CHAPTER 19

Care of the Older Client

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Priority Concepts

Development, Safety

I. Aging and Gerontology
- A. Aging is the biopsychosocial process of change that occurs in a person between birth and death.
- B. Gerontology is the study of the aging process.

II. Physiological Changes
- A. Integumentary system
  1. Loss of pigment in hair and skin
  2. Wrinkling of the skin
  3. Thinning of the epidermis and easy bruising and tearing of the skin
  4. Decreased skin turgor, elasticity, and subcutaneous fat
  5. Increased nail thickness and decreased nail growth
  6. Decreased perspiration
  7. Dry, itchy, scaly skin
  8. Seborrheic dermatitis and keratosis formation (overgrowth and thickening of certain areas of the skin)
- B. Neurological system
  1. Slowed reflexes
  2. Slight tremors and difficulty with fine motor movement
  3. Loss of balance
  4. Increased incidence of awakening after sleep onset
  5. Increased susceptibility to hypothermia and hyperthermia
  6. Short-term memory decline possible
  7. Long-term memory usually maintained
- C. Musculoskeletal system
  1. Decreased muscle mass and strength and atrophy of muscles

2. Decreased mobility, range of motion, flexibility, coordination, and stability
3. Change of gait, with shortened step and wider base
4. Posture and stature changes causing a decrease in height, also known as kyphosis (Fig. 19-1)
5. Increased brittleness of the bones due to demineralization
6. Deterioration of joint capsule components

The older client is at risk for falls because of the changes that occur in the neurological and musculoskeletal systems.

D. Cardiovascular system
1. Diminished energy and endurance, with lowered tolerance to exercise
2. Decreased compliance of the heart muscle can be due to remodeling of the heart after myocardial infarction or long-standing hypertension, with heart valves becoming thicker and more rigid due to calcification
3. Decreased cardiac output and decreased efficiency of blood return to the heart
4. Decreased compensatory response, so less able to respond to increased demands on the cardiovascular system
5. Decreased resting heart rate, which may be medication-related
6. Peripheral pulses can be weak due to lower cardiac output
7. Increased blood pressure but susceptible to postural hypotension, especially with certain cardiac medications such as diuretics

E. Respiratory system
1. Decreased stretch and compliance of the chest wall
2. Decreased strength and function of respiratory muscles
3. Decreased size and number of alveoli
4. Respiratory rate usually unchanged
5. Decreased depth of respirations
6. Decreased ability to cough and expectorate sputum

F. Hematological system
1. Hemoglobin and hematocrit levels average toward the

low end of normal

2. Prone to increased blood clotting

3. Decreased protein available for protein-bound medications

G. Immune system

1. Tendency for lymphocyte counts to be low with altered immunoglobulin production

2. Decreased resistance to infection and disease

H. Gastrointestinal system

1. Decreased caloric needs because of lowered basal metabolic rate
2. Decreased appetite, thirst, and oral intake
3. Decreased lean body weight
4. Slowed gastric motility

5. Increased tendency toward constipation due to poor oral intake and slowed motility
6. Increased susceptibility for dehydration
7. Tooth loss
8. Difficulty in chewing and swallowing food

I. Endocrine system

1. Decreased secretion of hormones, with specific changes related to each hormone's function
2. Decreased metabolic rate
3. Decreased glucose tolerance, with resistance to insulin in peripheral tissues

J. Renal/urinary system

1. Decreased kidney size, function, and ability to concentrate urine
2. Decreased glomerular filtration rate
3. Decreased capacity of the bladder

4. Increased residual urine and increased incidence of infection and possibly incontinence

5. Impaired medication excretion

K. Reproductive system

1. Decreased testosterone production and decreased size of the testes
2. Changes in the prostate gland, leading to urinary problems such as retention, hesitancy, or stress incontinence, predisposing to urinary tract infections
3. Decreased secretion of hormones with the cessation of menses

4. Vaginal changes, including decreased muscle tone and lubrication

5. Impotence or sexual dysfunction for both sexes; sexual function varies and depends on general physical condition, mental health status, and medications

L. Special senses

1.  Decreased visual acuity
2. Decreased accommodation in eyes, requiring increased adjustment time to changes in light
3. Decreased peripheral vision and increased sensitivity to glare
4. Presbyopia and cataract formation

5. Possible loss of hearing ability; low-pitched tones are heard more easily
6. Inability to discern taste of food
7. Decreased sense of smell
8. Changes in touch sensation

9. Decreased pain awareness

III. Psychosocial Concerns

A. Adjustment to deterioration in physical and mental health and well-being
B. Threat to independent functioning and fear of becoming a burden to loved ones
C. Adjustment to retirement and loss of income
D. Loss of skills and competencies developed early in life
E. Coping with changes in role function and social life
F. Diminished quantity and quality of relationships and coping with loss
G. Dependence on governmental and social systems
H. Access to social support systems
I. Costs of health care and medications
J. Loss of independence in living, driving, and other daily functions

IV. Mental Health Concerns

A. **Depression**: The increased dependency that older adults may experience can lead to hopelessness, helplessness, lowered sense of self-control, and decreased self-esteem and self-worth; these changes can interfere with daily functioning and lead to depression.
B. Grief: Client reacts to the perception of loss, including physical, psychological, social, and spiritual aspects.
C. Isolation: Client is alone and desires contact with others but is unable to make that contact.

D. Suicide: Depression can lead to thoughts of self-harm.
E. Depression differs from delirium and **dementia** (Table 19-1).

Any suicide threat made by an older client should be taken seriously.

V. Pain

A. Description
1. Pain can occur from numerous causes and most often occurs from degenerative changes in the musculoskeletal system.
2. The nurse needs to monitor the older client closely for signs of pain; failure to alleviate pain in the older client can lead to functional limitations affecting his or her ability to function independently.

B. Assessment
1. Restlessness
2. Verbal reporting of pain
3. Agitation
4. Moaning
5. Crying

C. Interventions
1. Monitor the client for signs and symptoms of pain.
2. Identify the type and pattern of pain.
3. Identify the precipitating factor(s) for the pain.
4. Monitor the impact of the pain on activities of daily living.
5. Set realistic goals for pain management, and use functional outcome as a measure of attaining the goal.
6. Provide pain relief through measures such as distraction, relaxation, massage, biofeedback, ice, heat, and stretching.
7. Administer pain medication as prescribed, and instruct the client in its use. Opioid use should be avoided as much as possible.
8. Over-the-counter preparations such as acetaminophen, ibuprofen, lidocaine patches, and creams may be prescribed.
9. Evaluate the effects of pain-reducing measures.

VI. **Infection** (Box 19-1)

A. Altered mental status is a common sign of infection in the older adult, especially infection of the urinary tract.
B. Carefully monitor the older adult with infection because of the diminished and altered immune response.
C. Nonspecific symptoms may indicate illness or infection (see Box 19-1).

VII. Medications

A. Major problems with prescriptive medications include adverse effects, medication interactions, medication errors, nonadherence, polypharmacy, and cost. See Box 19-2 for information on medications to avoid in the older adult client. This information is based on Beers Criteria from the American Geriatrics Society. Information on this criteria and a full list of medications to avoid can be located at https://geriatricscareonline.org/ProductAbstract/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001

B. Determine the use of over-the-counter medications.

C. **Polypharmacy**

1. Routinely monitor the number of prescription and nonprescription medications used and determine whether any can be eliminated or combined.
2. Keep the use of medications to a minimum.
3. Overprescribing medications leads to increased problems with more side and adverse effects, increased interaction between medications, duplication of medication treatment, diminished quality of life, and increased costs.

D. Medication dosages normally are prescribed at one-third to one-half of normal adult dosages.

E. Closely monitor the client for adverse effects and response to therapy because of the increased risk for medication toxicity (see Box 19-2).

F. Assess for medication interactions in the client taking multiple medications.

G. Advise the client to use one pharmacy and notify the consulting primary health care provider(s) of the medications taken.

A common sign of an adverse reaction to a medication in the older client is a sudden change in mental status.

H. Safety measures for medication administration (see Priority Nursing Actions box)

1. The client should be in a sitting position when taking medication.
2. The mouth is checked for dryness because medication may stick and dissolve in the mouth.
3. Liquid preparations can be used if the client has difficulty swallowing tablets.
4. Tablets can be crushed if necessary and given with textured food (nectar, applesauce) if not contraindicated.

5. Enteric-coated tablets are not crushed, and capsules are not opened.
6. If administering a suppository, avoid inserting the suppository immediately after removing it from the refrigerator; a suppository may take a while to dissolve because of decreased body core temperature.
7. When administering parenteral solution or medication, monitor the site because it may ooze or bleed because of decreased tissue elasticity; an immobile limb is not used for administering parenteral medication.
8. Monitor client adherence with taking prescribed medications.
9. Monitor the client for **safety** in correctly taking medications, including an assessment of his or her ability to read the instructions and discriminate among the pills and their colors and shapes.
10. Use a medication cassette or checklists/schedules to facilitate proper administration of medication.
11. Encourage client to keep a complete and up-to-date list of medications with them at all times.
12. Educate the client on each medication, common side effects, and when to notify the primary health care provider.
13. Allow time for the client to ask questions, and use the teach-back method when appropriate. Include support persons in the teaching.

Priority Nursing Actions

Administering Oral Medications to a Client at Risk for Aspiration

1. Check the medication prescription and compare against the medical record. Clarify any incomplete prescriptions prior to administration. Check the rights of medication administration.
2. Review pertinent information related to the medication and any related nursing considerations, such as laboratory parameters.
3. Assess for any contraindications to the administration of oral medications, such as NPO (nothing by mouth) status or decreased level of consciousness.
4. Place the client in a sitting position. Assess aspiration risk using a screening tool or per agency policy. Check for an ability to swallow and cough on command. Check for the presence of a gag reflex. Following this assessment, if aspiration is a serious concern, the nurse would collaborate with the primary health care provider and speech therapist before administering the medication.
5. Prepare the medication in the form that is easiest to swallow, checking the rights of medication administration again. Mix medications whole or crush medications and mix with applesauce or pudding if indicated (use sugar-free and low carbohydrate products for clients with diabetes). Do not crush sustained-release tablets, and use liquid preparations when possible. Thicken liquids when indicated, and avoid the use of straws.
6. Check the rights of medication administration one more time, and administer the medications 1 at a time in the prepared form, ensuring that the client has effectively swallowed everything. Ensure that the client is comfortable and safe, and document the medications given using an electronic system or per agency policy.

Reference
Potter et al. (2017), pp. 634-635

VIII. Mistreatment of the Older Adult

A. Domestic mistreatment takes place in the home of the older adult and is usually carried out by a family member or significant other; this can include physical, psychological, financial, and sexual maltreatment, **neglect**, or abandonment.
B. Institutional mistreatment takes place when an older adult experiences **abuse** when hospitalized or living somewhere other than home (e.g., long-term care facility).
C. **Self-neglect** is the choice by a mentally competent individual to avoid medical care or other services that could improve optimal function, to not care for oneself, and to engage in actions that negatively affect his or her personal safety; unless declared legally incompetent, an individual has the right to refuse care.

Individuals at most risk for abuse include those who are dependent because of their immobility or altered mental status.

D. For additional information on abuse of the older client, see Chapter 67.

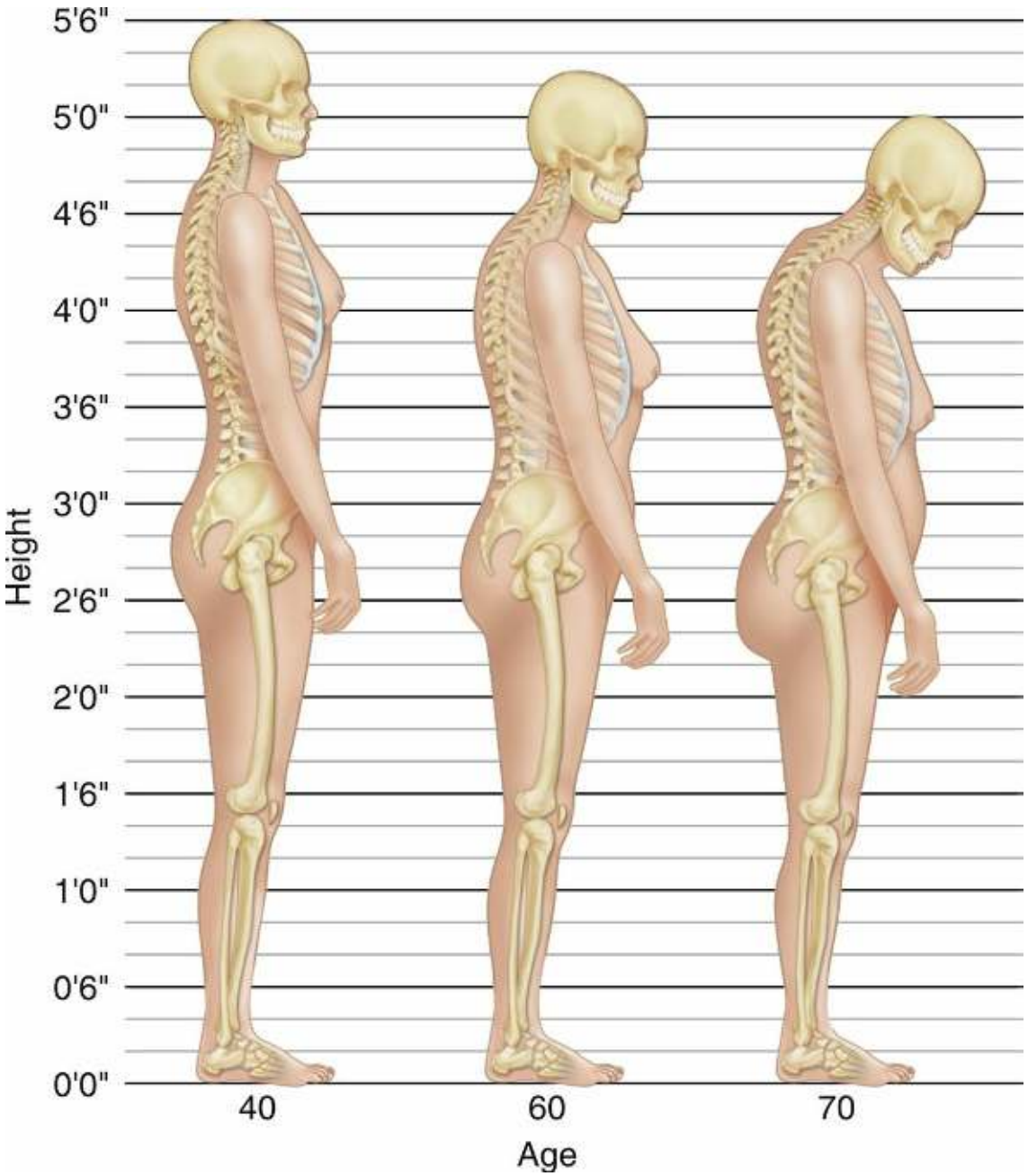

FIG. 19-1 A normal spine at 40 years of age and osteoporotic changes at 60 and 70 years of age. These changes can cause a loss of as much as 6 inches (15 cm) in height and can result in the so-called dowager's hump *(far right)* in the upper thoracic vertebrae.

Table 19-1

Differentiating Delirium, Depression, and Dementia

Characteristic	Delirium	Depression	Dementia
Onset	Sudden, abrupt	Recent, may relate to life change	Insidious, slow, over years and often unrecognized until deficits are obvious
Course over 24 hr	Fluctuating, often worse at night	Fairly stable, may be worse in the morning	Fairly stable, may see changes with stress; sundowning may occur
Consciousness	Reduced	Clear	Clear
Alertness	Increased, decreased, or variable	Normal	Generally normal
Psychomotor activity	Increased, decreased, or mixed	Variable; agitation or retardation	Normal; may have apraxia or agnosia; agitation can occur
Duration	Hours to weeks	Variable and may be chronic	Years
Attention	Disordered, fluctuates	Little impairment	Generally normal but may have trouble focusing; overwhelmed with multiple stimuli
Orientation	Usually impaired, fluctuates	Usually normal, may answer "I don't know" to questions or may not try to answer	Often impaired, may make up answers or answer close to the right thing, or may confabulate, but tries to answer
Speech	Often incoherent, slow or rapid, may call out repeatedly or repeat the same phrase	May be slow	Difficulty finding word, perseveration
Affect	Variable but may look disturbed, frightened	Flat	Slowed response, may be labile

Adapted from Sendelbach S, Guthrie PF, Schoenfelder DP: Acute confusion/delirium, *J Gerontol Nurse* 35(11):11–18, 2009.

Box 19-1

Nonspecific Symptoms That Possibly Indicate Illness or Infection

- Anorexia
- Apathy
- Changes in functional status
- Altered mental status, including delirium
- Tachypnea
- Hyperglycemia
- Dyspnea
- Falling
- Fatigue
- Incontinence
- Self-neglect
- Shortness of breath
- Blood pressure below baseline

Box 19-2

Medications to Avoid in the Older Client

Analgesics

- Indomethacin
- Ketorolac
- Nonsteroidal antiinflammatory drugs (NSAIDs)
- Meperidine

Antidepressants

- First-generation tricyclic antidepressants

Antihistamines

- First-generation antihistamines

Antihypertensives

- $Alpha_1$-blockers
- Centrally acting $alpha_2$-agonists

Urge Incontinence Medications

- Oxybutynin
- Tolterodine

Muscle Relaxants

- Carisoprodol
- Cyclobenzaprine
- Metaxalone
- Methocarbamol

Sedative-Hypnotics

- Barbiturates
- Benzodiazepines

Reference

Based on Beers Criteria from the American Geriatrics Society. Information on this criteria and a full list of medications to avoid can be located at https://geriatricscareonline.org/ProductAbstract/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001

Practice Questions

174. The nurse is providing medication instructions to an older client who is taking digoxin daily. The nurse explains to the client that decreased lean body mass and decreased glomerular filtration rate, which are age-related body changes, could place the client at risk for which complication with medication therapy?
    1. Decreased absorption of digoxin
    2. Increased risk for digoxin toxicity
    3. Decreased therapeutic effect of digoxin
    4. Increased risk for side effects related to digoxin
175. The nurse is caring for an older client in a long-term care facility. Which action contributes to encouraging autonomy in the client?
    1. Planning meals
    2. Decorating the room
    3. Scheduling haircut appointments
    4. Allowing the client to choose social activities
176. The home care nurse is visiting an older client whose spouse died 6 months ago. Which behaviors by the client indicates **effective** coping? **Select all that apply.**
    - ☐ 1. Neglecting personal grooming
    - ☐ 2. Looking at old snapshots of family
    - ☐ 3. Participating in a senior citizens program
    - ☐ 4. Visiting the spouse's grave once a month
    - ☐ 5. Decorating a wall with the spouse's pictures and awards received
177. The nurse is providing instructions to the assistive personnel (AP) regarding care of an older client with hearing loss. What should the nurse tell the AP about older clients with hearing loss?
    1. They are often distracted.
    2. They have middle ear changes.
    3. They respond to low-pitched tones.
    4. They develop moist cerumen production.
178. The nurse is providing an educational session to new employees, and the topic is abuse of the older client. The nurse helps the employees identify which client as **most** typically a victim of abuse?
    1. A man who has moderate hypertension
    2. A man who has newly diagnosed cataracts
    3. A woman who has advanced Parkinson's disease
    4. A woman who has early diagnosed Lyme disease
179. The nurse is performing an assessment on an older client who is having difficulty sleeping at night. Which statement by the client indicates the **need for further teaching** regarding measures to improve sleep?
    1. "I swim 3 times a week."
    2. "I have stopped smoking cigars."

3. "I drink hot chocolate before bedtime."
4. "I read for 40 minutes before bedtime."

180. The visiting nurse observes that the older male client is confined by his daughter-in-law to his room. When the nurse suggests that he walk to the den and join the family, he says, "I'm in everyone's way; my daughter-in-law needs me to stay here." Which is the **most important** action for the nurse to take?
    1. Say to the daughter-in-law, "Confining your father-in-law to his room is inhumane."
    2. Suggest to the client and daughter-in-law that they consider a nursing home for the client.
    3. Say nothing, because it is best for the nurse to remain neutral and wait to be asked for help.
    4. Suggest appropriate resources to the client and daughter-in-law, such as respite care and a senior citizens center.
181. The nurse is performing an assessment on an older adult client. Which assessment data would indicate a potential complication associated with the skin?
    1. Crusting
    2. Wrinkling
    3. Deepening of expression lines
    4. Thinning and loss of elasticity in the skin
182. The home health nurse is visiting a client for the first time. While assessing the client's medication history, it is noted that there are 19 prescriptions and several over-the-counter medications that the client has been taking. Which intervention should the nurse take **first?**
    1. Check for medication interactions.
    2. Determine whether there are medication duplications.
    3. Determine whether a family member supervises medication administration.
    4. Call the prescribing primary health care provider (PHCP) and report polypharmacy.
183. The long-term care nurse is performing assessments on several of the residents. Which are normal age-related physiological changes the nurse should expect to note? **Select all that apply.**
    - ☐ 1. Increased heart rate
    - ☐ 2. Decline in visual acuity
    - ☐ 3. Decreased respiratory rate
    - ☐ 4. Decline in long-term memory
    - ☐ 5. Increased susceptibility to urinary tract infections
    - ☐ 6. Increased incidence of awakening after sleep onset

Answers

174. ***Answer:*** 2

Rationale: The older client is at risk for medication toxicity because of decreased lean body mass and an age-associated decreased glomerular filtration rate. This age-related change is not specifically associated with decreased absorption, decreased therapeutic effect, or increased risk for side effects. Toxicity, or toxic effects, occurs as a result of excessive accumulation of the medication in the body.

Test-Taking Strategy: Focus on the **subject,** age-related body changes that could place the client at risk for medication toxicity. Recall that toxicity occurs as a result of medication accumulation in the body, which usually occurs as a result of decreased renal function. Note that the correct option is the only one that addresses renal excretion.

Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Developmental Stages: Early Adulthood to Later Adulthood
Health Problem: N/A
Priority Concepts: Client Education; Safety
Reference: Lewis et al. (2017), pp. 72-73.

175. ***Answer:*** 4

Rationale: Autonomy is the personal freedom to direct one's own life as long as it does not impinge on the rights of others. An autonomous person is capable of rational thought. This individual can identify problems, search for alternatives, and select solutions that allow continued personal freedom as long as others and their rights and property are not harmed. Loss of autonomy, and therefore independence, is a real fear of older clients. The correct option is the only one that allows the client to be a decision maker.

Test-Taking Strategy: Focus on the **subject,** encouraging autonomy. Recalling the definition of autonomy will direct you to the correct option. Remember that giving the client choices is essential to promote independence.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Caring
Content Area: Developmental Stages: Early Adulthood to Later Adulthood
Health Problem: N/A
Priority Concepts: Health Care Quality; Professionalism
Reference: Ignatavicius, Workman, Rebar (2018), p. 9.

176. ***Answer:*** 2, 3, 4, 5

Rationale: Coping mechanisms are behaviors used to decrease stress and anxiety. In response to a death, ineffective coping is manifested by an extreme behavior that in some cases may be harmful to the individual physically or psychologically. Neglecting personal grooming is indicative of a behavior that identifies ineffective coping in the grieving process. The remaining options identify appropriate and

effective coping mechanisms.

Test-Taking Strategy: Note the **strategic word**, *effective,* and focus on the **subject,** effective coping behaviors. Note that options 2, 3, 4, and 5 are **comparable or alike** and are positive activities in which the individual is engaging to get on with his or her life.

Level of Cognitive Ability: Analyzing
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Mental Health
Health Problem: Mental Health: Coping
Priority Concepts: Coping; Family Dynamics
Reference: Potter et al. (2017), pp. 775, 777.

177. ***Answer:*** 3

Rationale: Presbycusis refers to the age-related irreversible degenerative changes of the inner ear that lead to decreased hearing ability. As a result of these changes, the older client has a decreased response to high-frequency sounds. Low-pitched voice tones are heard more easily and can be interpreted by the older client. Options 1, 2, and 4 are not accurate characteristics related to aging.

Test-Taking Strategy: Focus on the **subject,** age-related changes related to hearing. Think about the physiological changes associated with aging. Recalling that the client with a hearing loss responds to low-pitched tones will direct you to the correct option.

Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Developmental Stages: Early Adulthood to Later Adulthood
Health Problem: Adult Health: Ear: Hearing Loss
Priority Concepts: Development; Sensory Perception
Reference: Lewis et al. (2017), pp. 361, 391.

178. ***Answer:*** 3

Rationale: Elder abuse includes physical, sexual, or psychological abuse; misuse of property; and violation of rights. The typical abuse victim is a woman of advanced age with few social contacts and at least 1 physical or mental impairment that limits her ability to perform activities of daily living. In addition, the client usually lives alone or with the abuser and depends on the abuser for care.

Test-Taking Strategy: Focus on the **subject,** elder abuse. Note the **strategic word,** *most*. Read each option carefully and identify the client who is most defenseless as the result of the disease process. This will direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Assessment
Content Area: Developmental Stages: Early Adulthood to Later Adulthood
Health Problem: Mental Health: Abusive Behaviors

Priority Concepts: Interpersonal Violence; Safety
Reference: Lewis et al. (2017), pp. 66-67.

179. ***Answer:*** 3

Rationale: Many nonpharmacological sleep aids can be used to influence sleep. However, the client should avoid caffeinated beverages and stimulants such as tea, cola, and chocolate. The client should exercise regularly, because exercise promotes sleep by burning off tension that accumulates during the day. A 20- to 30-minute walk, swim, or bicycle ride 3 times a week is helpful. Smoking and alcohol should be avoided. Reading is also a helpful measure and is relaxing.
Test-Taking Strategy: Note the **strategic words,** *need for further teaching*. These words indicate a **negative event query** and ask you to select an option that is an incorrect statement. Options 1, 2, and 4 are positive statements indicating that the client understands the methods of improving sleep. Remember that chocolate contains caffeine.
Level of Cognitive Ability: Evaluating
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Developmental Stages: Early Adulthood to Later Adulthood
Health Problem: N/A
Priority Concepts: Client Education; Palliation
Reference: Potter et al. (2017), p. 1006.

180. ***Answer:*** 4

Rationale: Assisting clients and families to become aware of available community support systems is a role and responsibility of the nurse. Observing that the client has begun to be confined to his room makes it necessary for the nurse to intervene legally and ethically, so option 3 is not appropriate and is passive in terms of advocacy. Option 2 suggests committing the client to a nursing home and is a premature action on the nurse's part. Although the data provided tell the nurse that this client requires nursing care, the nurse does not know the extent of the nursing care required. Option 1 is incorrect and judgmental.
Test-Taking Strategy: Note the **strategic words,** *most important.* Using principles related to the ethical and legal responsibility of the nurse and knowledge of the nurse's role will direct you to the correct option. Option 1 is a nontherapeutic statement, option 2 is a premature action, and option 3 avoids the situation.
Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Developmental Stages: Early Adulthood to Later Adulthood
Health Problem: Mental Health: Abusive Behaviors
Priority Concepts: Ethics; Health Care Law
Reference: Lewis et al. (2017), 69.

181. ***Answer:*** 1

Rationale: The normal physiological changes that occur in the skin of older adults include thinning of the skin, loss of elasticity, deepening of expression lines, and wrinkling. Crusting noted on the skin would indicate a potential complication.

Test-Taking Strategy: Note the **subject,** a potential complication. Think about the normal physiological changes that occur in the aging process in the integumentary system to direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process—Assessment
Content Area: Developmental Stages: Early Adulthood to Later Adulthood
Health Problem: N/A
Priority Concepts: Clinical Judgment; Tissue Integrity
Reference: Lewis et al. (2017), p. 397.

182. ***Answer:*** 2

Rationale: Polypharmacy is a concern in the older client. Duplication of medications needs to be identified before medication interactions can be determined, because the nurse needs to know what the client is taking. Asking about medication administration supervision may be part of the assessment but is not a first action. The phone call to the PHCP is the intervention after all other information has been collected.

Test-Taking Strategy: Note the **strategic word,** *first*. Also note that the nurse is visiting the client for the first time. Options 1, 3, and 4 should be done after possible medication duplication has been identified.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Foundations of Care: Safety
Health Problem: N/A
Priority Concepts: Clinical Judgment; Safety
Reference: Potter et al. (2017), pp. 187-188.

183. ***Answer:*** 2, 5, 6

Rationale: Anatomical changes to the eye affect the individual's visual ability, leading to potential problems with activities of daily living. Light adaptation and visual fields are reduced. Although lung function may decrease, the respiratory rate usually remains unchanged. Heart rate decreases and heart valves thicken. Age-related changes that affect the urinary tract increase an older client's susceptibility to urinary tract infections. Short-term memory may decline with age, but long-term memory usually is maintained. Change in sleep patterns is a consistent, age-related change. Older persons experience an increased incidence of awakening after sleep onset.

Test-Taking Strategy: Focus on the **subject,** normal age-related changes. Read each characteristic carefully and think about the physiological changes that occur with aging to select the correct items.

Level of Cognitive Ability: Analyzing
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process—Assessment
Content Area: Developmental Stages: Early Adulthood to Later Adulthood
Health Problem: N/A
Priority Concepts: Development; Safety
Reference: Potter et al. (2017), p. 36.