Chapter 2: Common Health Problems of Older Adults

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Ignatavicius: Medical-Surgical Nursing, 8th Edition

MULTIPLE CHOICE

1. A nursing faculty member working with students explains that the fastest growing subset of the older population is which group?

a. Elite old

b. Middle old

c. Old old

d. Young old

ANS: C

The old old is the fastest growing subset of the older population. This is the group comprising those 85 to 99 years of age. The young old are between 65 and 74 years of age; the middle old are between 75 and 84 years of age; and the elite old are over 100 years of age.

DIF: Remembering/Knowledge REF: 9

KEY: Adulthood| aging| old old MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

2. A nurse working with older adults in the community plans programming to improve morale and emotional health in this population. What activity would best meet this goal?

a. Exercise program to improve physical function

b. Financial planning seminar series for older adults

c. Social events such as dances and group dinners

d. Workshop on prevention from becoming an abuse victim

ANS: A

All activities would be beneficial for the older population in the community. However, failure in performing one's own activities of daily living and participating in society has direct effects on morale and life satisfaction. Those who lose the ability to function independently often feel worthless and empty. An exercise program designed to maintain and/or improve physical functioning would best address this need.

DIF: Applying/Application REF: 12

KEY: Independence| autonomy| older adult

MSC: Integrated Process: Nursing Process: Planning

NOT: Client Needs Category: Psychosocial Integrity

3. A nurse caring for an older client on a medical-surgical unit notices the client reports frequent constipation and only wants to eat softer foods such as rice, bread, and puddings. What assessment should the nurse perform first?

a. Auscultate bowel sounds.

b. Check skin turgor.

c. Perform an oral assessment.

d. Weigh the client.

ANS: C

Poorly fitting dentures and other dental problems are often manifested by a preference for soft foods and constipation from the lack of fiber. The nurse should perform an oral assessment to determine if these problems exist. The other assessments are important, but will not yield information specific to the client's food preferences as they relate to constipation.

DIF: Applying/Application REF: 10

KEY: Nutrition| dentures| older adult

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Physiological Integrity: Basic Care and Comfort

4. A nurse caring for an older adult has provided education on high-fiber foods. Which menu selection by the client demonstrates a need for further review?

a. Barley soup

b. Black beans

c. White rice

d. Whole wheat bread

ANS: C

Older adults need 25 to 50 grams of fiber a day. White rice is low in fiber. Foods high in fiber include barley, beans, and whole wheat products.

DIF: Applying/Application REF: 11

KEY: Nutrition| fiber| older adult

MSC: Integrated Process: Nursing Process: Evaluation

NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

5. A nurse is working with an older client admitted with mild dehydration. What teaching does the nurse provide to best address this issue?

a. "Cut some sodium out of your diet."

b. "Dehydration can cause incontinence."

c. "Have something to drink every 1 to 2 hours."

d. "Take your diuretic in the morning."

ANS: C

Older adults often lose their sense of thirst. Since they should drink 1 to 2 liters of water a day, the best remedy is to have the older adult drink something each hour or two, whether or not he or she is thirsty. Cutting "some" sodium from the diet will not address this issue. Although dehydration can cause incontinence from the irritation of concentrated

urine, this information will not help prevent the problem of dehydration. Instructing the client to take a diuretic in the morning rather than in the evening also will not directly address this issue.

DIF: Applying/Application REF: 11

KEY: Dehydration| older adult| hydration MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

6. A home health care nurse is planning an exercise program with an older client who lives at home independently but whose mobility issues prevent much activity outside the home. Which exercise regimen would be most beneficial to this adult?

a. Building strength and flexibility

b. Improving exercise endurance

c. Increasing aerobic capacity

d. Providing personal training

ANS: A

This older adult is mostly homebound. Exercise regimens for homebound clients include things to increase functional ability for activities of daily living. Strength and flexibility will help the client to be able to maintain independence longer. The other plans are good but will not specifically maintain the client's functional abilities.

DIF: Applying/Application REF: 12

KEY: Exercise| functional ability| older adult

MSC: Integrated Process: Nursing Process: Planning

NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

7. An older adult recently retired and reports "being depressed and lonely." What information should the nurse assess as a priority?

a. History of previous depression

b. Previous stressful events

c. Role of work in the adult's life

d. Usual leisure time activities

ANS: C

Often older adults lose support systems when their roles change. For instance, when people retire, they may lose their entire social network, leading them to feeling depressed and lonely. The nurse should first assess the role that work played in the client's life. The other factors can be assessed as well, but this circumstance is commonly seen in the older population.

DIF: Applying/Application REF: 12

KEY: Depression| older adult

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Psychosocial Integrity

8. A nurse is assessing coping in older women in a support group for recent widows. Which statement by a participant best indicates potential for successful coping?

a. “I have had the same best friend for decades.”

b. “I think I am coping very well on my own.”

c. “My kids come to see me every weekend.”

d. “Oh, I have lots of friends at the senior center.”

ANS: A

Friendship and support enhance coping. The quality of the relationship is what is most important, however. People who have close, intimate, stable relationships with others in whom they confide are more likely to cope with crisis.

DIF: Remembering/Knowledge REF: 12

KEY: Coping| relationships| older adult

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Psychosocial Integrity

9. A home health care nurse has conducted a home safety assessment for an older adult. There are five concrete steps leading out from the front door. Which intervention would be most helpful in keeping the older adult safe on the steps?

a. Have the client use a walker or cane on the steps.

b. Install contrasting color strips at the edge of each step.

c. Instruct the client to use the garage door instead.

d. Tell the client to use a two-footed gait on the steps.

ANS: B

As a person ages, he or she may experience a decreased sense of touch. The older adult may not be aware of where his or her foot is on the step. Installing contrasting color strips at the end of each step will help increase awareness. If the client does not need an assistive device, he or she should not use one just on stairs. Using an alternative door may be necessary but does not address making the front steps safer. A two-footed gait may not help if the client is unaware of where the foot is on the step.

DIF: Applying/Application REF: 13

KEY: Safety| falls| older adult

MSC: Integrated Process: Nursing Process: Implementation

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

10. An older adult is brought to the emergency department because of sudden onset of confusion. After the client is stabilized and comfortable, what assessment by the nurse is most important?

a. Assess for orthostatic hypotension.

b. Determine if there are new medications.

c. Evaluate the client for gait abnormalities.

d. Perform a delirium screening test.

ANS: B

Medication side effects and adverse effects are common in the older population. Something as simple as a new antibiotic can cause confusion and memory loss. The nurse should determine if the client is taking any new medications. Assessments for orthostatic hypotension, gait abnormalities, and delirium may be important once more is known about the client's condition.

DIF: Applying/Application REF: 13

KEY: Medications| medication safety| older adult

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

11. An older adult client takes medication three times a day and becomes confused about which medication should be taken at which time. The client refuses to use a pill sorter with slots for different times, saying "Those are for old people." What action by the nurse would be most helpful?

a. Arrange medications by time in a drawer.

b. Encourage the client to use easy-open tops.

c. Put color-coded stickers on the bottle caps.

d. Write a list of when to take each medication.

ANS: C

Color-coded stickers are a fast, easy-to-remember system. One color is for morning meds, one for evening meds, and the third color is for nighttime meds. Arranging medications by time in a drawer might be helpful if the person doesn't accidentally put them back in the wrong spot. Easy-open tops are not related. Writing a list might be helpful, but not if it gets misplaced. With stickers on the medication bottles themselves, the reminder is always with the medication.

DIF: Applying/Application REF: 14

KEY: Medications| medication safety| older adult

MSC: Integrated Process: Nursing Process: Implementation

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

12. An older adult client is in the hospital. The client is ambulatory and independent. What intervention by the nurse would be most helpful in preventing falls in this client?

a. Keep the light on in the bathroom at night.

b. Order a bedside commode for the client.

c. Put the client on a toileting schedule.

d. Use siderails to keep the client in bed.

ANS: A

Although this older adult is independent and ambulatory, being hospitalized can create confusion. Getting up in a dark, unfamiliar environment can contribute to falls. Keeping the

light on in the bathroom will help reduce the likelihood of falling. The client does not need a commode or a toileting schedule. Siderails used to keep the client in bed are considered restraints and should not be used in that fashion.

DIF: Applying/Application REF: 21

KEY: Falls| safety| older adult

MSC: Integrated Process: Nursing Process: Implementation

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

13. An older client had hip replacement surgery and the surgeon prescribed morphine sulfate for pain. The client is allergic to morphine and reports pain and muscle spasms. When the nurse calls the surgeon, which medication should he or she suggest in place of the morphine?

a. Cyclobenzaprine (Flexeril)

b. Hydromorphone hydrochloride (Dilaudid)

c. Ketorolac (Toradol)

d. Meperidine (Demerol)

ANS: B

Cyclobenzaprine (used for muscle spasms), ketorolac, and meperidine (both used for pain) are all on the Beers list of potentially inappropriate medications for use in older adults and should not be suggested. The nurse should suggest hydromorphone hydrochloride.

DIF: Remembering/Knowledge REF: 16

KEY: Medications| Beers list| older adult

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

14. A nurse admits an older client from a home environment where she lives with her adult son and daughter-in-law. The client has urine burns on her skin, no dentures, and several pressure ulcers. What action by the nurse is most appropriate?

a. Ask the family how these problems occurred.

b. Call the police department and file a report.

c. Notify Adult Protective Services.

d. Report the findings as per agency policy.

ANS: D

These findings are suspicious for abuse. Health care providers are mandatory reporters for suspected abuse. The nurse should notify social work, case management, or whomever is designated in policies. That person can then assess the situation further. If the police need to be notified, that is the person who will notify them. Adult Protective Services is notified in the community setting.

DIF: Applying/Application REF: 19 KEY: Abuse| older adult

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

15. A nurse caring for an older client in the hospital is concerned the client is not competent to give consent for upcoming surgery. What action by the nurse is best?

a. Call Adult Protective Services.

b. Discuss concerns with the health care team.

c. Do not allow the client to sign the consent.

d. Have the client's family sign the consent.

ANS: B

In this situation, each facility will have a policy designed for assessing competence. The nurse should bring these concerns to an interdisciplinary care team meeting. There may be physiologic reasons for the client to be temporarily too confused or incompetent to give consent. If an acute condition is ruled out, the staff should follow the legal procedure and policies in their facility and state for determining competence. The key is to bring the concerns forward. Calling Adult Protective Services is not appropriate at this time. Signing the consent should wait until competence is determined unless it is an emergency, in which case the next of kin can sign if there are grave doubts as to the client's ability to provide consent.

DIF: Applying/Application REF: 16

KEY: Competence| autonomy| older adult

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. A nursing student working in an Adult Care for Elders unit learns that frailty in the older population includes which components? (Select all that apply.)

a. Dementia

b. Exhaustion

c. Slowed physical activity

d. Weakness

e. Weight gain

ANS: B, C, D

Frailty is a syndrome consisting of unintentional weight loss, slowed physical activity and exhaustion, and weakness. Weight gain and dementia are not part of this cluster of manifestations.

DIF: Remembering/Knowledge REF: 9

KEY: Frailty| frail elderly| older adult

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Health Promotion and Maintenance

2. A home health care nurse assesses an older client for the intake of nutrients needed in larger amounts than in younger adults. Which foods found in an older adult's kitchen might indicate an adequate intake of these nutrients? (Select all that apply.)

a. 1% milk

b. Carrots

c. Lean ground beef

d. Oranges

e. Vitamin D supplements

ANS: A, B, D, E

Older adults need increased amounts of calcium; vitamins A, C, and D; and fiber. Milk has calcium; carrots have vitamin A; the vitamin D supplement has vitamin D; and oranges have vitamin C. Lean ground beef is healthier than more fatty cuts, but does not contain these needed nutrients.

DIF: Applying/Application REF: 10

KEY: Nutrition| nutritional requirements| older adults

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Physiological Integrity: Basic Care and Comfort

3. A nurse working with older adults assesses them for common potential adverse medication effects. For what does the nurse assess? (Select all that apply.)

a. Constipation

b. Dehydration

c. Mania

d. Urinary incontinence

e. Weakness

ANS: A, B, E

Common adverse medication effects include constipation/impaction, dehydration, and weakness. Mania and incontinence are not among the common adverse effects, although urinary retention is.

DIF: Remembering/Knowledge REF: 14

KEY: Medications| adverse effects

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

4. A nurse manager institutes the Fulmer Spices Framework as part of the routine assessment of older adults in the hospital. The nursing staff assesses for which factors? (Select all that apply.)

a. Confusion

b. Evidence of abuse

c. Incontinence

d. Problems with behavior

e. Sleep disorders

ANS: A, C, E

SPICES stands for sleep disorders, problems with eating or feeding, incontinence, confusion, and evidence of falls.

DIF: Remembering/Knowledge REF: 20

KEY: SPICES| older adult

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

5. A visiting nurse is in the home of an older adult and notes a 7-pound weight loss since last month's visit. What actions should the nurse perform first? (Select all that apply.)

a. Assess the client's ability to drive or transportation alternatives.

b. Determine if the client has dentures that fit appropriately.

c. Encourage the client to continue the current exercise plan.

d. Have the client complete a 3-day diet recall diary.

e. Teach the client about proper nutrition in the older population.

ANS: A, B, D

Assessment is the first step of the nursing process and should be completed prior to intervening. Asking about transportation, dentures, and normal food patterns would be part of an appropriate assessment for the client. There is no information in the question about the older adult needing to lose weight, so encouraging him or her to continue the current exercise regimen is premature and may not be appropriate. Teaching about proper nutrition is a good idea, but teaching needs to be tailored to the client's needs, which the nurse does not yet know.

DIF: Applying/Application REF: 10

KEY: Nutrition| older adult

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

6. A hospitalized older adult has been assessed at high risk for skin breakdown. Which actions does the registered nurse (RN) delegate to the unlicensed assistive personnel (UAP)? (Select all that apply.)

a. Assess skin redness when turning.

b. Document Braden Scale results.

c. Keep the client's skin dry.

d. Obtain a pressure-relieving mattress.

e. Turn the client every 2 hours.

ANS: C, D, E

The nurses' aide or UAP can assist in keeping the client's skin dry, order a special mattress on direction of the RN, and turn the client on a schedule. Assessing the skin is a nursing responsibility, although the aide should be directed to report any redness noticed. Documenting the Braden Scale results is the RN's responsibility as the RN is the one who performs that assessment.

DIF: Applying/Application REF: 22

KEY: Skin breakdown| older adult| delegation| unlicensed assistive personnel

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. A nurse admits an older client to the hospital who lives at home with family. The nurse assesses that the client is malnourished. What actions by the nurse are best? (Select all that apply.)

a. Contact Adult Protective Services or hospital social work.

b. Notify the provider that the client needs a tube feeding.

c. Perform and document results of a Braden Scale assessment.

d. Request a dietary consultation from the health care provider.

e. Suggest a high-protein oral supplement between meals.

ANS: C, D, E

Malnutrition in the older population is multifactorial and has several potential adverse outcomes. Appropriate actions by the nurse include assessing the client's risk for skin breakdown with the Braden Scale, requesting a consultation with a dietitian, and suggesting a high-protein meal supplement. There is no evidence that the client is being abused or needs a feeding tube at this time.

DIF: Applying/Application REF: 20

KEY: Nutrition| malnutrition| older adult| Braden Scale

MSC: Integrated Process: Nursing Process: Implementation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care