daily, sometimes weekly, sometimes monthly—depending on the goal to be accomplished. When the goals have been stated in observable, measurable terms, then the assessment of their achievement is relatively easy. In the course of the disease or traumatic injury, in-depth documentation is extremely important for noting the progress of the person. A systematic approach to fulfill all the stated goals assures the patient, family, and health-care team that a holistic approach has been incorporated into the older adult's care. This approach reassures both the older adult and the nurse that custodial care will be avoided and that rehabilitation and restorative nursing from a holistic perspective is in place.

Goals Specific to the Elderly Population

Restorative nursing goals specific to older adults include:

- Improvement of function
- Delay of deterioration
- Accommodation to dysfunction
- Comfort in the dying process

Improvement of Function

Functionality is defined as the ability to continue to live one's preferred lifestyle without disruption. To put that concept into different terms, it means that each older adult can live independently, do activities of daily living (ADLs) and instrumental ADLs (IADLs), be mobile, and have self-care ability. To live independently suggests that there is no need for physical assistance or supervision from another person. Goal assessment on a daily or weekly basis is essential to good care.

To improve function, it is necessary to take into account the impact of the older person's social and environmental situation, the functional implications of acute or chronic disease processes, and the physical factors that may influence function. By combining these factors, a picture of the capability of older adults to live and function should emerge for the health-care team.

Range of motion is a series of exercises performed on a regular basis to preserve the function of the joints and muscles. It is extremely important that this maintenance function be performed correctly and on a schedule so that no deterioration of the physical status of the person occurs. The nurse, under the direction of the physical therapist, does this activity or instructs another health team member to carry out this procedure correctly.

Improving the strength of the muscles necessitates that some resistance be exerted so that the muscle works hard to maintain or improve its function. This is often accomplished through the use of weights or by pushing against an object to provide resistance. The actual testing of the muscle strength and endurance is done by the physical therapist, and a plan of exercise is identified. This plan must be carried out meticulously so that every muscle and its function is duly exercised and strength and endurance are improved.

Mobility is identified in various stages, depending on the type of injury or disease present in the older adult. Usually, the progression is from bed mobility, through transfer activities, to

wheelchair or ambulatory locomotion. Transfer includes getting from bed to a chair and back to bed, on and off a toilet, and in and out of a bathtub or car. These activities involve standing, sitting, pivoting, turning, or side-slide movement (sliding from bed to chair using a transfer board). To promote function in mobility involves locomotion or moving from one point to another. Older adults may need to use a wheelchair, so the ability to propel and maneuver the wheelchair is important. Wheelchair use involves the development of arm strength with the use of weights or other forms of strength building. Other assistive devices such as crutches, braces, and splints may be needed to assist in locomotion. To help the individual reach optimal function, instruction needs to be given regarding the best approaches to maintaining balance and endurance as well as in the use of devices to prevent falls.

When the goal is to improve function, there is a positive outcome orientation. For example, if the nursing diagnosis is stated:

- Body Image Disturbance: functional—self-esteem disturbance related to function limitations, role and lifestyle change.

Then the goal should be written:

- The older adult will verbalize positive statements about self.
- The older adult will identify and demonstrate appropriate strategies to deal with functional limitations.

Some of these strategies could be the ability to manipulate buttons and zippers, to tie shoelaces, and to put on underwear. If the older adult is unable to perform these functions, then devices such as long-handled reachers, button hooks, and elastic shoelaces may allow the person to perform more independently.

In helping older people retain functional ability and avoid deterioration, it is important to be aware of the disease processes that may interfere with their ability to achieve independent living. Such limiting problems most often involve cardiorespiratory, neurological, or musculoskeletal systems. Many of these conditions may impose significant functional limitations on the person. All of these factors are to be kept in mind when implementing goals for rehabilitative and restorative care for the elderly person. Dedication to the restorative care plan helps older people keep motivated and engage in the purposeful and varied activities that promote function and performance.

Delay of Deterioration

A primary goal of rehabilitative and restorative nursing is the delay of deterioration in all functional aspects. For example, if bouts of depression are noted on admission and during the course of treatment, this factor should be documented in terms of the behaviors exhibited as well as their frequency and duration. The RN is to be notified and a psychiatric consult requested if it is determined to be appropriate for the individual. Depression signals initial deterioration of motivation. Helping the person maintain a spirit of hopefulness is one way to assist in the delay of deterioration.

Another approach to ensure delay of deterioration is to make certain that the nursing-care plan calls for exercise of all mobile bodily parts, that is, legs, arms, fingers, toes, neck, hips, and knees. Movement of all of these joints is essential in the maintenance of a healthy state. No nurse should ever allow a contracture to occur. Use of pillows, a footboard to prevent foot drop, and resting splints for wrists and fingers aids in proper alignment of the body to maintain function and delay deterioration. Properly aligned and supported body parts assume their natural posture and position. Passive range-of-motion exercises for all joints can delay deterioration to a great extent. However, caution must be exercised. If care is not used in moving the joints, soft tissue injury can result from undue stretching of the muscles and joints; this could cause additional injury and slow the rate of recovery or cause great pain when the person becomes active once again.

Another priority concern is the prevention of pressure ulcers. Excellent skin care should be a daily part of nursing care for all persons. This is especially important for elderly people who have impaired nutritional status. Pressure ulcers may develop over any bony prominence as well as on the occiput, ear parts, sacrum, and greater trochanter. Special devices to cushion these parts need to be used as a preventive measure and include special pillows, donuts, and gauze dressings, as well as special mattresses (egg crate, circulating water, or air). Turning the person every 2 hours is the best preventive measure that can be taken to ensure skin integrity. When turning the person, the support of limbs and back for good body alignment is essential to keep weakened muscles from further deterioration.

Cognitively impaired elderly persons are in need of individualized nursing care. These people need appropriate sensory stimulation to maintain their contact with the world. Putting the

person in a position where others can be seen as well as the careful use of the radio and TV can help stimulate cognitive functions and lessen the possibility of further deterioration.

To delay deterioration, older adults should participate in out-of-bed activities as soon as they have achieved a medically stable condition. First, they should dangle their feet for several minutes to gain a sense of balance. Once this activity is tolerated, the nurse should help the older adult to stand by the side of the bed with whatever assistive device is needed, for example, a walker or cane. Finally, the person should be assisted to walk to a chair and sit with proper support for approximately 15 minutes at a time. You, as an LPN, are essential for providing the appropriate encouragement to the individual.

Accommodation to Dysfunction

The goal of helping elderly people accommodate to dysfunction requires a great deal of motivation on the part of the nurse. It is essential for the LPN to listen attentively and actively to the personal fears, hopes, thoughts, feelings, and values that are expressed by the person who is adjusting to the deficits left by an accident, injury, or stroke. Nurses should be aware that a rehabilitation program is primarily a learning and training process. Each person must have the ability to absorb new information on how to use personal potential and how to practice new skills. For example, if a person has sustained an injury that created a drop-foot gait, the individual must learn to accommodate walking by lifting the foot intentionally so that it remains flat as weight is shifted from one side of the body to the next. This requires major concentration until the old adage "practice makes perfect" becomes second nature to the walker. The nurse's role is to encourage the person to keep working for the highest outcome possible.

This woman was admitted to the nursing home in a weakened condition. Her family did not assist her out of bed because "she was too weak." Once admitted, it was determined that she did not have any acute conditions, but instead was deconditioned because of her prolonged time in bed. The first goal was to not let her deteriorate any further. As you can see, she now can be up in a wheelchair for short periods of time. This is the result of excellent nursing care.

Holistic wellness occurs for the restorative care older adult when:

- The psychological self-image of the person incorporates personal limitations into a healthy and acceptable image
- Social activities and interactions with friends and family continue to be a major part of the person's life
- The person exhibits acceptance of the new lifestyle with joy, peace, and gratitude for the remaining strengths of his or her personhood

These are the elements to be found when the goal of accommodation to dysfunction is achieved. As the grief and sense of loss diminish, a healthier view of life strikes older people so that life once again is worth living for them.

Comfort in the Dying Process

It has been noted that 75% of deaths in older people suffering from trauma were caused by falls, thermal injury, and motor vehicle accidents. Falls, for both elderly men and women, are the leading cause of death. Falls constitute approximately 50% of all fatalities. The most common injuries are associated with fractures of the hip, femur, proximal humerus, Colles' fracture of the wrist, and head injuries. In deaths in people 65 years of age and older, 25% are from motor vehicle accidents. As the population continues to age, this percentage of deaths and injuries will undoubtedly increase. Death from thermal injury accounts for approximately 8% of all accidental deaths in those 65 years of age and older. These injuries include burns and inhalation injuries, electrical injury, and contacts with sources of heat. The most commonly reported types of ther-

mal injuries include scalds, flame burns, and contact with hot objects.

Restorative nursing may include providing comfort measures and palliative care to those elderly patients who, because of severe injury and trauma, are in the process of dying. Palliative care means providing the care requested by the older person in terms of advance directives and a living will. The individual's decisions are to be honored by the nurse and family members. It may be that the older adult has requested that no food or water be given after it has been determined that no benefits will be derived from such comfort measures. Life-sustaining technologies such as intravenous solutions or use of a respirator also may be terminated if no positive outcome is predicted. All of these wishes are to be followed using the Code of Ethics for Nurses.

Nurses are to be supportive of dying elderly persons and their family members. You must be accountable to the dying person for decisions that have been made and facilitate their implementation. All decisions are to be carried out in a humane and compassionate manner. The dying process is a precious approach to the end of one's life. Nurses need to approach death with reverence for the body, mind, and spirit of the older person who moves into the terminal state of life. The nurse should attend to the dying person with dignity, respect, and appreciation for personal uniqueness. Refer to Chapter 9 for more information on end-of-life issues.

CLINICAL IMPLICATIONS OF REHABILITATIVE AND RESTORATIVE CARE

Using the framework of the restorative care principles and guidelines cited earlier, four clinical rehabilitative programs for older adults are outlined. These programs include the following:

- Walking or ambulation programs
- Bladder and bowel continence training
- Feeding and self-feeding programs
- Self-care—ADL programs

Walking Programs

Mobility is critical to optimal functioning for older people. To be mobile means that the individual will enjoy the satisfaction of independence in living. Nurses play a key role in providing motivation for a walking program. Depending on the type of assistive device needed by the older adult to aid in gait control, the nurse follows the directions given by the RN, physician, or the physical therapist. A key point is that excellent foot care is critical to maintaining a walking program. Also, properly fitting shoes are important to establish proper posture while walking.

The older adult may need braces or crutches to walk in a way that is beneficial. Leg and back braces are devices that are used to support body weight, limit involuntary movements, or prevent and correct deformities. Crutches are devices that may be necessary to help the person learn to walk again in a normal manner. Crutches may be used on a temporary or permanent basis, depending on the type of injury sustained during the trauma.

For successful crutch walking, it is important to strengthen the muscle groups used in this activity. This should begin as soon as the physician believes that the older adult has recovered sufficiently to consider walking. Strengthening exercises should be provided while the patient is still confined to bed. These exercises include the muscles of the arms, shoulders, chest, and back. Before ambulation, the older adult should be taught how to move from the bed to the chair and should be capable of performing this movement without assistance. Older people who need assistance to learn to stand, balance themselves, and ambulate again sometimes experience difficulty. This makes patience on the part of the nurse an important quality.

As people grow older, they need to keep moving! This woman cannot go for long walks or work out in a gym, but she does love to play pool. This motivates her to get up and get dressed, walk to the pool room, and stand up while she plays. It also adds to her social life. The secret is to move anywhere and any way.

Important points in crutch walking include correct measurements for crutches so they will have a proper fit. It is important that they have heavy rubber tips to prevent the crutch from sliding. The crutches need to be moved in a rhythmical way that propels the person forward. Finally, the crutches should have padding on the underarm piece so weight is not placed on the radial nerve. The handhold on the crutches may have padding to reduce irritation there as well. The nurse should emphasize good posture for the person who is crutch walking; the head should be held high and the pelvis should be kept over the feet for excellent balance. Crutch walking is best taught in several short lessons to reduce fatigue in the older adult. When ambulation begins, it is important to have an attendant both in front and in back of the person to provide stability and to reduce anxiety about possible falls.

There are several types of gaits that may be used in crutch walking, depending on the type of injury and the physician's orders. These types are given in the following list:

- **Four-point gait:** The person bears weight on both feet and has four-point contact with the floor (both crutches and both feet).
- **Two-point gait:** There are two points of contact with the floor (crutches only).
- **Swing-to gait:** Crutches are placed ahead of the person and, with weight on the crutches, the body swings through to the crutches.
- **Three-point gait:** Partial weight bearing is permitted.

As the older adult practices the walking program outlined earlier, the person should master sufficient ADLs to be independent. This independence includes being able to get up and down steps, and in and out of cars. It is important for nurses to be very familiar with all assistive devices used in walking programs.

Walking programs also are initiated for those without assistive devices. It is recognized that walking for the older adult is an excellent physical fitness activity. It provides cardiovascular fitness as well as aerobic exercise. Walking for 20 to 30 minutes, three times a week, has been supported by research as a way to maintain good physical fitness and conditioning. Walking should be a lifelong program to promote wellness and joy in living.

Continence Training

A second major clinical challenge is maintenance of bladder and bowel continence in the traumatized, disabled older adult. The older adult who is the recipient of good nursing care should not experience urinary or bowel incontinence. The use of an indwelling catheter is not effective bladder management. This is because urinary infection can result within 24 hours of catheter insertion. Catheter insertion also lowers the self-esteem and self-concept of the person trying to regain control of a traumatized life.

Bladder retraining is generally successful when a regular time schedule is established for emptying the bladder. Retraining of the bladder takes patience on the part of both the older adult and the nurse. A similar program for bowel training should be initiated soon after admission. As noted earlier, increasing the patient's fiber and fluid intake and a regular toileting regimen promotes bowel elimination on a regular schedule. If constipation does occur, stool softeners are the treatment of choice to resolve this problem. The use of enemas is not part of a retraining program. They should be used only in an emergency.

Feeding and Self-Feeding Programs

The clinical challenge of maintaining nutrition adequate for tissue repair and health demands a high level of skill on the part of the LPN. In the early stages of rehabilitative and restorative nursing, the older adult may need to be fed through a nasogastric tube. A specially formulated feeding prepared to caloric specifications is fed through the tube on a regular basis. The tube should be patent, and sufficient fluid should be used to keep it clear and unclogged. After each feeding, flush the tube with 30 mL of water.

As the older adult progresses in recovery, he or she may need to be placed on a feeding program in which manual assistance by the LPN or aide is needed until the person has sufficient strength for self-feeding. Older adults should be fed at regular mealtimes, and snacks also should be provided. Promoting the older person to a self-feeding program is a definite sign of progress. Encouragement is to be given by the nurse so that the older adult consumes sufficient calories to have adequate nutrition to meet the energy demands of rehabilitation.

Self-Promoting Behaviors and Activities of Daily Living

Independence in personal care is a definite challenge for older adults with disabilities that affect their range of motion, mobility, strength, coordination, and dexterity. It is important that mem-

bers of the nursing-care team allow older adults to have time to independently perform aspects of their own care. Occupational therapists can provide assistive equipment that makes self-care easier. Built-up handles for toothbrushes and hairbrushes are easier for older adults to hold. A chair in the tub or shower may allow a weak individual to be able to bathe independently. Lowered sinks, counters, and mirrors might allow a wheelchair-bound person to sit up to the sink to wash and perform other personal care. Specially designed plastic devices with long handles are available to insert inside a person's socks, and long-handled shoe horns allow older people who are unable to bend over to put on their own socks and shoes. Clothing with Velcro fasteners is easier to fasten and unfasten when dressing. Adjustments in the care environment and education of all of the personal care staff are essential to the success of self-care–ADL programs.

CONCLUSION

This chapter provides an overview of the principles that govern rehabilitation and restorative nursing practices for LPNs who care for older adults in various settings. Through appreciation of the uniqueness of older adults and their special needs, rehabilitative and restorative nursing care can help them achieve optimal functioning to live life to the fullest.

CASE STUDY

At the age of 60, Mr. A. suffered a severe, incapacitating stroke on the left side of his body. Mr. A. and his wife had planned to retire in 5 years and travel. The stroke created major difficulties regarding the couple's anticipated retirement. While hospitalized, Mr. A. developed a drop-foot condition that interfered with his rehabilitative program. He became despondent over his condition and refused to participate in the walking program.

Discussion

As the LPN responsible for Mr. A.'s care, you need to do an assessment of his holistic needs. What are the priorities of care?

Solution

1. Mr. A. needs assurance from the health professionals, nurses, and therapists that he will gain sufficient strength to walk with the aid of a walker and eventually to walk independently.
2. The LPN and Mr. A. contract to carry out the walking and exercise program on a daily basis to correct the drop-foot problem.
3. By setting goals, Mr. A. perceives his condition in a more positive light and is encouraged by his progress.
4. The LPN also is concerned about Mr. A's despondency. She documents Mr. A.'s behavior and informs the registered nurse about his psychological state. Together, the nurses talk with Mr. A. about his depression and seek his approval to obtain a psychiatric consultation. This problem is then referred to a mental health professional.
5. The LPN arranges for Mr. A. and his wife to become participants in a clinical conference in which the rehabilitative team reviews Mr. A.'s case and allows him to make informed decisions on how to proceed on discharge. This may include referral to various social agencies that could assist him in obtaining medical equipment for home use, receiving nursing care in the home if his wife feels unable to take care of Mr. A., and seeking social security/pension payments if Mr. A. believes he can no longer work.
6. Mr. A. is encouraged to eat nutritious meals so his tissue can make repairs. He needs sufficient energy from his nutritional intake to do his exercises and walking program properly.
7. Activities are scheduled for him so that he can regain his social skills and interact with people without embarrassment and hesitation. Mr. A. was discharged from the hospital within 2 weeks of the incident, feeling that he once again was in charge of his life and that life was worth living. He also could see that the goals he and his wife had established for retirement could indeed be accomplished. Mr. A. learned to live with his disability, and because of good nursing care, the quality of his life was not diminished.

STUDY QUESTIONS

Select the best answer to each question.

1. The aim of rehabilitation for older adults is to:

a. Engage in limited ADLs

b. Deny function and performance that existed before the incident

c. Keep food and fluids at a level so that energy and strength are minimized

d. Restore an individual to his former or best possible function and environmental status

2. Which of the following directives most closely coincides with the desired goals of a successful rehabilitation program?

a. Keep physical changes at a minimum and promote self-esteem.

b. Promote independence and self-care, along with mobility and a holistic approach to living with the disability.

c. Promote involvement in limited activities and range-of-motion exercises.

d. Promote the fulfillment of the patient's life goals in spite of mobility problems.

3. Principles of rehabilitation include the most important step in nursing care, which is:

a. Doing passive range of motion

b. Understanding the patient's self-concept and encouraging feelings of dependency

c. Beginning rehabilitation immediately on the patient's admission

d. Giving selective information to the family

4. Rehabilitation goals specific to older adults include:

a. Range-of-motion exercises, transfer skills from bed to chair, dependency on enema usage

b. Improvement of function, delay of deterioration, development of codependent behavior

c. Accommodation to dysfunction, comfort in the dying process, accommodation to an indwelling catheter

d. Delay of deterioration, improvement of function, accommodation to dysfunction, comfort in the dying process

5. In continence training for bladder control, the nurse should:

a. Increase fluids, especially during the evening hours, and toilet the patient every 4 hours

b. Restrict fluids during the nighttime hours and toilet the patient at his or her request

c. Increase fluids during the daytime hours and toilet the patient every 1000 mL

d. Increase fluids during the daytime hours and toilet the patient every 2 hours

19 Pharmacology and Its Significance for Older Adults

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Identify physiological changes of aging that affect pharmacotherapeutics in older adults.
2. Identify sensory changes of aging that affect pharmacotherapeutics in older adults.
3. Identify psychological changes of aging that affect pharmacotherapeutics in older adults.
4. Identify polypharmacy problems in older adults and nursing interventions to compensate for them.
5. Develop a nursing-care plan to synthesize interventions to assist older persons in maintaining proper pharmacotherapeutics.

INTRODUCTION

One of the biggest advances in medical care has been the discovery and rediscovery of plants and chemical compounds that formulate drugs. Drugs are prescribed to manage and sometimes even cure physical and mental illnesses. Ancient civilizations used a variety of herbs and other plant and mineral substances to ward off, prevent, and treat physical and mental problems. Many modern drugs used in Western medical practice have a long history of effectiveness in healing. Some medicines that are prescribed today were originally discovered and used by medical practitioners and healers from other cultures. Quality medical care and medications are responsible for increasing the life expectancy of large populations of people. A dilemma of Western medicine is the heavy dependence on the use of medications for managing and treating diseases. Many people do not consider a medical treatment complete unless they receive a prescription for a drug. This can be a serious issue for older adults. This chapter examines issues related to drug use and older adults. Some basic terms related to drug use are:

- *Pharmacology*—The study of medications.
- *Pharmacotherapeutics*—The use of medications to treat diseases. The benefit of a medication (desired effect) is weighed against the unwanted and dangerous effects (side effects) to measure the appropriate use of any medication.
- *Pharmacodynamics*—The effect of specific medications at the site of action. Pharmacokinetics, half-life, protein binding, disease processes, and aging affect pharmacodynamics.
- *Pharmacokinetics*—The study of how a medication moves into and through the body and how it is excreted from the body. The processes of absorption, distribution, metabolism, and excretion are affected by aging and diseases and influence the pharmacodynamics of any drug.
- *Half-life*—The time required for half the medication to be excreted or inactivated by the body.
- *Protein binding*—Binding properties of proteins. Proteins in the bloodstream are binding sites for many drugs. The portion of a drug that is bound to a protein is inactive (only a free drug is available to have a desired effect). Two drugs that are both highly protein bound compete for protein binding sites. This significantly increases the level of free drug in the bloodstream (drug molecules that were bound to the protein and have been released). The significant increase has an impact on the effects and adverse effects of the drug.
- *Adverse drug reactions (ADRs)*—Unwanted effects or side effects of a medication. Related to changes in pharmacokinetics, dosage amounts, timing of doses, and interactions of medications with other medications or foods.

AGING CHANGES THAT AFFECT PHARMACOTHERAPEUTICS

Changes in Vision

Changes in vision can have a serious impact on the safe use of medications by older adults. As individuals age, they experience increased difficulty distinguishing colors, especially blue and green, because of the hardening and yellowing of the lens in their eyes. This yellowing often makes it difficult to differentiate shades of blue, purple, brown, and green, yet older people can see bright yellow, red, and black more clearly. Many older adults have difficulty distinguishing individual pills by color. When older patients are instructed to take the "pink pill in the morning and the blue one at night," they may make errors.

Reading small print is also a challenge for many older adults. Older people often have trouble reading the label on drug bottles because of the small print. Attaching a large print tag to a bottle and having a magnifying glass by drug bottles can help an older person read the medication bottle label and avoid medication errors. Using a medication box or mediplanner is a good idea for many older individuals. Medication boxes are filled with the person's ordered medication. For each time during the day that the older person has to take a medication, the box has a separate compartment. Usually, the box is filled for a week at a time, and the days of the week and times of medication doses are clearly marked in large, bold, raised initials and symbols. Family members and friends can be taught to assist their older family member in preparing the medication box for a week at a time.

Sensitivity to glare is another visual challenge for aging eyes. Shiny surfaces like plastic tape over medication labels can be difficult for older people to read. Portions of instructions written on paper that has been laminated may be missed or difficult to read because of reflecting

glare. Labels for drug bottles should be printed on paper that is not shiny. Medication instructions should be in bold, large print on white or yellow paper to ensure they can be read.

Decreased Hearing Acuity

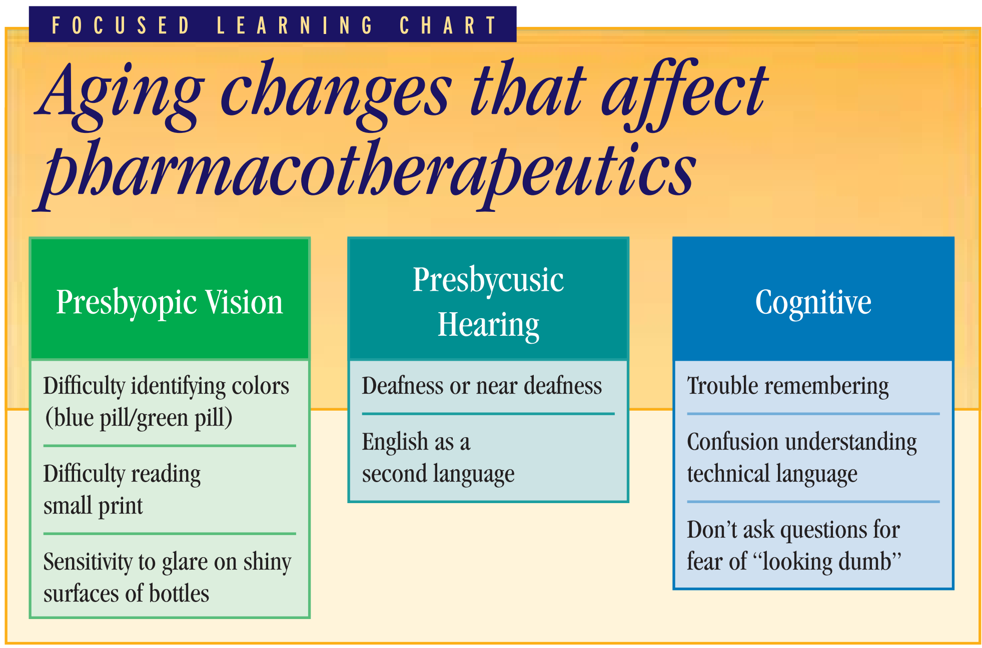
Hearing changes, such as presbycusis, increase the possibility that an older person may be unable to hear and understand instructions. Often, out of habit, older adults may nod their heads or state that they understand instructions even if they did not hear them all. Asking them to repeat or demonstrate instructions are excellent ways to ensure that the instructions have been heard. Using large print instructions and following them when giving verbal instructions also helps most older people. Many people with hearing difficulties develop lip-reading skills. Make sure that the older adult can see your mouth while you are giving instructions. Wearing lipstick if you are female and speaking slowly and intentionally, rather than louder, enhances an older person's ability to read lips. Throughout the time that you, the nurse, are giving verbal instructions, stop and ask older people if they have any questions. Clarify information and have them restate and demonstrate the teaching that is occurring.

Decreased Taste Acuity

With age, older adults experience changes in taste. It is most obvious in foods. A common complaint is that food is bland or has no taste. Changes in recognizing tastes and flavors result from changes in the taste buds and often in the sense of smell. The ability to differentiate medications by taste is inhibited, and the potential for unknowingly taking nonmedications or caustic poisons increases. Encourage older adults to throw away old prescription bottles and not to use them for storing household cleaning products and other poisons that may be mistaken for medications.

Changes in Touch and Dexterity

Older adults experience decreased touch sensitivity as they age. This can be worsened with decreased circulation and peripheral nerve deterioration in the hands and feet. Arthritic joint changes can combine with decreased touch to minimize strength seriously, which, in turn, can make it difficult to open modern packages. Childproof lids that require a person to push down and turn at the same time are very difficult for older people to open. Individual drug doses in plastic bubbles that require the plastic to be torn or the backing to be ripped off also are difficult. Pharmacists use alternative packaging for older adults if the older person requests it. Flip-top lids can replace the hard-to-twist childproof lids. Bubble-packed medications can be cut out of the packaging and placed in a pill bottle or a pill box.



Cognitive Changes

With increasing age and subsequent risk for disease, older adults may have changes in their thought patterns. It is important for the nurse to question what has caused the thought pattern changes. Are the causes pathological or drug induced? Sometimes older adults have trouble remembering if they have taken their medications. Multiple drugs with varying dosages administered at different hours often create confusion.

The technical language that health-care professionals frequently use can be difficult for older people to understand, and they often are unwilling to ask questions. Many older adults do not want to seem uninformed and state that they trust the doctor or nurse to do what is right.

Compliance Factors

Often individuals do not correctly follow their drug regimen. This can be intentional or the result of poor understanding. If older adults do not understand how a drug works or do not like the effect of a drug, they may make mistakes in administering their medications. Common problems are taking doses at the wrong time and altering the dosage amounts.

Forgetting to take medications is a routine compliance issue. When giving older people medication instructions, ask them to describe a typical day. Instructions to take a medication everyday before breakfast rather than instructing them to take the drug at 8:00 a.m. may encourage compliance, especially if they sleep until noon or are up at 5:00 a.m. Studies have demonstrated that more medication doses are forgotten when a drug is dosed frequently during the day rather than once a day. Simplified dosing schedules that consider the older person's daily routine and the use of medications that are dosed only once a day can help the person be compliant in taking medications.

Drugs are taken for the chemical effect that they have on the body. Unfortunately, unwanted effects or side effects are common for many medications. Individuals often choose to alter the dosages or quit taking an ordered medication because of the side effects. One of the most common side effects that older adults complain of is upset stomach. This often is caused by the medication dissolving in the stomach and irritating the stomach lining. Stomach irritation can be lessened by instructing the older adult to take the medication with food. If the medication needs to be taken on an empty stomach, encourage the person to take at least 8 oz (1 cup) of water with the medication. This washes the medication through the stomach faster and, it is hoped, lessens stomach irritation. Encourage people to talk about the uncomfortable side effects of their medications. Often by simply changing the timing of a medication dosage (from morning to bedtime dosing), unwanted or bothersome side effects may decrease significantly.

It is not uncommon for people to simply stop taking a medication. News in the media and advice from neighbors or friends may make older people uncomfortable with specific drugs or even fearful of the drug's long-term effects on their body. Encourage them to discuss these concerns. Unfortunately, people who are not accurately following prescribed drug regimens are reluctant to tell their doctor. Not following orders could be interpreted as questioning the doctor's skill and knowledge, and most older people do not want to be disrespectful. Many older adults manipulate drug routines to fit their beliefs about

Both of these women take medications daily. Because they are compliant and correctly follow their drug regimen, they are able to attend, for example, this cookout. They also spend time with their families and give a great deal of service to their community. They both agree that their health is improved because of the medications they take.

personal medication needs. Encourage an open dialogue about medications. Allow the expression of concerns or questions. Review magazines and newspapers that older people read to keep informed regarding potential questions and concerns they may have regarding their medications.

Polypharmacy and Chronic Health Changes

A good rule to follow for pharmacotherapeutics in older people is "the smallest number of drugs should be prescribed at the lowest possible dose." Two-thirds of physician office visits by older adults result in the prescription of one or more new drugs. Of these prescriptions, 50% will not have the desired therapeutic action for various reasons that range from too high or too low a dosage to not getting the prescription filled. Studies have shown that many physicians who prescribe for older people do not make adjustments in dosages although the need for such adjustments related to age have been clearly established. Many physicians are not educated on dosage adjustment for older people. Most drugs are not tested for their effects on people age 65 and older. Studies on drug dosing, effects, and side effects are done most commonly with healthy middle-aged adults. The results of such studies are applied mistakenly to drug use for older adults. Such practices can lead to unanticipated drug effects and misdiagnosed drug side effects.

Older adults often have multiple chronic diseases. People with chronic health problems frequently have several drugs prescribed for each problem. The result for older adults often is complex, and is called multiple drug medication regimen. This complexity is compounded when the older individual has multiple physicians prescribing medications. Pharmacists are skilled at identifying potential drug interactions, but their effectiveness depends on awareness of the total medication regimen. If an older person uses more than one pharmacy, a pharmacist cannot be aware of other drugs the individual is taking. Increased numbers of medications and varied dosing schedules can lead to mistakes in taking medications and serious drug interactions. For example, an older adult with Alzheimer's disease may have periods of agitated behavior. A tranquilizer may be prescribed to decrease the agitation. Unfortunately, the tranquilizer has a sedating effect that can increase drowsiness and cause the older adult to be at a higher risk for immobility and falls. This can lead to joint pain and pain associated with injuries that may require pain medications that can further increase immobility related to drowsiness and increased risk of falls. Using drugs to treat disease symptoms and using other drugs to treat the side effects of such drugs can lead to the severe adverse drug effects of polypharmacy. A thorough assessment of drug regimens as an effort to simplify them are important steps in avoiding adverse effects of polypharmacy.

Complex prescription routines are not the only cause of polypharmacy. Many older individuals take multiple nonprescription medications, such as laxatives, herbs, vitamins, and other home remedies. These widely available, over-the-counter (OTC) medications may interfere with prescribed medications, leading to adverse drug reactions.

Older adults are significantly more prone to having undesirable drug reactions than younger adults. This potential increases in direct proportion to the number of medications being taken. Studies have shown that the potential for adverse drug reactions is 100% when an older adult is taking eight or more drugs a day. Common symptoms of adverse drug reactions or drug toxicity are changes in mood or behavior, restlessness, confusion, irritability, anxiety, insomnia, and hallucinations suggestive of mental deterioration. Many of these symptoms can be confused with acute brain problems, and the adverse drug reaction may go unrecognized. More medications may be prescribed to treat the symptoms of adverse drug reactions, and the cycle of problems continues.

POINT OF INTEREST

It is becoming more and more common for older adults to travel to Mexico or Canada either personally or through the Internet to purchase medications. The medications in both countries are cheaper to buy and are a boon for the older adult's budget. However, scientists suggest that medications made in Mexico are not done so under the strict controls that drugs in the United States and Canada are made. This is an important point for discussion with older persons.

Financial Concerns

Medications are expensive. Sometimes older adults self-prescribe rather than pay money for an office visit and a prescription. The end result of this behavior is the use of limited financial resources on OTC, self-prescribed medication that may or may not be beneficial. Older people spend three times more on nonprescription drugs than the general public.

Many older adults experience nutritional changes related to decreased financial resources. This may mean a decreased consumption of protein, resulting in decreased serum protein levels and decreased drug-binding ability. An increased use of alcohol, with resulting liver damage, may increase the metabolism time of the drug so it circulates longer in the body.

The cost of physician office visits and getting prescriptions filled may be difficult for an older person to manage. Some people never get their prescriptions filled. Some save their prescriptions until they can get to the pharmacist with the right amount of money (this may result in not taking the medications for a month or more). Some people choose over-the-counter medications for relief of the same symptoms as the prescribed drug and never get the prescription filled. Some older persons "save" their drugs by taking only one dose a day instead of two so the medication will last longer. For the home-bound individual, filling a prescription may necessitate the added expense of hiring someone to deliver the prescription or of being driven to the pharmacy and back home. Some people take the medications until the symptoms decrease and then put the rest away for "later." Other people share "over-the-fence" medications and health information with their friends and neighbors to save the money of an office visit or prescription filling. "Over-the-fence" medications appear in scenarios in which Aunt Matilda has a pill that worked for her shoulder pain and a friend with shoulder pain then calls her to borrow some of the pills that helped Aunt Matilda. The friend may seem to benefit by not having to pay for and make a physician's office visit; Aunt Matilda may feel good about helping another person; but in actuality the drug may not help or may indeed be detrimental to Aunt Matilda's friend.

This is the gentleman whose wife has rheumatoid arthritis. You met them playing Scrabble in a previous chapter. He feels concern over being able to pay for the medication necessary for her to move as little as she does. However, his commitment is to his wife and the quality of her life. He says he always has made it work, and he will in the future as well.

PHARMACOKINETICS

Physiological changes related to normal aging and various disease processes affect the pharmacokinetics of many medications. When an individual takes a medication, there are certain expected events that assist the medication in getting to the intended site of action or effect. Medications in pill form are usually formulated to break down in the stomach acid or the small intestine. The dissolved medication is then absorbed in the same place. If the individual has had a part of the stomach removed or has a low concentration of stomach acid, the pill may not be dissolved enough to be absorbed as expected. A good blood supply is necessary for the distribution of medication. Diminished blood supply to or from an area of the body alters the effective distribution of the medication. Most medications are metabolized by the liver. Liver disease or changes in the blood circulation to the liver change the expected metabolism of a medication. Excretion is the last step in pharmacokinetics. The kidneys have a major role in the excretion of most medications. Kidney disease or decreased blood flow to the kidneys can seriously change the intended excretion of medications. The following information is a discussion of the specific pharmacokinetic concerns for older adults.

Decreased Absorption

The overall effect of aging changes in older adults is decreased absorption. A major complaint by many older individuals is change in gastrointestinal (GI) motility, with resulting diarrhea or constipation. Drugs are absorbed poorly if they travel through the intestines at a rapid rate. Chronic diarrhea and overuse of laxatives move a medication through the intestines at a rapid rate

and decrease the time that the drug is in contact with the intestinal wall to be absorbed. Drugs also are absorbed poorly if the intestine is impacted with stool, as in constipation.

Changes in the gastrointestinal tract probably interfere with normal absorption of medications. Older adults often have changes in the quality and quantity of digestive enzymes that are important for dissolving and transforming medications into a form that can be absorbed through the intestine. Gastric pH becomes less acidic, and there is an overall decrease in the number of absorbing cells in the intestinal mucosa. The smooth muscle tone and motor activity of the gastrointestinal tract decline with advancing age. These changes, along with slowed intestinal motility, decreased intestinal blood flow, and slowed gastric emptying time serve to decrease potential drug absorption further. Atherosclerotic changes reduce the flow of blood to the major organs, resulting in slower disintegration of solid dosage forms such as tablets. Because of the changes in GI motility, drugs that are manufactured for normal adult GI motility are not suited to the slower geriatric bowel. Some drugs may be absorbed in lesser amounts; for example, acidic drugs are ionized to a greater extent, resulting in decreased absorption. Acetylsalicylic acid (aspirin), for example, is more ionized in older people because their secretion of stomach acid is decreased. Aspirin, therefore, may have decreased absorption in older adults. Some drugs may be absorbed in greater amounts. For example, drugs that are absorbed from the intestines are more thoroughly absorbed if they remain in contact with the intestinal wall for longer periods of time.

Distribution

Drug distribution is greatly altered in older persons. As people age, the body mass becomes leaner, with decreased parenchymal tissue and increased fat content. Increased fat results in increased absorption of fat-soluble drugs. This results in decreased activity and prolonged effects for such drugs. Examples of drugs showing this effect are hypnotics, sedatives, fat-soluble vitamins, and heparin.

Changes in the cardiovascular system of the aged may result in delayed arrival of the medication at the target receptors, slow release of the drug from the storage tissue, and slowed excretion of the drug. Decreased blood flow to the specific target tissue may result in decreased drug distribution.

Older people have decreased plasma protein concentrations. Plasma protein is an important factor in drug binding in the serum. Most drug dosages are set for people with normal plasma protein levels. If the older person has less plasma protein, more of the drug is free (i.e., unbound to the protein) and, therefore, is free to act on the receptors and cause its effect. Warfarin (Coumadin), for example, is 90% bound in the average adult. Its dosage is regulated because 90% of it is bound to protein and will not be available to the person. If the person is elderly and has half the normal adult protein level, a normal dose of warfarin would be an overdose. Some researchers believe that with aging, the number and nature of drug receptors in the body change. This could result in a decreased or increased response to a normal dosage of medication.

Another factor influencing drug distribution is the chronically dehydrated state that many older adults experience. Decreased fluid consumption frequently results in a lower blood volume; this factor, in turn, decreases distribution in the blood.

Metabolism

Older adults experience a decrease in the rates of overall metabolism, microsomal metabolism of the drug, and hepatic biotransformation of the drug, as well as a decline in the body's ability to transform active drugs into inactive drugs. The overall effect of these changes is that the drug remains for a longer time in an active form in older people. Some drugs may remain in the body twice as long as in younger adults.

Excretion

The altered filtration and decreased plasma volume that occur with dehydration commonly found in older people change the excretion of medications. Age-related renal changes result in slower excretion of the drug. Slowed excretion keeps drugs in the body longer and can lead to drug toxicity. Decreased respiratory and vital capacity, with increased carbon dioxide retention, results in decreased excretion of those drugs normally excreted by respiration, for example, anesthetics. Decreased and changed excretion results in an overall increased pharmacological effect of medications in older people.

The overall effect of aging changes in older adults is increased pharmacological effect. Although less medication is absorbed, it stays

longer in the body and remains in the circulation for a longer time.

PHARMACOLOGY PROBLEMS

Pharmacology in older adults is frequently identified as a "can of worms." Problems include misuse, overuse, underuse, erratic use, and contraindicated use of drugs. Misuse phenomena include incorrect dosing, sharing of "over-the-fence" medications between neighbors and friends, and use of the same medications for a variety of purposes. Incorrect dosing involves physicians who prescribe dosages based on guidelines for mature adults. As an individual ages, the dosage requirements for most medications decrease. Many medications given in normal adult doses to older adults result in an overdose. Another aspect of misuse occurs when a drug is taken for a variety of symptoms. An older adult may reason, "Well, this pill works for my upset stomach; it will probably work for my diarrhea."

Overuse may result from the theory that if one pill works well, then two pills will work better. People may feel that if they feel better with a vitamin supplement, two vitamin supplements will definitely improve their health. This behavior may actually poison the older person's system.

In underuse problems, the person takes less medication than prescribed to "save" pills or money if finances are a problem. Many older adults are on fixed and limited incomes, the cost of medication is high, and medication is sometimes too expensive for the person to afford. Erratic use frequently occurs with short-term memory loss or forgetfulness; for example, a person may forget to take medications for a day or two.

Contraindicated use can apply in a number of situations. For example, sometimes older adults receive several drugs from several physicians. They also may have the prescriptions filled at several pharmacies. The end result is that the older population is at a much greater risk for drug interactions, allergic reactions, and problems with polypharmacy (taking multiple medications).

Specific Drug Problems for Older Adults

If all medications were carefully monitored and taken properly, and if the dosage were regulated and accompanied with instructions, the older adult would still be at greater risk than a younger adult for drug-specific problems due to aging changes in drug absorption, metabolism, and excretion. For example, if an older person was prescribed the proper dosage of digoxin, understood the medication regimen, and was in full compliance, the person would still be at a higher risk for complications to develop. Older people simply experience more side effects and difficulties.

The problem with polypharmacy is a challenging one for older adults. This gentleman quilts for a hobby and does not live a strenuous life. However, he still has multiple chronic diseases. If he takes the medication prescribed for him from his three physicians, he will be taking 22 pills each morning and 12 at night. It worries him, and he wants help in organizing the medications. Where would you refer him if he were your neighbor or family member?

Table 19.1 identifies categories of drugs that may precipitate side effects and adverse effects in older persons. It is important that you, as the LPN, be aware of the possibility of potential problems and monitor for them. Another specific drug problem is the use of OTC medications. Antacids, laxatives, alcohol, and home remedies frequently interfere with the proper functioning of medication.

Antacid Abuse

Sometimes antacids are consumed in large amounts by older people. Physically, a decreased amount of gastric acid has been documented with aging; paradoxically, however, antacid use usually increases with age. The antacids may be used by the elderly patient for symptoms of chest pain. Early angina attacks may be considered heartburn and treated with antacids. Other pathological

TABLE 19.1. Specific Drug Problems of Elderly Patients

Effect	Drugs
Drugs that cause dry mouth	Analgesics, anticholinergics, antidiarrheals, antilipemics, antiemetics, antipsychotics, antiulcer medications, muscle relaxants, antihistamines, antiparkinson medications, antihypertensives
Drugs that promote gastroesophageal reflux	Anticholinergics, beta-blockers, diazepam, dopamine, theophylline
Drugs associated with ulcer formation	Adrenocorticotropic hormones, aspirin, indomethacin, iron, histamine, phenacetin, potassium
Drugs that alter absorption of nutrients	Colchicine, neomycin, cholestyramine, antacids, tricyclic antidepressants, carafate
Drugs that promote constipation	Aluminum- and calcium-containing antacids, narcotic analgesics, anticholinergics, diuretics, iron, tricyclic antidepressants
Drugs that may promote diarrhea	Analgesics, anti-inflammatory agents, antacids, antiulcer medications, antibiotics, antihypertensive medications, asthma drugs, cardiovascular drugs, diuretics, iron
Drugs that may promote hepatic damage	Acetaminophen (Tylenol), analgesics, anesthetics, antibiotics (especially penicillin and sulfa), antineoplastics, cardiovascular drugs, oral hypoglycemics, steroids
Drugs that may cause excessive depression	Antihistamines, antipsychotics, anxiolytics, cardiac glycosides, narcotics, sedatives/hypnotics
Drugs that may cause dysrhythmias	Antidepressants, cardiac glycosides, phenytoin
Drugs that may damage the kidneys	Aminoglycosides, antibiotics, colchicine
Drugs that may precipitate electrolyte imbalances	Corticosteroids, diuretics
Drugs that may precipitate blood dyscrasias	Antineoplastics, antipsychotics

processes also may be perceived as heartburn. This behavior can result in lack of care for serious health problems. Many antacids are high in sodium content. Excessive use of antacids can increase the severity of cardiovascular and renal disease, exacerbate hypertension, and result in increased fluid load for the aged body. Antacids are notorious for altering the motility of the gut, with resulting diarrhea or constipation.

Use of home remedies frequently interferes with pharmacotherapeutics. Some home remedies have actual benefits, some have only psychological benefits, and some are actually detrimental. For example, the use of bicarbonate of soda for "acid stomach" is detrimental and may result in serious acid–base imbalance. The ingredients of the home remedy need to be evaluated. The LPN must evaluate the frequency of use and the possible interactions.

Laxative Abuse

Another class of drugs sometimes abused by the older adults is laxatives. Laxatives may be taken once, twice, or more than three times a day. Some older people forget that they have had a bowel movement and take more laxatives to facilitate another bowel movement. Although there is no consistent alteration in frequency of bowel movements with advancing age, the ingestion of laxatives increases significantly.

Laxative abuse may result in actual damage to the intestinal mucosa. The ascending colon is often the site for this damage and it may dilate and shorten, losing its typical muscular features, so there is decreased absorption of other medications (and nutrients) that are administered orally. Laxatives also inhibit the absorption of medications from the intestine. This results in decreased levels of the available drug being absorbed, causing a decreased therapeutic effect. Laxatives also result in fluid and electrolyte imbalances that may exacerbate cardiovascular or renal problems. The person who is a frequent abuser of laxatives should be assisted in developing other bowel-training methods. Psychological intervention may even be necessary.

Alcohol Abuse

Alcohol abuse is a social health problem in some older people. It is the primary drug of abuse worldwide. Alcohol abuse interferes with pharmacotherapeutics and also frequently results in altered nutritional status. This may be seen in decreased serum protein levels (as discussed earlier in this chapter), decreased protein binding, and resultant overdosing of older people. Acid–base balance and fluid and electrolyte levels are adversely affected by alcohol abuse. Changes in these two homeostatic mechanisms result in changes in the pharmacotherapeutic effects of the medication regimen.

Alcohol impairs thinking, judgment, and psychomotor coordination, all of which may lead to decreased medication compliance. Alcohol increases or decreases the effects of several other drugs, and other drugs often increase or decrease the effects of alcohol. Alcohol is a central nervous system depressant that potentiates other central nervous system depressants, particularly barbiturates. When taken concurrently, these two drugs may result in central nervous system depression, coma, and death.

Alcohol has a vasodilating effect and, consequently, increases the hypotensive effects of most antihypertensive drugs. The effect of alcohol on oral anticoagulants varies. Alcohol intake decreases the effects of the anticoagulants until liver damage occurs, at which point the anticoagulant effects are increased.

NURSING CARE OF OLDER ADULTS RECEIVING MEDICATIONS

When managing care of older adults receiving medications, the nurse should follow the nursing process as taught in Chapter 3 of this book. The five-stage nursing process consists of assessment, diagnosis, planning, implementation, and evaluation.

Assessment

Before administration of medication, a thorough assessment of the older adult should be completed. A thorough health history is extremely important. Ask the person about past diseases, illness, or symptoms and how they were handled. Inquire about the person's current health status. The history must include past use of drugs, present use of drugs, prescribed drugs, OTC drugs, "over-the-fence drugs," and street drugs. Specifically ask about use of laxatives and antacids. Assess the person's allergies. Did the allergic reaction cause the person to have difficulty breathing? Hives? Nausea? Vomiting?

Assess the older person's social support network and home environment. Is the person able to get prescriptions filled? Are there family members or friends to help with medication compliance? Assess cognitive skills. Is the person confused or disoriented? Is this problem transitory? Is the person capable of understanding any teaching that occurs? Is depression present?

Assess the older adult's sensory status. Is vision impaired? Is hearing impaired? Is the person strong enough to open pill bottles? Assess the individual's current understanding of therapies and medication regimen. Does the person understand the drugs, dosage, side effects, and/or adverse effects of current medications?

Assess compliance. Does the person take medications at the proper time? For what reasons would the older adult miss a medication? Is there someone to provide transportation to the doctor's office or the pharmacy?

A thorough physical examination must be performed. Watch the older adult for nutrition and fluid status. Is the person thin and emaciated? Dehydrated? Is the person's serum protein level low? This may necessitate a reduction in some drug dosages. Is the person obese? If so,

CRITICALLY EXAMINE THE FOLLOWING:

You are doing clinical hours for school in a community setting in an economically deprived area of the city. There are predominately older adults with multiple chronic diseases being seen by the nurse practitioner (NP). You have been asked to review the laboratory work before the person is seen by the NP. You notice that approximately 50% of the older adults have a serum albumin below the norm (3.5 to 5.5). You are puzzled by this occurrence and begin interviewing the older persons in an attempt to identify what is causing the problem. Consider what you would be most likely to discover if this scenario were true, answer the questions listed below, and bring your best thinking to class. Whatever you discover, describe what impact a serum albumin level below normal might have on a person's drug regimen.

1. Most likely causative factor:
2. Impact on drug regimen:

the person may require increased dosages of fat-soluble vitamins and medications.

Diagnosis

Many nursing diagnoses are applicable to the older adult undergoing medication therapy. Some applicable diagnoses include:

- Altered Health Maintenance related to insufficient teaching
- Ineffective Management of Therapeutic Regimen related to lack of motivation
- Noncompliance related to lack of financial resources
- Noncompliance related to inability to open bottles

Planning

To promote responsible medication habits in older adults, LPNs must help them become informed medication consumers. Because many older people remain in acute-care settings for only a very limited time, discharge planning and teaching must begin on admission.

Before beginning any teaching session, some preparations are important. Choose an environment with good lighting and minimal environmental distractions. Make sure that the older adult who has glasses and hearing aids is wearing them. Prepare visual aids and reading materials with strong colors and large print.

Plan the teaching session to be only 15 to 20 minutes long. Speak clearly and slowly. Use a low-pitched voice (some older people have difficulty hearing a higher pitch). Always face the person when speaking.

Whenever possible, relate the learning to prior life experiences. For example, when teaching about the thyroid drug methimazole, help the patient identify personal health problems that occurred before seeking medical treatment and relate those symptoms to how the person will feel if the medication dose is too low. Tie administration times for medications to the person's daily schedule. If the older person eats oatmeal every morning without fail, the morning dose of digoxin can be associated with the oatmeal breakfast.

Treat older adults as the mature and capable people they are. Do not be patronizing in your teaching approach. Teach a family member,

PRIORITY SETTING 19.1

When setting priorities for teaching medication administration to older adults, you must think holistically. Before you begin any medication administration instructions, sit and talk with the older persons you are teaching. Can they hear what you are saying? Can they read? Does the person have the visual ability to identify colors in order to differentiate pills? Do they have arthritic hands that make it difficult or impossible to open medication wrappings and bottles? What are their financial resources; can they afford the medication ordered? Who else should be invited to the teaching session (e.g., spouse, children, other care takers)? Have a family member bring in the proverbial "brown bag" of medication that the older adult has been taking so you can make sure there is nothing at home that is contraindicated.

Once you have determined the answers to the previous questions, you can plan your teaching session. When you teach, sit close so the older person can both see and hear you. Be organized and have a plan ready that meets the needs you assessed previously.

Those of you with more clinical experience may be thinking "no one has time for such a demanding teaching session." This is where you learn THE PRIORITY for medication administration. You must take the time to assess, plan, and teach all older adults about their medications and how to take them!

What good is the power of modern medications, many of them actually miracle drugs, if the person taking them does not do it properly? It does no good. Many older persons take multiple medications with diverse administration schedules, such as diuretics every other day and potassium twice each day. If that person is admitted to the emergency room because of a fall from low potassium and dehydration, what could be the cause? Yes, you're right. The older adult mixed up the instructions and was taking the diuretic twice a day and potassium once every other day. The fall could easily result in a fracture "somewhere" and a prolonged hospital stay after surgery to repair the break.

The priority with medication administration is to assess, plan, and teach the person about all pertinent aspects of the medications given.

friend, or neighbor at the same time. Have the older person teach the other person and observe the integration of knowledge. Provide sufficient time for review, questions, and return demonstrations.

Consider the need for assistive devices. Medication boxes come in a multitude of styles with individual slots for different days and times. Consider the need for nonchildproof caps. Medication containers can be color coded and accompanied by a wall chart with the color coding system shown. Teach the patient to turn bottles upside down once the medication is taken. Allow the older person to be responsible for taking personal medication the last few days in the hospital. The nurse should monitor these actions and review any areas of knowledge deficit.

Encourage all older adults to carry a list of medications (including prescription and nonprescription drugs) at all times. Another family member should carry the same list as well. The older person should be encouraged to share the list with all physicians and pharmacists before receiving or filling any new prescriptions. Encourage all older adults to locate a pharmacy they like and fill all prescriptions there. On all admissions to the hospital, the nurse should review all medications and refer incompatibilities to the physician or pharmacist.

Implementation

In administering medications to older persons, several strategies are important. When administering medications by mouth, be aware of the medication form. Time-release capsules (e.g., theophylline, cold capsules) should not be opened or crushed and mixed with food. If the person is unable to swallow the capsule, contact the physician or pharmacist for a liquid form. Enteric-coated capsules should not be crushed or dissolved. Disruption of the enteric coating allows gastric acid to come into contact with the medication and inactivate it. Offer the most important medication first. Give the person enough fluid so the medication reaches the stomach.

Parenteral injections should be given into the dorsogluteal or ventrogluteal sites. The deltoid muscle should be avoided, because in most older people, it has lost much of its mass. The vastus lateralis muscle should be avoided owing to its decreased muscle mass and decreased circulation. Avoid injections into edematous areas that have decreased circulation.

Intravenous therapy needs to be closely monitored in older people because many older adults operate in a slightly dehydrated state. Fluid overload is especially critical in the person who may have underlying cardiac and renal disease that would be exacerbated by excess fluid.

Some older people experience visual changes with changes in a medication regimen. Recommend that the person not change prescription eyewear until the medication regimen is established.

Evaluation

Evaluation, the final step in the nursing process, is critical in administering medication for older adults. Evaluate the person's learning curve by doing a return demonstration teaching session. Ask questions about situations the older adult may encounter in the home setting. Allow the person to ask questions of you.

Evaluation of compliance is based primarily on personal and family report. Ask the older adult if medications are being taken, and then clarify how and when the medications are being consumed. Ask about the occurrence of side effects. If expected side effects do not occur, the nurse should question whether or not the medication is being taken. Blood levels (if available for a given medication) should be evaluated to determine whether the levels are commensurate

POINT OF INTEREST

You are admitting an older person to the medical unit for chest pain, shortness of breath, and edema, and neither the older person nor the family member can recall the medications the older person is taking; you have a problem. A solution that is easy for the family is the "brown-bag solution." Ask the family member to go home and put all medications the older person is taking into a brown bag and bring them to you. Be sure the family member brings prescription, over-the-counter, and natural remedies. Assure the family member that all medications will be returned. This will give you the opportunity to make an accurate list of medications being taken by the older adult. It also gives you the opportunity to point out outdated medications that should be discarded.

with the person's report. Monitor the older adult's laboratory results to determine kidney and liver function. Ask for a personal evaluation of how the new medication is working. Does it help? What concerns does the person have?

The outcome of a successful medication plan can be evaluated by the following criteria:

- The older adult's ability to solve problems related to polypharmacy
- Communication of adverse reactions
- Adherence to regimen

CONCLUSION

Pharmacology in older adults is a complex issue. The nursing care of the older person must include attention to the details of the medication regimen. The LPN needs to be familiar with the aging changes that affect pharmacotherapeutics, including pharmacokinetic changes, sensory changes, psychological changes, problems of polypharmacy, chronic health changes, and financial changes. It is important that the nurse understand the drugs likely to be misused and be aware of specific drugs of frequent misuse by the elderly population. These are antacids, laxatives, alcohol, and home remedies.

The nurse needs to be able to implement the nursing process on behalf of older adults to assist them to develop into well-informed medication consumers. The ability to teach regarding medication administration and to evaluate the impact of medications on the older person are critical skills for you, the LPN, to have.

CASE STUDY

Mr. W., 74 years of age, lives at home alone. He does fairly well on his own. He has difficulty seeing, but he can read soup can labels. He has arthritis in his hands and opens cans with an electric opener.

Mr. W.'s drug history includes:

- Digoxin 0.4 mg p.o. q.d.
- Hydrochlorothiazide 50 mg p.o. b.i.d.
- Potassium supplement daily
- Propranolol 40 mg t.i.d.

Note: p.o. = orally; q.d. = daily; b.i.d. = twice daily; t.i.d. = three times a day.

Mr. W. denies any use of street drugs and states that he "doesn't believe in that stuff." When asked about other medications, he states that he uses Mylanta "several times a day, just one tablespoon full" and Ex-Lax every day for a bowel movement. He also takes a small blue-and-white capsule that his brother gave him because it helps his brother's arthritis. He takes that capsule "once or twice, maybe three or four times a week."

Mr. W. is currently complaining of weakness, dizziness, and occasional chest pains that he treats with Mylanta. His feet and hands seem to be swelling lately.

Mr. W.'s neighbor called the home health-care agency where you work and requested that a home visit be made because Mr. W. seems to be getting thinner and thinner. The agency assigns you to go visit. You find Mr. W. sitting on the porch with his feet propped up and half asleep.

Discussion

1. What is the first step in your home visit?
2. What nursing diagnoses may apply to Mr. W. at this time?
3. While looking at his brother's blue-and-white capsule, you discover the word "indomethacin" on the side. What is your best course of action regarding this over-the-fence drug?
4. Mr. W. is wondering why his feet are swelling and he is feeling weak and dizzy. What drug interactions could be causing these symptoms?
5. What role does the Ex-Lax play in Mr. W.'s pharmacotherapeutics?
6. What referrals does the nurse need to make?
7. What should the nurse do to assist Mr. W. in becoming compliant?

Solution

1. Introduce yourself, explain why you have come, and begin a complete assessment. The history, drug history, and physical assessment need to be complete. View Mr. W.'s environment. Ask about support services, friends, family, and neighbors. Explore nutritional status and assess what food is available for Mr. W. Assess eyesight. Can he read drug labels? Assess compliance. Does he know when and how to take the medications?
2. Knowledge deficit related to medication regimen
   Noncompliance related to lack of understanding
   Ineffective management of therapeutic regimen
   Sensory deficit related to diminished visual acuity
3. Although indomethacin is a nonnarcotic analgesic and nonsteroidal anti-inflammatory drug, it has not been prescribed for Mr. W. Identify his feelings about the medication. Does it seem to help his arthritis? Does he have side effects with the drug? Explain to the patient why it is important not to use this drug unless it is prescribed by the physician. Identify interactions of indomethacin with other prescribed medications (decreases the effectiveness of diuretics and antihypertensive therapy, increases gastric irritation, increases serum levels and risk of toxicity from digoxin). Stress the importance of not taking drugs unless they are prescribed by the physician. Offer to make an appointment for him to see his physician and ask for a prescription for a medication to relieve arthritis pain.
4. Increased sodium intake from use of Mylanta could result in peripheral edema. Use of indomethacin could decrease the effect of the hydrochlorothiazide and propranolol, thereby increasing body fluid volume. With increased body fluid volume, the heart could be working

CASE STUDY *(continued)*

harder, increasing myocardial oxygen demand and causing angina.

5. Ex-Lax facilitates movement through the gut, thereby decreasing absorption of all the other medications; it probably contributes to fluid and electrolyte imbalance.
6. Refer to the physician for evaluation of chest pain (if this resembles cardiac angina, consider emergency referral) or to social services for necessary social support. Call on family members for assistance with medications and transportation, and suggest Meals-on-Wheels.
7. Set up a scheduling plan. Draw a calendar with medications depicted. Teach Mr. W. to take medications at specific times each day. Encourage discontinuance of Ex-Lax, Mylanta, and indomethacin. Build on the knowledge that he already has. Relate medications to events in Mr. W.'s lifestyle. If he seems unable to manage medications on his own, ask the physician for a referral for home-health nurses to administer medications as needed.

STUDY QUESTIONS

Select the best answer to each question.

1. Considering the pharmacokinetics in the OLDER person, which of the following statements is true?

- **a.** Overall absorption is decreased.
- **b.** Overall distribution is enhanced.
- **c.** There is an increase in receptors with aging.
- **d.** Excretion is facilitated, resulting in a shorter duration of drug action.

2. Which of the following factors would be the strongest in influencing compliance in the older person on a fixed income?

- **a.** Dietary habits
- **b.** Cost of filling prescriptions
- **c.** Body fat-to-lean muscle weight ratio
- **d.** Family support

3. Mrs. M., age 82, lives at home alone. Her daughter visits once a day and helps her bathe. Mrs. M. cooks her own meals and works in her home and yard. Which of the following factors could place Mrs. M. at risk of making a medication error?

- **a.** Multiple medications
- **b.** Visual changes
- **c.** Different schedules for different drugs
- **d.** All of the above

4. Mrs. M.'s daughter reports that she seems to take laxatives two or three times per day. What effect would laxative abuse have on the other medications Mrs. M. is taking?

- **a.** Increased absorption due to clearance of the GI tract
- **b.** Increased absorption due to facilitation of medication through the GI tract
- **c.** Decreased absorption due to increased gut motility
- **d.** Decreased distribution due to increased fluid consumption

5. Mrs. M. seems to have difficulty remembering whether or not she has taken her pills. Which of the following would assist her in this endeavor?

- **a.** Medication pill boxes with compartments
- **b.** Turning the bottles upside down
- **c.** Color coding the medications with a check-off list
- **d.** All of the above

20 Laboratory Values and the Older Adult

Mary Ann Anderson

Learning Objectives

After completing this chapter, the student will be able to:

1. Identify laboratory tests that are important indicators of health and disease in the elderly patient.
2. Apply an understanding of laboratory tests to the health of elderly persons.
3. Identify at least three reference resources for understanding laboratory values.
4. Identify medications that have an influence on laboratory tests for elderly people.
5. Describe nursing actions appropriate for abnormal laboratory values.

INTRODUCTION

Among the tools for health and illness measurement are laboratory tests. A battery of laboratory tests are done on admission to a hospital or nursing home, and, for elderly persons, they also are often done when visiting the physician. As a licensed practical nurse (LPN), you have studied laboratory values and their meanings in your medical and surgical nursing classes. You also use laboratory resources at the facility where you work in order to correctly interpret laboratory values of older adults. The purpose of this chapter is not to repeat that information; instead, it is to provide a ready reference of significant tests for elderly people along with specific and pertinent information that relates to the elderly.

PRIORITY SETTING 20.1

Generally the laboratory employees are responsible for obtaining blood specimens from the people in your care. You, or a CNA you supervise, will be responsible for obtaining any urine, stool, wound, or sputum specimens. The priority for you is to gather all specimens PERFECTLY. That may seem a bit demanding, but there is no reason to send a specimen to the laboratory if it will not give you accurate results.

When an older person is asked to give you a midstream urine specimen, the individual may not understand what that means. Not wanting to look "dumb," the individual may not ask for clarification. You need to determine if the person understands the instructions by asking for feedback on what you want. When asked to cleanse the urinary meatus before voiding for a clean catch specimen, an older person may think that is not "proper" and simply not do it. You are the person responsible to see that these things are done properly so the specimen will give accurate results.

When obtaining a sputum specimen, you are the person who must see that the specimen comes from a deep cough so it is the best specimen possible. Most people don't like mucus, or perhaps it is painful for the older person to cough deeply. You need to plan ahead and be prepared with a strategy that will get the specimen needed for the proper treatment. As in all things you do, be patient and caring, as these are the hallmark behaviors of professionals in nursing.

MEANING OF LABORATORY VALUES IN THE ELDERLY PERSON

Laboratory tests are a routine part of the health examination for all people. For many tests, the normal ranges are different for elderly people than for people younger than 65 years of age. For others, there is no change with age. Also, elderly people may have greater deviations from normal laboratory indicators when under stress, and their return to normal is often slower than younger people's. Conditions such as anemia, electrolyte imbalances, and infections are common in the elderly population. They can be discovered and treatment can be monitored through the use of laboratory tests. The diagnosis and treatment of these conditions result in substantial

It is important to remember that behind every laboratory procedure there is a human being who is anxious about the procedure itself or the results of the procedure.

improvement in health, even in elderly individuals with multiple health problems.

Relationship to Clinical Status

You, as the LPN, need to remember that all laboratory findings must be evaluated in relation to the individual's total clinical situation. The elderly person's gender, dietary pattern, activity level, use of tobacco and alcohol, current medications, and aggressive medical and nursing interventions can alter laboratory findings. Laboratory values should never be considered in isolation, especially when dealing with the often frail elderly person seen in clinical settings. For example, abnormal laboratory values may indicate a physiological stressor such as dehydration or medication side effect rather than illness. It is essential that you consider all facets of the individual's health and habits when you review the laboratory results.

Routine Laboratory Evaluations

A routine laboratory evaluation generally consists of the following:

- Complete blood cell count
- Serum glucose
- Serum creatinine level
- Serum electrolytes
- Thyroid function tests
- Urinalysis
- Stool guaiac test

Other specific laboratory tests that are not part of the routine evaluation may be ordered to help diagnose illness and disease. They include:

- Chest X-ray studies for those with symptoms or who are at risk of pulmonary disease
- Tuberculosis testing, which is recommended for individuals in group-living situations or for those who are at risk of exposure
- Baseline electrocardiograms, which should be done in all elderly persons and repeated when there is suspicion of heart rate or rhythm changes or myocardial infarction

This chapter includes discussion of the most common laboratory tests ordered and their meanings for elderly people. The values shown under headings are normal reference values from *Harrison's Principles of Internal Medicine* (Wilson, 2005), unless otherwise indicated. As an LPN, you must refer to the reference intervals used by the clinical laboratory where you work for the most precise reference ranges.

COMMON SCREENING TESTS

There are three common screening tests that should be performed on elderly people. The physician may request additional tests, but these three are those most commonly used for general screening and are important for you to know.

Tuberculin Skin Test

Tuberculin Skin Test

Negative result	<10 mm of induration

General Information

The tuberculin skin test, using purified protein derivative (PPD), is the screening method of choice for the detection of tuberculosis. Unfortunately, as many as 25% of older adults who are clinically ill with tuberculosis show no reaction (<10 mm of induration) to intradermal injections of 5 U of tuberculin.

Some older adults who show no initial reaction to the test respond after the test is repeated 1 week later. The majority of people who react positively to the test have no clinical evidence of infection. Nursing home residents, whose risk of infection is five times greater than that of nonresidents, should be screened with a tuberculin skin test on admission and annually thereafter. Although the incidence of infection is low and treatment with isoniazid is known to be effective, congregate living poses the risk of epidemic infection.

Nursing Implications

Because anergy (lack of reaction to specific antigens) is common in elderly people, some clinicians recommend that all PPDs should be placed with appropriate intradermal technique and should be done annually.

Urinalysis

Urinalysis

Appearance	Clear yellow/straw
Specific gravity	1.005–1.020
pH	4.5–8.0

General Information

The normal urine should test negative for glucose, ketones, blood, bilirubin, lupus erythe-

matosus, protein nitrates, and calculi in the elderly person, although traces of protein may be present. There may be between zero and three red blood cells (RBCs), zero and four white blood cells (WBCs), a few epithelial cells, and a few crystals per high-power field on microscopic examination. Elderly people commonly have the presence of zero to three hyaline casts on low-power field. In addition, between 10% and 50% of older people have asymptomatic bacteriuria.

Nursing Implications

- Usually a midstream, clean-catch specimen is requested. For this sample, the urinary meatus is cleansed with soap and water or a mild cleaning solution, voiding is initiated, and then a sample is collected in midstream to allow clearing of contamination from outside the urinary meatus.
- First-morning and fasting urine specimens are collected when the individual awakes and can provide the most concentrated urine of the day. Analytic values for protein, nitrite, fasting urine glucose, and urinary sediment are highest at that time.
- The 24-hour urine specimen measures the average excretion for substances eliminated in variable amounts during the day.
- Urine specimens should be sent to the laboratory within 10 minutes or refrigerated to prevent growth of bacteria, as well as to prevent the bacteria from using the glucose.

Urinary tract infection is a specific illness that is common in the elderly population. The highest incidence of reported urinary tract infections is in long-term care facilities. This occurs because the urinary tract pathogens often become resistant to antibiotics in nursing homes.

1. Typical symptoms are:
   Frequency
   Burning
   Hematuria
2. In an older person, the only symptoms exhibited may be:
   Nocturia
   Incontinence
   Confusion
   Anorexia
   Lethargy

Stool for Occult Blood

Stool for Occult Blood	
Negative result	Absence of test color

General Information

Gastrointestinal (GI) bleeding is common in older people, especially in those taking aspirin-containing medications and nonsteroidal anti-inflammatory agents (NSAIDS). Approximately 2.5 mL of blood per day normally appears in the stool. Hemorrhoids and colorectal cancer are the most common causes of minor bleeding in the elderly population.

Abnormal bleeding from the GI tract may be either occult (hidden) or obvious by observation. Minor bleeding may be accompanied by a decrease in the hemoglobin and hematocrit, as well as by symptoms of fatigue and weakness. The fecal occult blood test is useful in screening for colorectal cancer.

Nursing Implications

- There are various tests for fecal occult blood, all requiring the contact of a reagent with a stool specimen.
- A positive test result, indicated by color (usually blue), occurs when there is more than the normal amount of GI blood loss.
- Recommendations are to test at least three stool specimens and to sample from at least two areas of each stool.
- Instruct the person to avoid red meats, vitamin C intake, iron supplements, and aspirin for 2 to 3 days before and during stool testing to avoid invalidating the results. Check the manufacturer's directions for other restrictions.

HEMATOLOGICAL INDICATORS

In addition to the three common screening tests, hematologic tests are routinely done on all people.

Complete Blood Count

The complete blood count (CBC) includes RBC count, hemoglobin, hematocrit, RBC indices, white blood cell (WBC) count, platelets, and frequently, but not always, a differential. Values for the CBC do not change with age.

Red Blood Cell Count	
Men	5.4 ± 0.9 × 1012/L
Women	4.8 ± 0.6 × 1012/L

General Information

The RBC count is used to compute and support other hematological tests to diagnose anemia, polycythemia, and other bone marrow abnormalities.

1. Decreased RBC count may indicate:
   Anemia
   Fluid overload
   Kidney problems
   Bone marrow invasion of other cells or tumors
   Recent hemorrhage
   Chronic illness and autoimmune diseases
2. An increased RBC count may be caused by:
   Polycythemia
   Dehydration
   Hypoxia
   Congestive heart failure
   Impaired pulmonary ventilation
   Abnormal hemoglobin

Hemoglobin

Men	14–18 g/dL
Women	12–16 g/dL

General Information

Normal hemoglobin levels are maintained throughout life in healthy individuals. Hemoglobin concentration in whole blood correlates closely with the RBC count.

1. Increased hemoglobin levels may be caused by:
   Polycythemia
   Dehydration
2. Decreased hemoglobin levels may be caused by:
   Anemia
   Recent hemorrhage
   Fluid retention causing hemodilution
   Kidney disease

Hematocrit

Men	47.0 ± 5.0%
Women	42.0 ± 5.0%

General Information

Hematocrit measures the percentage by volume of packed RBCs in whole blood.

1. Decreased hematocrit levels may be caused by:
   Anemia
   Hemodilution
   Bone marrow disease
   Kidney disease
2. Increased hematocrit may be caused by:
   Polycythemia
3. Significant volume depletion with an associated increased blood urea nitrogen (BUN) and creatinine

Red Blood Cell Indices

MCV	90 ± 7 fL
MCH	29 ± 2 pg
MCHC	34 ± 2%

General Information

RBC indices—mean corpuscular volume (MCV), mean corpuscular hemoglobin (MCH), and mean corpuscular hemoglobin concentration (MCHC)—aid in the diagnosis and classification of anemias by providing information about the size, hemoglobin concentration, and hemoglobin weight of an average RBC.

White Blood Cell Count

4.5–11.0 × 10^9/L

General Information

The WBC count is also known as the leukocyte count. It is used to identify infectious or inflammatory processes, to evaluate the need for further tests, and to monitor the older person's response to chemotherapy or radiation therapy. There is a decrease in the WBC count with age due to a reduction in lymphocyte cells. This results in fewer lymphocytes to resist infection.

1. A decreased WBC count (leukopenia) may be caused by:
   Bone marrow depression, due to primary disease (leukemia, myeloma, and other tumors)
   Reactions to antineoplastics or other toxins
   Viral infections (influenza, infectious hepatitis)
   Sepsis
   Radiation treatments
   Drug use, including phenytoin, NSAIDS, and metronidazole
2. An increased WBC count (leukocytosis) may be caused by:
   Infection
   Inflammation
   Tissue necrosis
   Leukemia
   Excessive exercise
   Stress

In elderly persons, infection may not be accompanied by a normal increase in the number of WBCs (leukocytes). Therefore, a WBC differential is required to detect and diagnose disease.

White Blood Cell Differential

Neutrophils 1.8–7.7 × 10^9/L or 30%–60%
Eosinophils 0–0.45 × 10^9/L or 1%–4%
Basophils 0–0.20 × 10^9/L or 0%–0.5%
Lymphocytes 1.0–4.8 × 10^9/L or 25%–35%
Monocytes 0–0.8 × 10^9/L or 1%–4.0%

General Information

The WBC differential is used to determine the severity of an infection, detect allergic reactions and parasitic infections, identify various leukemias, and assess the individual's capacity to resist and overcome infection.

Five types of WBCs are classified in the normal differential:

- Neutrophils
- Eosinophils
- Basophils
- Lymphocytes
- Monocytes

Platelet Count

130,000–400,000/mL

General Information

Platelets, also called thrombocytes, are necessary for the formation of the aggregate or plug necessary for clot formation and hemostasis. Platelets also supply phospholipids for the process of coagulation in the thromboplastin generation pathway. When the platelet count is below 50,000/mm^3, spontaneous bleeding may occur.

1. A decreased platelet count (thrombocytopenia) may be caused by:
   Bone marrow disease
   Folic acid or vitamin B_{12} deficiency
   Disseminated intravascular coagulation
   Drugs (antineoplastics, furosemide, indomethacin, penicillin, phenytoin, quinidine sulfate, salicylates, sulfonamides, thiazides, tricyclic antidepressants, and others)
   Destruction due to immune disorders, radiation, or mechanical injury
   Disseminated intravascular coagulation
2. An increased platelet count (thrombocytosis) may be caused by:
   Iron-deficiency anemia
   Hemorrhage
   Splenectomy
   Polycythemia vera
   Malignancies
   High altitudes
   Persistent cold temperature
   Strenuous exercise

This older couple goes to the hospital outpatient department monthly to have blood drawn to assist in their medication management. The man has Alzheimer's disease and sometimes gets aggressive with his wife. The woman worries each time they have to go to the hospital, yet she perseveres because she knows how important the results are to their health.

Coagulation

Prothrombin Time (PT)

Normal	9.5–11.8 s (control ± 1 s)
Therapeutic	1.5–2.0 times normal control

General Information

Anticoagulation therapy is indicated in many conditions, such as pulmonary embolus, deep-vein thrombosis, chronic atrial fibrillation, and heart valve prosthesis. Warfarin (Coumadin) is used in oral anticoagulation therapy. PT is an indirect measure of prothrombin and an overall evaluation of these extrinsic coagulation factors. The PT is determined before initiation of warfarin therapy and then daily until maintenance dosage is established. Thereafter, PT determinations may be made at 1- to 4-week intervals, depending on the stability of the person's therapeutic level.

Nursing Implications

- Risk of serious hemorrhage is high in elderly anticoagulated persons over age 70, especially those at risk for falls.
- Many drugs have a potentiating or inhibiting effect on warfarin, so all medications being taken by an individual taking warfarin must be reviewed. Diets high in vitamin K should be encouraged.

Activated Partial Thromboplastin Time (APTT)

Normal	25–36 s
Therapeutic	1.5–2.5 times normal control

General Information

APTT evaluates all of the clotting factors of the intrinsic pathway, except for two, by measuring the time required for formation of a fibrin clot. The APTT is used to monitor heparin anticoagulation therapy aimed at increasing the APTT to a therapeutic range. The APTT is more sensitive and is often used in place of the PT.

Nursing Implications

- If PT or APTT values are higher than the therapeutic range, or if bleeding or signs of bleeding such as hematuria, black tarry stools, hematemesis, bruising and petechiae, epistasis, hemoptysis, continuous abdominal or head pain, faintness, or dizziness occur, withhold the anticoagulant dose and notify the physician immediately.
- Periodic urinalyses as well as stool guaiac and liver function tests are carried out to detect hemorrhage or liver dysfunction.

BLOOD CHEMISTRY INDICATORS

Blood Glucose

Blood Glucose, Plasma

Fasting:

Normal	75–115 mg/dL
Diabetes mellitus	140 mg/dL on at least 2 occasions

Two hours after eating:

Normal	140 mg/dL
Impaired glucose tolerance	140–200 mg/dL
Diabetes mellitus	>200 mg/dL on at least two occasions

General Information

In elderly people, the exact definition of abnormal glucose tolerance is unclear. Using the National Diabetes Data Group and the World Health Organization diagnostic criteria, diabetes mellitus is present when the fasting (12- to 14-hour fast) plasma glucose is over 140 mg/dL on two separate occasions or over 200 mg/dL 2 hours after oral glucose administration.

A number of drugs and conditions affect plasma glucose levels.

1. Decreased blood plasma glucose (hypoglycemia) is indicated by:
   Plasma blood glucose values below 100 mg/dL
   Weakness
   Restlessness
   Hunger
   Nervousness
   Sweating
   Rapidly decreasing mental alertness in an elderly person without the common symptoms listed above
2. Decreased plasma glucose levels may be caused by:
   Beta-blockers
   Ethanol
   Clofibrate
   Monoamine oxidase inhibitors
   Strenuous exercise
   Failure to refrigerate the blood sample and analyze it within a few hours of collection

3. Increased blood plasma glucose (hyperglycemia) is indicated by:
   Plasma glucose levels, which usually exceed 600 mg/dL. Plasma glucose above 160–180 mg/dL is the average renal threshold, resulting in glycosuria in older persons.
   Lack of symptoms
   Urinary frequency
   Dehydration
   Weakness
4. Elevation of plasma glucose levels may be caused by:
   Chlorthalidone
   Thiazide diuretics
   Furosemide
   Oral contraceptives
   Benzodiazepines
   Phenytoin
   Phenothiazines
   Lithium
   Epinephrine
   Nicotinic acid
   Corticosteroids
   Recent illness or infection

If undetected, worsening hyperglycemia results in alterations in mental status and hyperosmolar coma in the older person with non-insulin-dependent diabetes mellitus.

Electrolytes

Normal values for electrolytes are the same for the young and old. Numerous conditions, medications, and dietary factors influence electrolyte values. Common electrolyte-related causes of weakness in elderly people are hypernatremia (high sodium), hyponatremia (low sodium), and hypokalemia (low potassium).

Sodium, Serum

136–145 mEq/L

General Information

The elderly population is at increased risk of serum sodium imbalance. Decreased sodium levels promote water excretion, and increased levels promote retention, primarily through stimulation or depression of aldosterone secretion. Loss of body water causes concentration of serum sodium (hypernatremia), whereas an increase in body water causes dilution of serum sodium (hyponatremia). Sodium also plays a role in acid–base balance, chloride and potassium levels, and neuromuscular function.

Hyponatremia

A sodium concentration of less than 136 mEq/L occurs when there is an excess of water in relation to total sodium.

1. Symptoms may be absent, or there may be:
   Fatigue
   Headache
   Restlessness
   Decreased skin turgor
   Nausea
   Muscle cramps and tremors
   Disorientation
   Confusion
   Coma
   Seizures
   Death
2. Conditions causing hyponatremia include:
   Vomiting
   Diarrhea
   Renal disorders
   Diuretics
   Congestive heart failure
   Cirrhosis
   Overhydration
   Adrenal insufficiency
   Use of nutritional support formulas without additional sodium
   Syndrome of inappropriate antidiuretic hormone secretion associated with numerous drugs and diseases

Hypernatremia

A sodium concentration greater than 146 mEq/L is a result of a deficit of body water relative to total sodium content and is usually caused by dehydration.

1. Symptoms include:
   Weakness
   Thirst
   Restlessness
   Dry, sticky mucous membranes
   Flushed skin
   Oliguria
   Diminished reflexes
2. Conditions contributing to hypernatremia include:
   Inadequate fluid intake
   Diarrhea
   Polyuria associated with diabetes mellitus
   Diuretics
   Increased insensible water loss from fever and tachypnea
3. Conditions causing hypernatremia include:
   Hypertension

Dyspnea
Edema
Kidney disease due to a lack of response to ADH
4. Conditions causing excess sodium concentration are:
Increased dietary intake
Aldosteronism
Intravenous infusion of normal saline for treatment of fluid loss or shock

Potassium, Serum

3.5–5.0 mEq/L

General Information

Potassium maintains cellular osmotic equilibrium and helps regulate muscle activity by maintaining electrical conduction within the cardiac and skeletal muscles. Potassium also helps regulate acid–base balance, enzyme activity, and kidney function. Potassium deficiency develops rapidly because the body has no effective way to conserve potassium.

1. Signs and symptoms commonly seen with hypokalemia (decreased serum potassium levels) include:
Mental confusion
Rapid, weak, irregular pulse
Hypotension
Anorexia
Decreased reflexes
Muscle weakness
Paresthesia
2. Hypokalemia is caused by:
Diuretics
Diarrhea
Vomiting
Renal tubular acidosis
Malnutrition
Urinary potassium losses associated with glycosuria and ketonuria and with hyperaldosteronism
3. Signs and symptoms of hyperkalemia (increased serum potassium) are:
Weakness
Malaise
Nausea
Diarrhea
Muscle irritability
Oliguria
Bradycardia
4. Hyperkalemia is caused by:
Renal failure
Cell damage from burns
Injuries
Chemotherapy
Acidosis
Addison's disease
Diabetes mellitus
5. Several drugs may increase serum potassium levels, including:
Spironolactone
Triamterene
NSAIDs
Beta-blockers
Angiotensin-converting enzyme inhibitors
Penicillin G
Amphotericin B
Methicillin
Tetracycline

General Information

Calcium, Plasma

9–10.5 mg/dL

Calcium absorption becomes less efficient in both men and women with age. Dietary calcium is associated with the loss of bone that begins in the 40s. Calcium helps regulate and promote neuromuscular and enzyme activity, skeletal development, and blood coagulation. Parathyroid hormone, vitamin D, calcitonin, and adrenal steroids control calcium blood levels. Almost all of the body's calcium is stored in the bones and teeth. Serum calcium varies inversely with the body's phosphorus level. The body requires ingestion of about 1 g per day of dietary calcium, because calcium is excreted in the urine and feces.

1. Signs and symptoms of hypocalcemia include:
Circumoral and peripheral numbness and tingling
Muscle twitching
Facial muscle spasm
Muscle cramping
Seizures
Dysrhythmias
2. The causes of hypocalcemia include:
Insufficient activity of the parathyroid glands
Hypomagnesemia
Hyperphosphatemia due to renal failure
Laxatives
Chemotherapy
Corticosteroids
Malabsorption
Acute pancreatitis
Alkalosis osteomalacia
Diarrhea
Rickets (vitamin D deficiency)
3. Signs and symptoms of hypercalcemia are:
Hypertension

Bone pain
Muscle hypotonicity
Nausea
Vomiting
Dehydration
Mental confusion
Coma
Cardiac arrest

4. The causes of hypercalcemia are:
   Hyperparathyroidism
   Thiazide diuretics
   Cancer
   Addison's disease
   Hyperthyroidism
   Paget's disease
   Immobilization
   Excessive vitamin D intake
   Calcium-containing antacids
   Androgens
   Progestins or estrogens
   Lithium carbonate

Phosphate, Serum

3–4.5 mg/dL

General Information

Phosphate helps regulate calcium levels, carbohydrate and lipid metabolism, and acid–base balance. Adequate levels of vitamin D are necessary for absorption of phosphates from the intestine. About 85% of the body's phosphate is found in bone. Calcium and phosphate have a reciprocal relationship. The kidneys regulate phosphate excretion to maintain a balance with serum calcium.

Family is this woman's greatest joy. She appreciates the monthly laboratory work that is done for her at the nursing home where she resides. She doesn't worry about the results because she knows the doctor and nurses will manage the situation for her. That leaves her more time to be with her family.

Chloride, Serum

98–106 mEq/L

General Information

Chloride interacts with sodium to maintain the osmotic pressure of the blood. Chloride is important in maintaining the acid–base balance in the body and varies inversely with the bicarbonate level. Low chloride levels are usually seen with low sodium and potassium levels.

End Products of Metabolism

Blood Urea Nitrogen (BUN), Serum

10–20 mg/dL

General Information

Blood urea nitrogen is the chief end product of protein metabolism. The BUN level reflects protein intake, liver function, and kidney excretory capacity. The normal BUN value remains unchanged with age. Because protein intake is often low in the elderly population, BUN values may be normal even with impaired renal function. Elevation of BUN levels without serum creatinine elevation suggests dehydration.

There are usually no signs or symptoms of an increased BUN level other than those associated with dehydration or other underlying renal disease. Likewise, with decreased BUN levels, the signs and symptoms are those of the underlying condition.

1. Increased BUN levels occur with:
   Renal disease
   Reduced renal blood flow
   Urinary tract obstruction
   Increased protein catabolism (starvation, burns)
   Drugs such as aminoglycosides, amphotericin B, and methicillin
2. Decreased BUN levels occur with:
   Severe liver failure
   Malnutrition
   Overhydration
   Chloramphenicol use

Creatinine, Serum

1.5 mg/dL

General Information

Creatinine values also are unchanged with age. Yet because lean body mass declines with age, the total daily production of creatinine also declines, staying below 1.2 mg/dL. This causes an overestimate of renal function in the elderly based on static measurements of serum creatinine.

Creatinine clearance declines by almost 10% per decade after 40 years of age and is a more reliable indicator of kidney function than the BUN and serum creatinine values. In elderly people, creatinine clearance is important for determining the dosage for drugs that are cleared by the kidney to avoid drug toxicity. Creatinine clearance (mL/min) is defined as a ratio. For men, the formula is:

$$\frac{[140 - \text{age (y)}] \times \text{body weight (kg)}}{\text{serum creatinine (mg/dL)} \times 72}$$

For women, multiply the result from the above formula by 0.85.

An increase in serum creatinine may be caused by:

- Renal disease
- Diabetic acidosis
- Starvation
- Muscle disease
- Hyperthyroidism
- Use of ascorbic acid
- Barbiturates
- Diuretics

A high serum creatinine level indicating renal failure may be associated with nonspecific symptoms such as weight loss and weakness. Because creatinine is easily excreted by the kidneys, with minimal tubular reabsorption, serum creatinine levels are directly related to the glomerular filtration rate (GFR).

Bilirubin, Serum

Total	0.3–1.0 mg/dL
Direct	0.1–0.3 mg/dL
Indirect	0.2–0.7 mg/dL

General Information

Bilirubin is the major product of hemoglobin breakdown and is excreted as a pigment in bile. The excretion of bilirubin is dependent on the normal production and destruction of RBCs and a functional hepatobiliary system, where bilirubin is conjugated and excreted. The direct bilirubin value increases with the obstruction of the flow of bile through the biliary system because this causes uptake of direct bilirubin into the circulation. Levodopa may cause false increases in bilirubin.

Uric Acid, Serum

Men	2.5–8.0 mg/dL
Women	1.5–6.0 mg/dL

General Information

Uric acid, the major end metabolite of dietary and endogenous purines, is excreted through the kidneys. Cell breakdown and catabolism of nucleic acids, excessive production and destruction of cells, and inability to excrete uric acid are causes of hyperuricemia. An increase in serum uric acid is found in a variety of conditions, including gout, impaired renal function, congestive heart failure, hemolytic anemia, polycythemia, neoplasms, and psoriasis.

Serum uric acid levels above 8 mg/dL in men and 6 mg/dL in women are often associated with symptoms of gout. Gout is an acute inflammation of a joint, commonly the metatarsophalangeal joint of the great toe, caused by uric acid crystal accumulation.

Causes of increased serum uric acid levels include:

- Loop diuretics
- Thiazides
- Starvation
- A high-purine diet
- Stress
- Alcohol abuse
- Chemotherapy

Levodopa, acetaminophen, ascorbic acid, and phenacetin may cause false elevations in uric acid levels.

Liver Function Tests

Most liver function tests remain unchanged in the elderly population. The alkaline phosphatase level is frequently elevated in older adults. Total alkaline phosphatase may rise owing to Paget's disease, bone fracture, trauma, or osteoporosis. For people taking tacrine (Cognex) for Alzheimer's disease, liver function tests are very important.

ALT (SGPT) (alanine aminotransferase, alanine transaminase, or serum glutamic-pyruvic transaminase)

0–35 U/L

General Information

Alanine aminotransferase, an enzyme necessary for tissue energy production, is present predominantly in the liver. It also is present in the kidney, heart, and skeletal muscles and is a relatively specific indicator of acute liver cell damage.

Elevated ALT levels are caused by:

- Liver disease
- Different medications
- Cholecystitis
- Intrahepatic cholestasis
- Pancreatitis
- Hepatic congestion due to heart failure
- Acute myocardial infarction
- Trauma
- Lead ingestion
- Carbon tetrachloride exposure

Falsely elevated ALT levels are caused by the use of barbiturates and narcotic analgesics.

Aspartate aminotransferase, aspartate transaminase (AST), or serum glutamic-oxaloacetic transaminase (SGOT)

0–35 U/L

General Information

Aspartate aminotransferase is an enzyme found in cells of the liver, heart, muscles, kidneys, pancreas, and RBCs. Serum levels are highest during acute cellular damage and decrease during tissue repair. The AST level is useful in monitoring the progress of myocardial infarction and acute liver disease.

Elevations are found in:

- Myocardial infarction
- Liver disease
- Extensive surgery
- Hemolytic anemia
- Pulmonary emboli
- Delirium tremens
- Diseases of the brain, muscle, pancreas, spleen, and lungs
- Alkaline phosphatase level

General Information

Alkaline phosphatase is an enzyme active in bone calcification and in lipid and metabolite transport. Serum alkaline phosphatase levels are sensitive to biliary obstruction by space-occupying hepatic lesions, such as tumors or abscesses, and to metabolic bone disease. Alkaline phosphatase isoenzymes may be identified to differentiate hepatic and skeletal diseases.

Increases in alkaline phosphatase are found in:

- Gallbladder disease associated with obstruction
- Paget's disease
- Bone metastasis
- Hyperparathyroidism
- Liver disease
- Osteomalacia

Lactic Dehydrogenase (LDH), Serum

60–100 U/mL

General Information

Lactic dehydrogenase is most useful in diagnosing myocardial infarction but also is elevated in hepatic disease, pulmonary infarction, and anemias. It is present in almost all body tissues. Five tissue-specific isoenzymes may be measured; of these, LDH4 and LDH5 are found in the liver and the skeletal muscles. Elevated LDH values are diagnostic in hepatitis, active cirrhosis, and hepatic congestion.

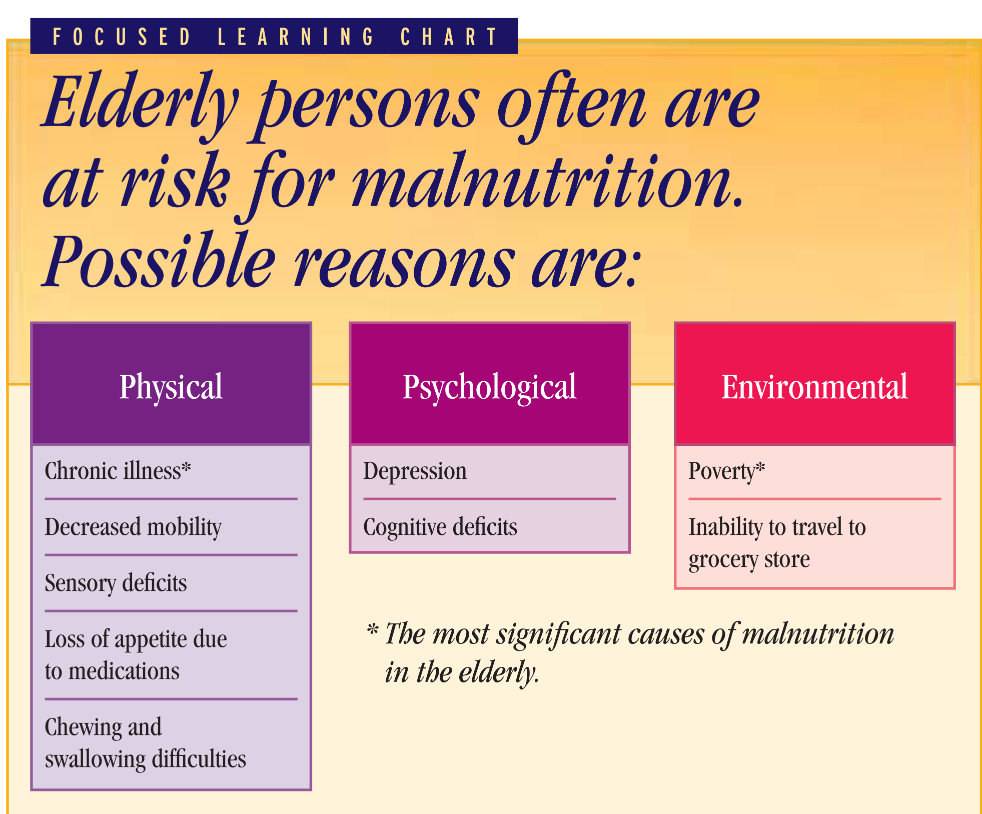
NUTRITIONAL INDICATORS

Elderly persons require and consume fewer total calories per day than younger adults. Carbohydrate intake may increase slightly (40% of total calories), whereas fat and protein intakes generally decline in older people. Lean body mass and total body protein decrease, whereas the percentage of body fat increases with age.

It is critical that you, as an LPN, recognize that elderly persons are often at risk for malnutrition. This is due to conditions such as decreased mobility, cognitive and sensory deficits, chewing and swallowing difficulties, and loss of appetite due to medications, illness, or the environment. The increased occurrence of wounds, infection, and dehydration creates additional nutritional demands on the elderly, yet the most significant causes of poor nutrition in older people are poverty and chronic illness.

Because of these physiological and societal factors, it is important to have baseline laboratory values for several indices of nutritional status and to understand their significance:

- Total serum proteins measure visceral protein stores.
- Serum albumin is the most widely used indicator of protein status.
- Serum transferrin is an indicator of protein stores.
- Serum cholesterol indicates lipid mass.
- Serum creatinine indicates lean body mass.



The hemoglobin, hematocrit, and lymphocyte count included in the CBC reflect the body's ability to transport nutrients and resist disease. Other common nutritional indicators are iron and micronutrients such as vitamins and minerals.

Nutritional deficiencies are often identified only when an associated problem such as weight loss, poor wound healing, or weakness occurs. Treating an underlying cause such as medication use or an illness may correct the deficiency. Otherwise, an increased dietary intake of the nutrient or vitamin and mineral supplements may be indicated.

Protein Indicators

Total Serum Protein

5.5–8.0 g/dL

General Information

The major blood proteins are serum albumin and the globulins, which together equal the total serum protein value. The measurement of total protein is performed by protein electrophoresis and aids in the diagnosis of protein deficiency, blood dyscrasias, and hepatic, GI, renal, and neoplastic diseases.

1. Symptoms commonly seen with low serum protein values are:
   Dermatitis
   Hair thinning
   Muscle wasting
   Weakness
   Poor wound healing
2. Total protein values are increased with:
   Dehydration
   Diabetic acidosis
   Infections
   Multiple myeloma
   Monocytic leukemia
   Chronic alcoholism
   Chronic inflammatory disease
3. Common causes are:
   Edema
   Tissue breakdown
   Poor wound healing
4. Total protein values decrease with:
   Malnutrition
   Hepatic disease
   Renal disease
   GI disease
   Hodgkin's disease
   Trauma such as burns, hemorrhage, and shock

Hyperthyroidism
Congestive heart failure

Albumin, Serum

3.5–5.5 g/dL

General Information

Albumin values of less than 3.5 g/dL indicate protein malnutrition and are accompanied by an increased incidence of morbidity and mortality. Albumin maintains oncotic pressure and transports substances such as bilirubin, fatty acids, hormones, and drugs that are insoluble in water.

1. Albumin is increased only in:
   Multiple myeloma
2. Albumin is decreased in:
   Malnutrition
   Liver and renal disease
   Collagen diseases
   Rheumatoid arthritis
   Metastatic carcinoma
   Hyperthyroidism
   Essential hypertension
   The use of cytotoxic agents

Globulins, Serum

2.0–3.0 g/dL

General Information

The four types of globulins identified by protein electrophoresis are found in differing quantities in various conditions. Alpha$_1$, alpha$_2$, and beta-globulin are carrier proteins that transport lipids, hormones, and metals through the blood. Gamma globulin is an important component of the immune system.

Globulins are increased in:

- Tuberculosis
- Chronic syphilis
- Subacute bacterial endocarditis
- Myocardial infarction
- Multiple myeloma
- Collagen diseases
- Rheumatoid arthritis
- Diabetes mellitus
- Hodgkin's disease

Nursing Implications

Because a consistent relationship between protein intake and serum albumin levels has not been established, a high-protein diet is not advised except for individuals with evidence of protein calorie malnutrition. Protein allowance is the same for older people as for younger ones: 0.8 g/kg body weight. Protein should provide at least 12% of total calories for the healthy older person. The proteins from animal sources such as beef, poultry, fish, and dairy products are the most complete, whereas complementary vegetable proteins have less biological value. Some older people may need nutritional supplementation through oral, enteral, or parenteral routes if malnutrition is severe.

Iron Indicators

Iron, Serum

Men	80–180 mg/dL
Women	60–160 mg/dL

General Information

Iron appears in the plasma bound to the glycoprotein transferrin. Iron is essential in the production and function of hemoglobin as well as other compounds. Dietary iron is absorbed by the intestine and distributed in the body for synthesis, storage, and transport. The body has no mechanism for eliminating excessive iron; therefore, total body and bone marrow iron stores increase with advancing age, although serum iron may be depleted. Serum iron values should be interpreted, together with the total iron-binding capacity (TIBC) and the serum ferritin. It may be necessary to seek bone marrow and liver biopsy as well as iron absorption or excretion studies to obtain a definitive diagnosis in iron-related disease. A decrease in serum iron with an increased TIBC occurs in iron-deficiency anemia, which is most commonly caused in the elderly person by GI blood loss or malabsorption.

Ferritin, Serum

15–200 ng/mL

General Information

Ferritin is an iron-storage protein. Serum ferritin level indicates the amount of available iron stored in the body. It is measured to distinguish between iron deficiency (decreased ferritin level) and chronic infection or inflammation (increased or normal ferritin level).

1. Serum ferritin is increased in:
   Hepatic disease
   Iron overload
   Leukemia
   Hodgkin's disease

Chronic renal disease
Hemolytic anemias
Acute or chronic infection and inflammation
2. Ferritin is decreased in:
Chronic iron deficiency

Total Iron-Binding Capacity (Transferrin), Serum

250–460 mg/dL

Total iron-binding capacity decreases with age and reflects the transferrin content of the serum. Transferrin, a beta-globulin protein, transports circulating iron that is stored in various forms in the bone marrow, liver, and spleen. In protein-energy malnutrition, the TIBC is less than 250 mg/dL (see discussion under serum iron above).

Lipoproteins

Total Plasma Cholesterol

Desired	<200 mg/dL
Borderline	200–239 mg/dL
High	240 mg/dL

High-Density Lipoprotein (HDL) Cholesterol

Desired	>35

Low-Density Lipoprotein (LDL) Cholesterol

Desired	130 mg/dL
Borderline	130–159 mg/dL
High	160 mg/dL
Triglycerides	160 mg/dL

General Information

Blood lipid and lipoprotein cholesterol levels that are influenced by heredity, diet, and obesity are directly related to atherosclerotic heart disease in the elderly population. Higher HDL cholesterol, lower LDL cholesterol, and a decreased level of plasma triglycerides are all associated with decreased incidence of coronary heart disease.

In women, the increase in plasma total cholesterol with age is due primarily to an increase in LDL cholesterol. HDL cholesterol increases slightly in men over 65 years of age but decreases in women of the same age. Without intervening therapy, the risk for coronary heart disease in the elderly population gradually increases.

Both total cholesterol and HDL cholesterol should be measured in screening tests for the elderly population. The findings of a high initial cholesterol value should be followed by two subsequent evaluations because there may be significant daily variations in values. Older persons may have a total cholesterol of less than 200 to 240 mg/dL but have elevated LDL cholesterol and decreased HDL cholesterol and so have an increased risk of coronary heart disease. Conversely, the HDL cholesterol may be high, accounting for a total cholesterol level greater than 200 mg/dL, so that there is a reduced risk for coronary heart disease. Total cholesterol and HDL cholesterol may be obtained from nonfasting blood samples. Triglyceride levels are only accurate after a 12-hour fast. LDL cholesterol levels may be calculated after the total cholesterol, HDL cholesterol, and triglycerides are known.

Lipid abnormalities are often familial, but secondary causes are common in the elderly population. They include the following:

- Diets high in saturated fat or cholesterol
- Excessive alcohol intake
- Estrogen supplements
- Thiazide diuretics
- Beta blockers
- Smoking
- Uncontrolled diabetes
- Hypothyroidism
- Uremia
- Corticosteroid use
- Sedentary lifestyle
- Morbid obesity

Cholesterol levels less than 120 to 156 mg/dL have been associated with increased mortality in nursing home residents. Cholesterol is decreased in:

- Malnutrition
- Hyperthyroidism
- Chronic obstructive pulmonary disease

Nursing Implications for Lipid Abnormalities

- Weight control
- Increased physical activity
- Restriction of alcohol
- Cessation of smoking
- Restriction of dietary fat

Dietary restriction must be made cautiously because maintaining adequate calorie and protein intake is a major concern among elderly people. Drug therapy to control lipid levels may be beneficial in older persons with known coronary heart disease or high risk of disease.

DRUG MONITORING AND TOXICOLOGY

Drug monitoring is important when the margin of safety between therapeutic and toxic blood levels is narrow. Drug blood levels are useful guides in maintaining therapeutic levels as well as in identifying toxic levels of drugs. Not all drugs have a known therapeutic blood level even though toxic levels have been identified. Some drugs, such as amphetamines, are monitored through urine testing. Elderly persons metabolize and eliminate drugs more slowly than mature adults, a fact that heightens the importance of drug monitoring.

Three commonly monitored drugs—digoxin, theophylline, and phenytoin—are discussed because they require close observation from you, the nurse. Numerous classes of drugs are commonly checked for therapeutic or toxic levels. Please review the list in Box 20.1. Refer to a basic laboratory manual for specific drug therapeutic and toxic values.

Digoxin

Digoxin (Lanoxin) level, serum

Therapeutic	0.5–20 ng/mL
Toxic	2.5 ng/mL

General Information

Digoxin, used in the treatment of congestive heart failure and cardiac arrhythmias, has a prolonged half-life in the elderly population because of its reduced renal clearance. Serum digoxin level has a narrow therapeutic range and

BOX 20.1 Commonly Monitored Drugs

Alcohol
ethanol
isopropanol (rubbing alcohol)
methanol (antifreeze)

Amphetamines (Urine Testing)
amphetamine
dextroamphetamine
methamphetamine (Desoxyn)
phenmetrazine (Preludin)

Antiarrhythmics
disopyramide (Norpace)
idocaine (Xylocaine)
procainamide (Pronestyl)
propranolol (Inderal)
quinidine (Quinaglute and others)
verapamil (Calan, Isoptin)

Antibiotics
amikacin (Amikin)
gentamicin (Garamycin)
kanamycin (Kantex)
netilmicin (Netromycin)
tobramycin (Nebcin)

Anticonvulsants
cabamazepine (Tegretol)
ethosuximide (Zarontin)
phenobarbital (Luminal)
phenytoin (Dilantin)
primidone (Mysoline)

Antidepressants
amitriptyline
nortriptyline (Pamelor, Aventyl)
desipramine (Norpramin)
doxepin (Sinequan and others)
imipramine (Tofranil)
lithium (Lithobid)

Barbiturates and Hypnotics
amobarbital (Amytal)
glutethimide (Doriden)
pentobarbital (Nembutal)
phenobarbital (Luminal)
secobarbital (Seconal)

Bronchodilators
aminophylline
theophylline (Theo-Dur and others)

Cardiac Glycosides
digitoxin (Crystodigin)
digoxin (Lanoxin)

Hemoglobin Derivatives
carboxyhemoglobin (Hg = CO)
methemoglobin
sulfhemoglobin

Nonnarcotic Analgesics
acetaminophen (Tylenol and others)
salicylates (aspirin)

Phenothiazines
chlorpromazine (Thorazine)
prochlorperazine (Compazine)
thioridazine (Mellaril)
trifluoperazine (Stelazine)

despite the availability of tests for serum drug levels, digitalis toxicity is relatively common in elderly persons.

The most common side effects of digitalis toxicity are:

- Visual changes
- Headache
- Nausea and vomiting
- Weakness and fatigue

Weakness and fatigue are sometimes the only indicators of digitalis toxicity in elderly people.

Quinidine significantly increases the serum level of digoxin. Consequently, the digoxin dose must be reduced when both of these drugs are prescribed. Also, a change from tablet to elixir preparation of digoxin increases the absorption and serum level, so that the digoxin dose again needs to be reduced. Both low-serum potassium level and high-serum calcium level increase the risk of serious arrhythmias in persons on digoxin therapy.

Nursing Implications for Digoxin Blood Levels

- Draw blood samples for determining serum digoxin levels at least 5 to 6 hours after the daily dose and preferably just before the next scheduled daily dose.
- Check the apical pulse for 1 full minute.
- Suspect digitalis toxicity when there is a sudden change in heart rhythm or pulse (especially a decrease).
- Withhold the medication and report to the physician when there is a sudden change in pulse or rhythm.
- Monitor the serum potassium level, especially if the person is taking diuretics.

Theophylline

Theophylline, Serum

Therapeutic	10–20 μg/mL
Toxic	20 μg/mL

General Information

Theophylline, a bronchodilator, may or may not be associated with improved respiratory effort on spirometry testing. Nevertheless, theophylline improves mucocilliary clearance of the lungs and may improve myocardial contractility, stimulate respirations, and act as a mild diuretic.

Wide variations in the rate and extent of absorption and rate of metabolism for theophylline result in peak-to-trough fluctuations in serum concentrations and subsequent subtherapeutic or toxic responses.

1. Indications of possible toxicity include:
   Anorexia
   Abdominal discomfort
   Nausea
   Vomiting
   Dizziness
   Shakiness
   Restlessness
   Irritability
   Palpitations
   Tachycardia
   Hypotension
   Heart arrhythmias and seizures
2. Dizziness is a common side effect at the initiation of theophylline use in elderly people.
3. Elimination of the drug is reduced in persons with:
   Heart failure
   Kidney or liver dysfunction
   Alcoholism
   Fever
4. Smoking and phenytoin increase the elimination of theophylline so that an increase in dosage is required. The macrolide antibiotics (e.g., erythromycin), as well as others, may increase serum theophylline levels and cause toxicity.

Nursing Implications

- Regular monitoring of serum concentrations of theophylline is necessary to determine therapeutic dosage.
- The serum level must be checked when signs or symptoms of toxicity develop or when medications affecting serum levels are added or discontinued.

Phenytoin

Phenytoin (Dilantin), Serum

Therapeutic	10–20 μg/mL
Toxic	30 μg/mL

General Information

Phenytoin, an anticonvulsant that also has antiarrhythmic properties, is metabolized by the liver and excreted in the bile and partially by the kidneys. Unfortunately, phenytoin has a number of potentially serious adverse reactions and side effects that necessitate monitoring of several parameters, including liver, kidney, thyroid, and hematological functioning.

1. Potential adverse reactions and side effects are:
   Drowsiness
   Mental confusion
   Tremors
   Bradycardia
   Hypotension
   Photophobia
   Blurred vision
   Nausea
   Vomiting
   Epigastric pain
   Abnormal blood counts
   Fever
   Skin eruptions
   Pneumonitis
2. Acute kidney or liver dysfunction results in toxic drug levels.
3. Decreased phenytoin serum levels may result from:
   Chronic alcohol abuse
   Antacids
   Antihistamines
   Antineoplastics
   Barbiturates
   Excess of folic acid
   Rifampin
4. Increased serum levels may result from:
   Acute intake of alcohol
   Anticoagulants
   Aminosalicylic acid
   Benzodiazepines
   Cimetidine
   Dexamethasone
   Estrogens
   Isoniazid
   Methylphenidate
   Phenothiazines
   Salicylates
   Sulfonamides
   Phenylbutazone

Nursing Implications

- Liver and thyroid function tests, blood counts, and urinalysis are recommended before the initiation of therapy, at monthly intervals during early therapy, and at regular intervals thereafter.
- Lower doses are given to older adults and those with liver or kidney impairment.
- When phenytoin is given intravenously, vital signs and cardiac function must be monitored closely.
- Serum concentrations of magnesium, folic acid, vitamin D, and vitamin K may be decreased with phenytoin therapy and should be monitored.
- Symptoms of low serum magnesium may mimic those of phenytoin toxicity.

CONCLUSION

The use and interpretation of laboratory values are important in substantiating clinical judgment and providing comprehensive health assessment in the elderly. Physiological changes in older persons, presence of disease, use of medications, variance in diets, and even exercise affect laboratory values. Therefore, it is necessary to monitor changes in an individual's laboratory values, as well as to compare an individual's values with those of other older adults in similar situations.

Understanding laboratory values in the elderly population is a continuing endeavor for all health-care practitioners. It is important to refer consistently to comprehensive laboratory manuals and individual laboratory reference intervals used in a particular locality, as well as to specialized gerontological references. As new information becomes available, the interpretation of laboratory data will become more useful in determining care for older people.

CASE STUDY

Mr. K. is an 85-year-old resident of a small, independent group home where he has been caring for himself but sharing provided meals with the other residents. He underwent a transurethral resection of the prostate 4 years ago for benign prostatic hypertrophy. He has been treated for a heart irregularity and congestive heart failure in the past. Today he is being admitted to your intermediate care facility by his daughter because of several recent falls. Mr. K. reports that he has been nauseated and has not been eating well for the past few days. He also complains of wetting before reaching the restroom and blames this on his slow movement due to severe degenerative arthritis of his joints. Medications include:

- furosemide (Lasix) 40 mg in the morning
- digoxin 0.125 mg in the morning
- ibuprofen (Motrin) 600 mg twice a day
- acetaminophen (Tylenol) 500 mg every 4 hours as needed

On physical assessment, you find the following:

- Height 5 ft 10 in
- Weight 135 lb
- Blood pressure sitting 120/70 and pulse irregular at 80/min
- Blood pressure standing 90/60 and pulse irregular at 90/min
- Respirations 20/min and unlabored
- Temperature 98.8°F (36°C)
- Lungs are clear
- Skin is warm and dry, with dry mucous membranes

Laboratory values available are:

- Potassium 3.2 mEq/L
- Sodium 132 mEq/L
- Chloride 106 mEq/L
- BUN 30 mg/dL
- Creatinine 1.4 mg/dL
- Glucose 130 mg/dL
- Urinalysis 3 to 5 WBCs, 0 to 3 RBCs, positive bacteria, specific gravity 1.022

Discussion

1. What problems have you identified based on the resident's history and physical assessment?
2. What other laboratory tests would be helpful?
3. What nursing actions will you take immediately?

Solutions

1. Underweight with risk of malnutrition
   Heart arrhythmia with possible orthostatic hypotension
   Probable urinary tract infection with urinary incontinence
   Anorexia and nausea possibly related to medications or urinary tract infection
   Recurrent falls with several possible causes, including weakness due to decreased food and fluid intake, hypokalemia and hyponatremia, difficulty ambulating due to degenerative arthritis, orthostatic hypotension due to dehydration, and infection
2. CBC to assess for anemia and infection
   Digoxin level to check for toxicity as a cause of anorexia and nausea
   Urine culture and sensitivity to identify and quantify the urine bacteria and determine antibiotic sensitivity
   Total protein to evaluate nutritional status
3. Safety measures to prevent falls, such as having Mr. K. call for assistance before getting up to go to the restroom. Advise him to change positions slowly from lying to sitting and then from sitting to standing. Consider a bedside commode because he has urinary incontinence and difficulty ambulating.
   Provide fluids and simple, easily digested foods in frequent small amounts.
   If nausea occurs, notify the physician.
   Withhold digoxin until the level value is obtained. Report to the physician.
   Withhold the Lasix because the resident is dehydrated and has hypokalemia and hypona tremia, probably as a result of the diuretic. Report to the physician.
   Check any stools for occult blood because ibuprofen (an NSAID) is often the cause of GI bleeding. If the CBC indicates an iron deficiency anemia, the physician will probably discontinue this medication. Acetaminophen (Tylenol) may be used on a regular schedule to control arthritic pain.

STUDY QUESTIONS

Select the best answer to each question.

1. All laboratory test results for older adults should be:

a. Evaluated against younger clients

b. Evaluated against the other older adults on the unit

c. Evaluated against the client's total clinical situation

d. Evaluated against the person's CBC results

2. With tuberculosis on the increase among the elderly population, it is critical for the LPN to know that:

a. Tuberculosis (TB) skin tests are inaccurate on people over the age of 65

b. When there is no initial reaction to the TB skin test in elderly people, it should be given again 1 week later

c. It is unnecessary and expensive to do TB screening on nursing home residents

d. Isoniazid is not an effective TB drug of choice for the elderly

3. The PT test is a measure of the overall coagulation factors. The risk of serious hemorrhage is high in the elderly when:

a. Warfarin is used

b. Medication reviews on all medications are done

c. PTs are drawn daily until the therapeutic dose is determined

d. They are at risk for falls and subsequent bleeding

4. Potassium deficiency develops:

a. Slowly in elderly persons

b. In the kidneys

c. Rapidly because there is no way to conserve it

d. Only when using diuretics

5. Every elderly person with a low serum albumin level should be:

a. Put on a high-protein diet

b. Put on bed rest

c. Put on a diet of 12% complete proteins

d. Put on vitamin supplements

Unit Resources

UNIT 1

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Unit Resources

UNIT 2

The reader will note that many of the references in this section are older. They are used because they are "classic" references in that they are the original articles that defined the subjects discussed in them. I thought you would enjoy reading from the original work done on the topic.

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Appendix A

Sample Advance Directives: Living Will and Power of Attorney for Health Care

The following document is reproduced courtesy of Caring Connections, 1700 Diagonal Road, Suite 625, Alexandria, VA 22314. It is a sample for the state of California. To get a similar document for your state, please go to Caring Connection's Web site at www.caringinfo.org or call them at 800-658-8898.

Introduction to Your California Advance Directive

This packet contains a legal document, the California Advance Health Care Directive, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

1. Part 1, **Power of Attorney for Health Care,** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself or immediately if you designate this on the document. The Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you cannot or do not choose to make your own medical decisions, not only at the end of life.
2. Part 2, **Instruction for Health Care,** functions as your state's living will. It lets you state your wishes about medical care in the event that you can no longer speak for yourself.

Although you have the option to complete only one part of this document, Caring Connections suggests that you complete Part 1 and Part 2 to best ensure that you receive the medical care you want when you can no longer speak for yourself.

3. Part 3, **Donation of Organs at Death,** is an optional section that allows you to record your wishes regarding organ donation.
4. Part 4, **Primary Physician,** is an optional section that allows you to designate your primary physician.

Note: This document will be legally binding only if the person completing it is a competent adult who is 18 years of age or older.

Introduction to Your California Advance Health Care Directive

How do I make my advance health care directive legal?

In order to make your Advance Health Care Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses, who must also sign the document to show that they personally know you (or you provided convincing evidence of identity) and believe you to be of sound mind and under no duress, fraud, or undue influence.

Neither of your witnesses can be:

- the person you appointed as your agent,
- your health care provider, or an employee of your health care provider,
- the operator or employee of a community facility,
- the operator or employee of a residential care facility for the elderly.

In addition, only one of your witnesses may be:

- related to you by blood or marriage or adoption,
- entitled to any part of your estate either under your last will and testament or by operation of law.

OR

2. Sign your document in the presence of a notary public.

If you are a resident in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman designated by the State Department of Aging.

Are there any important facts that I should know?

A copy of your California Advance Health Care Directive has the same effect as the original.

Completing Part 1: Power of Attorney for Health Care

Whom should I appoint as my agent?

A health care agent is the person you appoint to make decisions about your medical care if you become unable to make these decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. The person you appoint as your agent **cannot be:**

1. your supervising health care provider or an employee of the health care institution where you are receiving care; or
2. an operator or employee of a community care facility or residential care facility at which you are receiving care.

Unless:

1. the employee is related to you by blood, marriage, adoption or is your registered domestic partner; or
2. the employee is your co-worker employed by the same health care institution, community care facility, or residential care facility for the elderly where you are a patient.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person you name as agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my Power of Attorney?

You can use the space provided under paragraph (2) to limit your agent's authority. Unless the form you sign limits the authority of your agent, your agent may make almost all health care decisions for you, including:

a) consenting or refusing consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
b) selecting or discharging health care providers and institutions;
c) approving or disapproving diagnostic tests, surgical procedures, programs of medications, and orders not to resuscitate; and
d) directing the provision, withholding and withdrawal of artificial nutrition and hydration, and all other forms of health care.

Your agent is not authorized to consent to:

- commitment to or placement in a mental health treatment facility,
- convulsive treatment,
- psychosurgery,
- abortion,
- sterilization

One of the strongest reasons for naming a health care agent is to have someone who can respond flexibly as your medical condition changes and can deal with situations that you did not foresee.

We urge you to talk with your health care agent about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you can use Part 2 of this document, Instructions for Health Care.

What if I change my mind?

If you wish to cancel your Durable Power of Attorney for Health Care Decisions, you may do so by a signed writing or by personally notifying your supervising health care provider of your intent to revoke.

Are there any important facts I should know?

Paragraph (4) contains various statement about your agent's authority. Cross out and initial any portion of these statements that do not reflect your wishes. Paragraph (5) gives your the agent the authority to make anatomical gifts, authorize an autopsy, and direct the disposition of your remains after your death. Cross out and initial any portion of these statements that do not reflect your wishes. Paragraph (6) nominates your agent or alternate agents to be your court-appointed guardian should one become necessary. If this is not your intention, cross out and initial this section.

Completing Part 2: Instructions for Health Care

Can I add personal instructions to my Instructions for Health Care?

Yes. Paragraphs (7) and (8) allow you to include instructions about certain care and treatment. If there are any specific instructions that you would like to include that are not already listed on the document, you may list them in paragraph (9). For example, you may want to include a sentence such as, "I especially do not want cardiopulmonary resuscitation, a respirator, or antibiotics." If you have appointed an agent, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Instructions for Health Care are to be decided by my agent."

What if I change my mind?

You may cancel your Instructions for Health Care at any time and in any manner that communicates your intent to do so.

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Caring Connections booklet, "Advance Directives and End-of-Life Decisions."

If you have questions about filling out your advance directive, please consult the list of state-based resources located in Appendix B.

You have filled out your Advance Directive, now what?

Your California Advance Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

1. Give photocopies of the signed original to your agent and alternate agent(s), doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
2. Be sure to talk to your agent and alternate agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
3. If you want to make changes to your document after it has been signed and witnessed, you should complete a new document.
4. Remember, you can always revoke one or both sections of your California Advance Health Care Directive.
5. Be aware that your California document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. **Caring Connections does not distribute these forms.**

These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. **Caring Connections does not distribute these forms.** We suggest you speak to your physician.

If you would like more information about this topic, contact Caring Connections or consult the Caring Connections booklet "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

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Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent. if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) Select or discharge health care providers and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication; and
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation;
(e) Make anatomical gifts, authorize an autopsy, and direct the disposition of your remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care. After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

INSTRUCTIONS

PRINT THE NAME, HOME ADDRESS, AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

PRINT THE NAME, HOME ADDRESS, AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT (OPTIONAL)

PRINT THE NAME, HOME ADDRESS, AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT (OPTIONAL)

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Part 1: Power of Attorney for Health Care

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(Name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(Name of individual you choose as first alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(Name of individual you choose as second alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

INSTRUCTIONS

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4, 5, OR 6 THAT DO NOT REFLECT YOUR WISHES

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(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

____

____

____

(6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

ADDITIONAL INSTRUCTIONS (IF ANY)

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Part 2: Instructions for Health Care

If you fill out this part of the form, you may strike any wording you do not want.

(7) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (**Initial only one box**)

[ ] (a) **Choice NOT To Prolong Life**

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

[ ] (b) **Choice To Prolong Life**

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

____

____

____

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

ORGAN DONATION (OPTIONAL)

MARK THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN (OPTIONAL)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN (OPTIONAL)

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Part 3: Donation of Organs at Death (Optional)

(10) Upon my death: (mark applicable box)

[ ] (a) I give any needed organs, tissues, or parts,

OR

[ ] (b) I give the following organs, tissues, or parts only

[ ] (c) My gift is for the following purposes:

(strike any of the following you do not want)

(1) Transplant

(2) Therapy

(3) Research

(4) Education

Part 4: Primary Physician (Optional)

(11) I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

SIGN AND DATE THE DOCUMENT AND THEN PRINT YOUR NAME AND ADDRESS

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) SIGNATURE: Sign and date the form here:

(date)	(sign your name)
(address)	(print your name)
(city) (state)	

WITNESSING PROCEDURE

(14) WITNESSES: This advance health care directive will not be valid for making health care decisions unless it is either:

(1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or
(2) acknowledged before a notary public.

BOTH OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

ALTERNATIVE NO. 1
STATEMENT OF WITNESSES
I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as an agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

First Witness:

(date)	(signature of witness)
(address)	(printed name of witness)
(city) (state)	

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Second Witness:

__________________ ____________________________

(date) (signature of witness)

__________________ ____________________________

(address) (printed name of witness)

__________________ ____________________________

(city) (state)

ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT

ADDITIONAL WITNESS STATEMENT
I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

HAVE ONE OF YOUR WITNESSES ALSO SIGN AND DATE THIS SECTION AND PRINT THEIR NAME AND ADDRESS

__________________ ____________________________

(date) (signature of witness)

__________________ ____________________________

(address) (printed name of witness)

__________________ ____________________________

(city) (state)

OR

A NOTARY PUBLIC SHOULD FILL OUT THIS SECTION OF YOUR DOCUMENT

ALTERNATIVE NO. 2: NOTARY PUBLIC

State of California)
) SS.
County of ____________)

On ________________ before me, ______________________

(insert name of notary public)

Personally appeared ____________________________________

(insert the name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person upon behalf of which the person acted, executed the instrument.
WITNESS my hand and official seal.
NOTARY SEAL ____

(signature of notary)

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THIS SECTION IS TO BE COMPLETED ONLY IF YOU ARE A RESIDENT IN A SKILLED NURSING FACILITY

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STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN
I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as witness as required by section 4675 of the Probate Code.

________________________ ________________________________

(date) (signature)

________________________ ________________________________

(address) (printed name)

________________________ ________________________________

(city) (state)

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Courtesy of Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

B Appendix

Answers to Chapter Study Questions

Chapter 1

1. c
2. a
3. b
4. d
5. a, b, c, and d

Chapter 2

1. b
2. a
3. a
4. d
5. b

Chapter 3

1. b
2. c
3. c
4. d
5. a

Chapter 4

1. a
2. d
3. b
4. c
5. a

Chapter 5

1. c
2. a
3. a
4. b
5. c

Chapter 6

1. c
2. c
3. d
4. d
5. a

Chapter 7

1. d
2. b
3. a
4. b
5. d

Chapter 8

1. c
2. d
3. d
4. a
5. d

Chapter 9

1. a
2. b
3. a
4. b
5. d

Chapter 10

1. d
2. c
3. a
4. d
5. d

Chapter 11

1. c
2. d
3. a
4. d
5. b

Chapter 12

1. d
2. d
3. c
4. t
5. t

Chapter 13

1. c
2. a
3. b
4. d
5. b

Chapter 14

1. b
2. c
3. c
4. d
5. d

Chapter 15

1. b
2. c
3. d
4. d
5. b

Chapter 16

1. d
2. c
3. d
4. c
5. d

Chapter 17

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5. d

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Chapter 19

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