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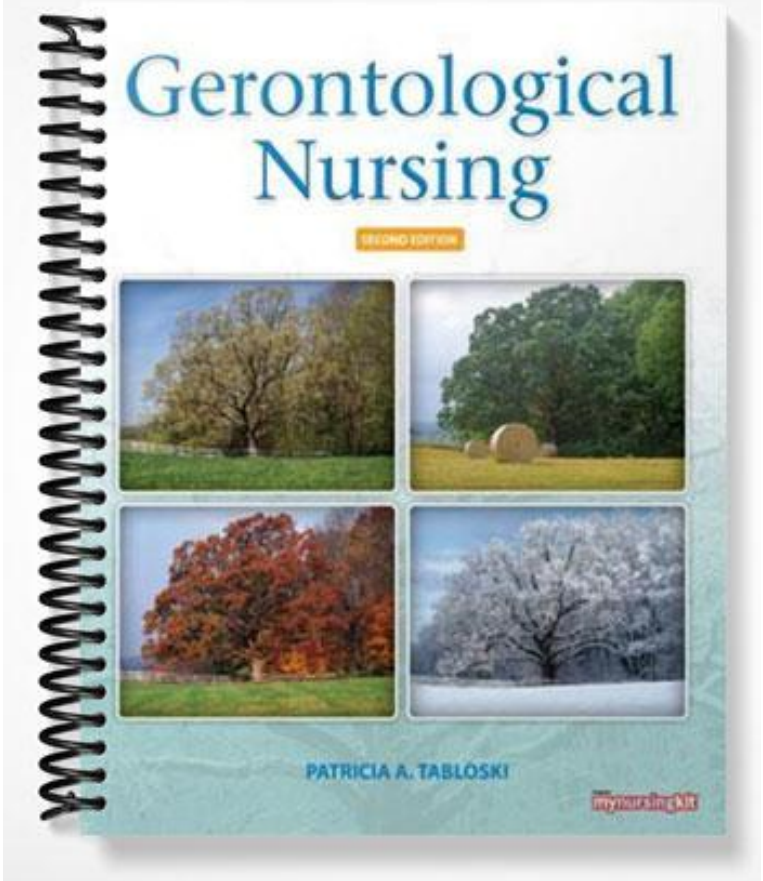
Gerontological Nursing
SECOND EDITION
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mynursingkit

CHAPTER 2
Gerontological Nursing Issues

2.1•A nurse assists a geriatric client to discuss the desire to complete advanced directives with the client's adult children. This is an example of

1. collaboration with the interdisciplinary team.
2. facilitation of palliative care.
3. engagement in professional development.
4. accountability to protect client's rights and autonomy.

Answer: 4

Rationale: The nurse demonstrates accountability in supporting the client in exercising control over end-of-life decisions and communicating client wishes to family members. This is included in the knowledge and skills of gerontological nurses. Collaboration with the interdisciplinary team would involve the nurse working with other professionals who provide care to clients. Palliative care alleviates pain and suffering. Professional development activities include continuing education and being part of professional organizations.
Implementation
Safe, Effective Care Environment
Analysis

2.2•The nurse is supportive of an elderly client's decision to stop further chemotherapy treatments after diagnostic testing shows a recurrence of the malignancy. The basic ethical principle involved is

1. justice.
2. beneficence.
3. autonomy.
4. nondisclosure.

Answer: 3

Rationale: The principle of autonomy involves respect for the client's need for self-determination and the right to accept or refuse a treatment. Justice involves fairness and equal distribution of resources to all in need. Beneficence is the principle of doing good and not doing harm to clients. Nondisclosure is an ethical issue when persons who care about a client, such as family, do not want a client to be told the entire facts of a negative prognosis in order to protect the client from anxiety and fear.
Implementation
Safe, Effective Care Environment
Knowledge

2.3•The major focus of nursing assessments based on functional health patterns is

1. effects of diseases.

2. client disabilities.
3. potential for rehabilitation.
4. client interaction with his or her environment.

Answer: 4

Rationale: The assessment framework of functional health patterns (Gordon, 1994) is based on the client's interaction with the environment, including client assessment of health status, lifestyle, activities, life demands, support systems, and the ability to function within the client's environment. Effects of diseases are viewed within the context of the individual client's ability to function with a disease that affects his or her life. Disability and the potential for rehabilitation are aspects of the functional assessment.

Assessment

Safe, Effective Care Environment

Application

2.4•An example of a gerontological nurse acting as a manager is

1. arranging respite care in a local nursing home for a client while the adult child caregiver recovers from surgery.
2. performing blood pressure screenings at a senior citizen health fair.
3. participating in a skin assessment survey of clients in a nursing home.
4. writing a letter of support for a client who is seeking custody of a grandchild.

Answer: 1

Rationale: The nurse functions as a manager by connecting a client to community resources and coordinating the transfer of care of the client needing respite care. Participating in the blood pressure screening and skin assessment surveys are within the traditional nursing role of clinical practitioner. The nurse is in an advocacy role by supporting the client to obtain custody of a grandchild.

Intervention

Health Promotion and Maintenance

Application

2.5•A nurse is conducting an interview with a resident who has just moved to a retirement community. The client discusses her volunteer activities in the past mayoral election. In an assessment based on functional health patterns, this information would be included under which category?

1. cognitive and perceptual
2. self-perception and self-concept
3. coping and stress tolerance
4. values and beliefs

Answer: 1

Rationale: The functional health pattern assessment consists of 11 health patterns. The cognitive–perceptual pattern includes how the client thinks and perceives the world and current events. The client's campaign activities would be part of this assessment. Self-perception and self-concept include how a person sees and values him- or herself. Coping and stress tolerance include the ways and effectiveness of coping strategies. The values and beliefs category includes the client's beliefs, values, and perceptions about the meaning of life.
Assessment
Psychosocial Integrity
Application

2.6•A client's religious affiliation and participation in the local parish would be included in which of the functional health pattern assessment categories?

1. cognitive and perceptual
2. self-perception and self-concept
3. coping and stress tolerance
4. values and beliefs

Answer: 4

Rationale: The functional health pattern assessment consists of 11 health patterns. The values and beliefs category includes beliefs, values, and perceptions about the meaning of life. A client's participation in a religion would be part of this assessment. Self-perception and self-concept include how a person sees and values him- or herself. Coping and stress tolerance include the ways and effectiveness of coping strategies. Cognitive-perceptual includes ways of perceiving the world.
Assessment
Psychosocial Integrity
Application

2.7•A client's family member asks a nurse what is the significance of being a certified nurse. He has noticed that some of the nurses caring for the client in a long-term care facility are certified gerontological nurses and others are registered nurses. Certification in gerontological nursing means that

1. the nurse must have a master's degree in nursing.
2. the nurse works in administration at the nursing home.
3. the nurse has completed a process of formal validation of clinical competence in gerontological nursing.
4. the nurse has worked full time at least 2 years in gerontological nursing.

Answer: 3

Rationale: Certification is the process of validation of clinical competence through which a nurse successfully completes an examination in a specialty area of nursing practice. Master's degreed nurses may be certified, but nurses with associate or baccalaureate degrees or diploma certificates may also be certified but at a generalist level. Certified

nurses may work in administration but also function in direct care and case management. In order to qualify to take the certification examination, the nurse must have practiced the clinically equivalent of 2 years full time or minimally 2,000 hours over the past 3 years.
Implementation
Safe, Effective Care Environment
Analysis

2.8•Select the statement that provides correct information about nursing homes in the United States.

1. The major fee source for nursing home care is Medicare.
2. Clients in nursing homes have more diverse and complex clinical needs than in the past.
3. Nursing homes employ the greatest percentage of nurses.
4. About 25% of persons age 65 or older live in nursing homes.

Answer: 2
Rationale: Many older clients requiring hospitalization stay in the hospital for shorter periods of time and recuperate in nursing homes or at home. Thus, the clients receiving care in the nursing home have a great variety of conditions that require complex care. Medicaid, the federal and state program for low-income persons, is the largest funding source of long-term care. Medicare accounted for about 14% of long-term care funding in 2000. Hospitals are still the major employers of nurses, at 59% of registered nurses in 2000. Approximately 5% of the population over age 65 live in nursing homes as of 2001.
Implementation
Safe, Effective Care Environment
Knowledge

2.9•During a health fair for older adults, a healthy woman tells the nurse that she thinks she has been losing weight unintentionally during the past 6 weeks. The nurse should

1. instruct the woman to add protein rich, low-fat snacks between meals and at bedtime.
2. encourage the woman to purchase a scale with a digital readout to accurately measure her weight on a daily basis.
3. explain to the client that the loss of muscle mass that occurs with aging could account for the weight loss.
4. ask the client to describe her eating habits and when she last had a checkup by her healthcare provider.

Answer: 4

Rationale: Asking about a client's eating habits and when the client last saw her healthcare provider is part of the assessment process, the first step of the nursing process. The other answers are all interventions to solve or reasons to explain the weight loss without adequate assessment.
Assessment

Physiological Integrity
Application

2.10•Which of the following statements is correct in describing nursing care plans for older adults?

1. Standardized care plans are more effective in goal attainment than individualized care plans.
2. Care plans are controlled by the nurses caring for the client; other members of the interdisciplinary team should develop their own specific plans of care.
3. The first step of creating a nursing care plan is a systematic assessment using a functional health pattern framework.
4. Older adults often have multiple nursing diagnoses and each diagnosis should be addressed at once.

Answer: 3

Rationale: Assessment must form the basis for determining problem areas (nursing diagnoses) of the client. The functional health pattern framework provides a systematic approach that includes the current level of functioning and self-concept of the client. The care plan should address problems or potential problems, some of which may be referred to and addressed by other members of the interdisciplinary team caring for the client. Many clients have multiple nursing diagnoses. The diagnoses need to be prioritized so that those diagnoses considered serious and of concern to the client are addressed initially.
Assessment
Safe, Effective Care Environment
Application

2.11•A client is talking to the nurse and begins to cry when he mentions the death of his daughter 20 years earlier. The most appropriate initial response by the nurse is

1. touching the client's arm and listening in silence.
2. explaining to the client that crying is an effective means to express emotions.
3. asking the client to describe the details of the death so the nurse can understand more completely.
4. asking the client if he thinks he could be suffering from depression.

Answer: 1

Rationale: Active listening is the key to effective communication, and the most appropriate response is to demonstrate empathy and support for the client in the expression of strong feelings. Appropriate touching and silence best meet this objective. Giving explanations, asking for clarifications, or focusing on depression are not appropriate. Asking about depression could give the client the impression that the expression of feelings of grief is not normal or healthy.
Intervention
Psychosocial Integrity

Application

2.12•The nurse assesses an older postoperative client and determines constipation is an appropriate nursing diagnosis. A goal for this nursing diagnosis is

1. knowing the importance of hydration and activity in regard to constipation.
2. decreasing the frequency of pain medication.
3. evacuating a formed bowel movement at least every 2 days with minimal distress.
4. drinking at least 1,500 ml of noncaffeinated and nonalcoholic beverages each day.

Answer: 3

Rationale: The goal should be linked to the nursing diagnosis; be measurable, realistic, and achievable; and include a time frame for attainment. The type and frequency of bowel movement is directly connected to the nursing diagnosis. Knowing is not a measurable verb. Indirectly, the client's frequency of bowel movement may be improved by decreasing pain medication and increasing fluids and activity. Pain control also must be addressed.

Implementation

Physiological Integrity

Application

2.13•During a home visit, an older client recovering from cardiac valve replacement surgery states to the nurse, "I am so weak that I will never be able to dance with my wife again." An appropriate statement for the nurse to reply is

1. "It's okay, honey, in time your strength will return."
2. "What type of dancing do you want to do, some are more strenuous than others?"
3. "Do you think you are pushing yourself enough to return to that type of activity in the near future? Is your wife encouraging you?"
4. "Tell me more about not feeling able to do what you want to do."

Answer: 4

Rationale: It is important that the nurse use attentive listening in communication. An open-ended statement will encourage the client to continue talking thus helping him clarify concerns and formulate solutions. "Honey" could be demeaning to the client. In the other answers, the nurse is giving advice and solutions without hearing the client's specific concerns.

Implementation

Psychosocial Integrity

Application

2.14•A student nurse asks the gerontological clinical nurse specialist to explain evidence-based practice. The nurse correctly states that this practice includes interventions that

1. are stated specifically in the policy and procedures manual of the healthcare facility.
2. have been included in research studies with supportive evidence of a cause-and-effect relationship between the intervention and a positive client outcome.

3. have been highly effective in the nurse's own practice and experience.
4. reflect methods that were previously effective for a particular client.

Answer: 2

Rationale: Evidence-based practice involves using interventions that have been studied through the research process. Research has shown a link between the prescribed intervention and the desired outcome of care. These interventions are considered to be more strongly linked to positive outcomes than interventions that have not been researched. Those interventions that are not evidenced based may be supported by nursing experience, client case, or institutional policy.
Evaluation
Safe, Effective Care Environment
Analysis

2.15•It is important that the nurse communicates effectively when caring for older adult clients. Which of the following guidelines promote effective communication?

1. avoiding periods of silence while communicating
2. changing the subject if the nurse begins to feel emotional about a subject
3. speaking loudly because most older clients are hard of hearing
4. asking for clarification if what the client is trying to say is not understandable

Answer: 4

Rationale: Active listening includes asking for clarification if the client is not clearly communicating to the nurse. Silence and pauses in conversations are often opportunities for the client to think out his or her feelings, and breaking the silence will stop the contemplative process. Nurses should acknowledge the clients feelings, and changing the subject will stop communication. It is not necessary to talk loudly to all older persons because all are not hard of hearing, and if the client is wearing a hearing aid, the loudness may be distressing.
Intervention
Psychosocial Integrity
Application

2.16•The family members of a hospitalized older adult contact social services concerning plans after discharge. The family members report intentions to take the client home with them after discharge but indicate a need for assistance during the day while they are at work. Based upon your understanding, what referral information should be provided?

1. A skilled nursing facility
2. A retirement community
3. An adult day care service
4. Community nursing care services

Answer: 3
Rationale: The family is in need of assistance to provide a supervised environment for their loved one during their work hours. A skilled nursing care

facility would not be appropriate for the older adult living at home. The retirement community is indicated for older adults planning to live in their own quarters. Community nursing care services provide nursing care in the home for specific tasks.
Assessment; Safe, Effective Care Environment; Application

2.17•A client hospitalized for a hip replacement is discussing discharge options with the nurse. The client states she is interested in having a visiting nurse come to the home to assist with her meals and housekeeping duties. What response is indicated by the nurse?

1. "You should discuss this referral with your physician."
2. "I will contact representatives from the agency to meet with you before discharge."
3. "You will need to determine if the agency fees will be covered by your insurance."
4. "The visiting nurse is used to provide a more skilled type of care for you."

Answer: 4
Rationale: The types of duties the client is interested in having the "nurse" provide are not consistent with home health nursing responsibilities. The misconceptions should be pointed out to the client. Referrals are generated after approval by the physician, but the nurse has the responsibility to ensure the client has an understanding of the concepts.
Implementation; Safe Effective Environment; Application

2.18•The daughter of a 67-year-old client hospitalized for pneumonia voices concerns to the nurse about the hospital bills. The daughter asks if her mother is old enough to qualify for Medicaid. What information should the nurse provide to the client?

1. Medicaid is available to individuals once they reach the age of 65.
2. Medicaid is intended to assist low-income individuals over the age of 65.
3. Older adults are eligible for Medicaid if they are planning to enter a long-term care facility.
4. Eligibility for Medicaid is based upon income, not age.
   Answer: 4
   Rationale: Medicaid is a joint federal and state program for low-income individuals. Age is the primary criteria. Income is the greatest determinant.

   Implementation; Psychological Integrity; Application

2.19•A 70-year-old client hospitalized after a CVA is preparing for transfer to a long-term care facility that offers rehabilitation care services. It is estimated the client will be

at the new facility for at least 4 weeks. When considering payment for the services, the nurse understands:

1. Medicaid is not an option for this client because the age criteria have not been met.
2. Medicaid will not be available to assist with the medical bills, as the client is planning to return home after leaving the rehabilitation facility.
3. Medicare may likely cover the rehabilitation as long as the appropriate documentation is submitted.
4. Medicare will cover only the acute care services, as the client is planning to return to home after leaving the rehabilitation facility.

Answer: 3
Rationale: Medicare is available to older adults and younger disabled individuals. It will cover rehabilitation or skilled care services as long as there is a 3-day qualifying stay in a hospital. Documentation must also be submitted for precertification.

Assessment; Safe Effective Care Environment; Application

2.20•A student nurse questions the nursing instructor about the constant information being relayed in reports about the client's method of payment. The student reports not understanding why this is being emphasized, as it is not the real focus of the nurse. What response by the nursing instructor is indicated?

1. "Since pay status is a concern of the client, it must be considered by nurses as well."
2. "Understanding healthcare reimbursement is important for nurses to best be able to manage resources."
3. "That information is just intended to be relayed to the case manager."
4. "We listen to that information so we understand how many days the client will be allowed to remain in the hospital."

Answer: 2

Rationale: The cost and management of cost of healthcare is the responsibility of all members of the healthcare team. Understanding the manner of payment is also important. A working knowledge of Medicare and Medicaid is needed to work with the older adult population.
Implementation; Safe, Effective Care Environment; Application

2.21•A registered nurse is planning an educational program for peers to discuss the current and anticipated nursing staffing needs of the future. Which of the following should be included in the presentation? Select all that apply.

1. The number of nurses employed in hospital settings has increased since 1980.
2. More complex nursing skills are needed to provide care in long-term care and rehabilitative care facilities.
3. The number of nursing homes has begun to increase over the last 10 years.
4. More nurses will be needed to work in assisted living care settings.

Answers: 2, 4
Rationale: The acuity of clients in hospital settings is increasing. The length of hospital stay is decreasing. These factors require the nurse to care for clients who are more and more ill each day. The number of nurses working in the acute care setting declined between 1980 and 2007. There is an increase in assistive care settings in the United States. This is accompanied by a reduction in number of and beds within nursing homes.
Planning; Safe, Effective Care Environment; Application

2.22•The nurse observes that a client under her care does not feel comfortable with the care choices planned by her family and the social services department. The client appears coherent. What action by the nurse is indicated?

1. Contact the family and organize a conference.
2. Notify the physician.
3. Consult with the unit's educator.
4. Discuss the matter with the unit's nurse manager.

Answer: 4
Rationale: The role of a unit manager is to ensure the rights of the client are being met. The unit manager can review the concerns of the nurse and provide guidance. It is important to follow the chain of command. The nurse manager is the first step along this path. Contact with the physician and arranging a conference are premature. The role of the traditional unit educator does not include matters of this nature.
Implementation; Psychological Integrity; Application

2.23•A newly licensed registered nurse is working with a preceptor on the acute care unit. He is developing the nursing care plan for a newly admitted client. The primary nursing diagnosis is knowledge deficit related to pre- and postoperative care. After developing goal statements for the plan, the preceptor reviews them. Which of the goal statements is most appropriate?

1. The client will understand the prescribed medications.

2. The nurse will administer the prescribed medications.
3. The client will be afibrile during the postoperative period.
4. The client will verbalize understanding of the preoperative medications prior to surgery.

Answer: 4
Rationale: Goal statements must be specific to the nursing diagnosis. Goal statements must be client focused. Time frames for attainment should also be included.
Planning; Psychological Integrity; Analysis

2.24•During a routine physical examination, the client reports feeling increasingly unable to maintain his home. He states he is looking for other options. The nursing assessment reveals a well-nourished male, age 66. His medical history is essentially negative except a mild myocardial infarction 10 years ago. He has significant financial resources. Which of the following will likely best meet the client's needs?

1. Skilled-nursing facility
2. Retirement community
3. Adult day care
4. Residential care facility

Answer: 2
Rationale: The client is likely a candidate for a retirement community. He does not appear to need the nursing services associated with a skilled or residential care facility. He appears independent and would not benefit from an adult day care.
Assessment; Psychological Integrity; Application

2.25•The nurse is assigned to provide care for a client recently admitted to a rehabilitation care facility. The client was severely injured in an automobile accident and requires assistance with the activities of daily living and occupational and physical therapy. The nurse notices the client is tearful one evening. When questioned, the client reports feeling "lonely" and "sad." What initial action by the nurse is indicated?

1. Ask the client what is wrong.
2. Sit with the client and encourage a discussion of feelings.
3. Obtain a referral for a psychological consult.
4. Offer to call the client's family members.

Answer: 2
Rationale: The client's demeanor is consistent with sadness after a traumatic injury and continued hospitalization. Encouraging verbalization of feelings may reduce feelings of isolation. Simply asking what is wrong may infer to the client that his or her feelings are "wrong." Sitting with the client provides additional support. There is not an indication that a

psychological consult is needed. It would be premature to contact the family members without first determining what is troubling the client.
Implementation; Psychological Integrity; Application