Ignatavicius: Medical-Surgical Nursing, 6th Edition

Chapter 3: Common Health Problems of Older Adults

Test Bank

MULTIPLE CHOICE

1. Which best represents the four subgroups of late adulthood that the nurse may encounter when caring for older clients?
   a. Young old, middle old, older old, oldest old
   b. Youthful old, mid-old, older old, oldest old
   c. Young old, middle old, older old, elite old
   d. Youthful old, mid-old, elite old, eldest old

   ANS: C
   Late adulthood can be divided into four subgroups: the young old (65 to 74 years), the middle old (75 to 84 years), the older old (85 to 99 years), and the elite old (100 years or older).

   DIF: Cognitive Level: Knowledge REF: p. 15
   OBJ: Learning Outcome 10
   TOP: Client Needs Category: Physiological Integrity (Physiological Adaptation)
   MSC: Integrated Process: Nursing Process (Assessment)

2. An older old client is agitated and confused on admission to the long-term care unit. How will the nurse minimize relocation stress syndrome for this client?
   a. Reorient the client frequently to his or her location.
   b. Obtain a certified sitter to remain with the client.
   c. Speak to the client as little as possible to avoid overstimulation.
   d. Provide adequate sedation for all procedures to avoid fear-provoking situations.

   ANS: A
   There are many nursing interventions that can be helpful to older adults who experience relocation stress syndrome. If the client becomes confused, agitated, or combative, the nurse should reorient the client to his or her surroundings. The nurse also can encourage family members to visit often, keep familiar objects at the client's bedside, and work to establish a trusting relationship with the client

   DIF: Cognitive Level: Comprehension REF: p. 18, Chart 3-2
   OBJ: Learning Outcome 4
   TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control) MSC: Integrated Process: Nursing Process (Implementation)

3. How will the nurse support a client who relates a feeling of "loss of control" after having a mild stroke?
   a. Explain to the client that such feelings are normal, but that expectations for rehabilitation must be realistic.

b. Encourage the client to perform as many tasks as possible and to participate in decision making.
c. Further assess the client's mental status for other signs of denial.
d. Obtain an order for physical and occupational therapy.

ANS: B
Older adults can experience a number of losses that affect their sense of control over their lives, including a decrease in physical mobility. The nurse should support the client's self-esteem and increase feelings of competency by encouraging activities that assist in maintaining some degree of control, such as participation in decision making and performing tasks that he or she can manage.

DIF: Cognitive Level: Application REF: N/A for Application and above
OBJ: Learning Outcome 9
TOP: Client Needs Category: Psychosocial Integrity (Coping Mechanisms)
MSC: Integrated Process: Nursing Process (Implementation)

4. What will the nurse teach the client with hypertension who complains that "food does not taste good without salt?"
a. Salt can be used as long as the blood pressure remains controlled.
b. All salt should be removed from the diet to preserve kidney function.
c. Table salt in small amounts in conjunction with diuretics can be used.
d. Herbs and spices can be substituted to season food.

ANS: D
Physical changes associated with aging can affect the intake of nutrients. Diminished senses of taste and smell, particularly a decline in the ability to taste sweet and salty, may lead the older adult to overuse sugar and salt. In such cases, the nurse should recommend that the client use herbs and spices to season food.

DIF: Cognitive Level: Application REF: N/A for Application and above
OBJ: Learning Outcome 5
TOP: Client Needs Category: Health Promotion and Maintenance (Self-Care)
MSC: Integrated Process: Teaching/Learning

5. What is a priority nursing intervention to prevent falls for an older adult client with multiple chronic diseases?
a. Providing assistance to the client in getting out of the bed or chair
b. Placing the client in restraints to prevent movement without assistance
c. Keeping all four side rails up while the client is in bed
d. Requesting that a family member remain with the client to assist in ambulation

ANS: A
Advanced age, multiple illnesses, particularly those that result in alterations in sensation, such as diabetes, predispose this client to falls. The nurse should provide assistance to the client with transfer and ambulation to prevent falls. The client should not be restrained or maintained on bedrest without adequate indication. Although family members are encouraged to visit, their presence around the clock is not necessary at this point.

DIF: Cognitive Level: Application REF: N/A for Application and above
OBJ: Learning Outcome 6
TOP: Client Needs Category: Health Promotion and Maintenance (Aging Process)
MSC: Integrated Process: Nursing Process (Implementation)

6. What is a priority nursing intervention for an older adult client in physical restraints?
   a. Assessing the client hourly, while keeping the restraints in place
   b. Assessing the client every 30 to 60 minutes, releasing the restraints every 2 hours
   c. Assessing the client once each shift, releasing the restraints for feeding
   d. Assessing the client twice each shift, keeping the restraints in place

   ANS: B
   The application of restraints can have serious consequences. Thus, the nurse should check the client every 30 to 60 minutes, releasing the restraints every 2 hours for positioning and toileting. The other answers would not be appropriate because the client would not be assessed frequently enough, and circulation to the limbs could be compromised. Assessing every hour and releasing the restraints every 2 hours is in compliance with federal policy for monitoring clients in restraints.

   DIF: Cognitive Level: Application REF: N/A for Application and above
   OBJ: Learning Outcome 4
   TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control) MSC: Integrated Process: Nursing Process (Implementation)

7. An older adult client has become agitated and combative toward the health care personnel on the unit. What is the first action that the nurse will take?
   a. Obtain an order for a sedative-hypnotic medication to reduce combative behavior.
   b. Attempt to soothe the client's fears and reorient the client to surroundings.
   c. Obtain an order to place the client's arms in restraints to protect personnel.
   d. Arrange for the client to be transferred to a mental health facility.

   ANS: B
   The nurse should establish a trusting relationship with the client, soothe the client's fears, and reorient the client to the facility before resorting to physical or chemical restraints. Restraints, both physical and chemical, may be overused in certain situations. Sedative-hypnotic drugs may have adverse effects in older adults and should be used sparingly. Physical restraints also can have serious repercussions. Transfer to a mental health facility requires evaluation by psychiatric staff and may not be appropriate here.

   DIF: Cognitive Level: Application REF: N/A for Application and above
   OBJ: Learning Outcome 4
   TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control) MSC: Integrated Process: Nursing Process (Implementation)

8. An older adult client presents with signs and symptoms related to digoxin toxicity. Which age-related change may have contributed to this problem?

a. Increased total body water
b. Decreased renal blood flow
c. Increased gastrointestinal motility
d. Decreased ratio of adipose tissue to lean body mass

ANS: B
Decreased renal blood flow and reduced glomerular filtration can result in slower medication excretion time, potentially resulting in toxic drug accumulation. Aging results in decreased total body water and gastrointestinal motility, and an increase in the ratio of adipose tissue to lean body mass.

DIF: Cognitive Level: Comprehension REF: p. 19
OBJ: Learning Outcome 6
TOP: Client Needs Category: Health Promotion and Maintenance (Aging Process)
MSC: Integrated Process: Nursing Process (Assessment)

9. Which statement indicates that the client does not understand medication therapy?
a. "My husband is on the same medication, so we always take our medications together in the morning."
b. "I prepare all my medication for the week and place the pills in a container labeled for each day."
c. "When I don't sleep well at night, I take two thyroid pills the next day instead of just one."
d. "I take my Coumadin every day when the noon news comes on the television."

ANS: C
Changing the dose of medication without correct understanding of the drug's use and appropriate schedule can cause serious problems.

DIF: Cognitive Level: Application REF: N/A for Application and above
OBJ: Learning Outcome 5
TOP: Client Needs Category: Health Promotion and Maintenance (Principles of Teaching/Learning) MSC: Integrated Process: Nursing Process (Evaluation)

10. An older adult client is being discharged from the hospital on several medications. What is the best way to reinforce medication teaching for this client?
a. Have the client actively participate in drug administration during hospitalization.
b. Include the client's children in discussions regarding proper medication administration.
c. Give the client a pamphlet outlining the actions, side effects, and doses of all prescribed drugs.
d. Make a chart for the client, showing exactly which drugs are to be taken at different times during the day.

ANS: A
Supervised self-administration of medications allows accurate assessment of the client's capabilities and hands-on learning opportunities for instruction or reinforcement.

DIF: Cognitive Level: Application REF: N/A for Application and above
OBJ: Learning Outcome 12
TOP: Client Needs Category: Physiological Integrity (Reduction of Risk Potential)
MSC: Integrated Process: Teaching/Learning

11. The family of an older adult client expresses concern regarding the gradual decline in cognitive functioning of their family member. The nurse focuses teaching on what clinical condition?
    a. Depression
    b. Psychosis
    c. Dementia
    d. Delirium

    ANS: C
    Dementia is characterized by a gradual decline in intellectual functioning that is chronic and progressive.

    DIF: Cognitive Level: Knowledge REF: p. 21
    OBJ: Learning Outcome 13
    TOP: Client Needs Category: Physiological Integrity (Physiological Adaptation)
    MSC: Integrated Process: Nursing Process (Assessment)

12. Which behavior exhibited by an older adult client should alert the nurse to the possibility that the client is experiencing delirium?
    a. The client becomes confused within 24 hours after hospital admission.
    b. The client displays a cheerful attitude despite a poor prognosis.
    c. The client becomes depressed and sleeps most of the day.
    d. The client begins to use slurred speech.

    ANS: A
    Delirium is characterized by acute confusion that is usually short term. Delirium can result from placement in unfamiliar surroundings, such as being hospitalized.

    DIF: Cognitive Level: Comprehension REF: p. 21
    OBJ: Learning Outcome 13
    TOP: Client Needs Category: Physiological Integrity (Physiological Adaptation)
    MSC: Integrated Process: Nursing Process (Assessment)

13. A client with Alzheimer's disease has been hospitalized for dehydration. In making an assessment, the nurse notes the presence of a cluster of bruises on the client's buttocks and suspects that the client may be the victim of elder neglect and abuse. What is the nurse's priority action?
    a. Calling the local police
    b. Notifying the client's physician and social worker
    c. Confronting the client's family caregiver with the suspicions
    d. Alerting hospital security to prevent visits by the client's caregiver

    ANS: B

If a nurse suspects elder abuse or neglect, the nurse notifies the physician and social worker to begin an investigation of the situation.

DIF: Cognitive Level: Application REF: N/A for Application and above
OBJ: Learning Outcome 3
TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control) MSC: Integrated Process: Nursing Process (Assessment)

14. An older adult client is suspected of being neglected by their caregiver. What assessments will the nurse make that assist in confirming a suspicion of neglect in an older adult client?
    a. Injuries noted in the "bathing suit" zone of the body
    b. Disorientation to time, place, and person
    c. Excessive weight loss
    d. Rapid heart rate

    ANS: C
    Neglect is often manifested by dehydration, under nutrition, pressure ulcers, or contractures. Injuries raise the suspicion for abuse, whereas disorientation and rapid heart rate can be the result of disease processes.

    DIF: Cognitive Level: Comprehension REF: p. 22
    OBJ: Learning Outcome 7
    TOP: Client Needs Category: Psychosocial Integrity (Abuse/Neglect)
    MSC: Integrated Process: Nursing Process (Assessment)

15. A nurse is caring for an older adult client who lives alone. Which economic situation presents the most serious problem for this client?
    a. Stock market fluctuations
    b. Increased provider benefits
    c. Social Security as the basis of income
    d. Costs associated with setting up a living will

    ANS: C
    Older adults on fixed incomes are unable to adjust their income to meet rising costs.

    DIF: Cognitive Level: Comprehension REF: p. 25
    OBJ: Learning Outcome 1
    TOP: Client Needs Category: Safe and Effective Care Environment (Management of Care)
    MSC: Integrated Process: Nursing Process (Planning)

16. What government resource is available to assist older adults to meet the cost of health care?
    a. Preferred provider organizations
    b. Health maintenance organizations
    c. Medicare
    d. Medicaid

    ANS: C

Medicare is a federal insurance program designed to assist older adults to meet the cost of health care. Medicare provides health insurance to those aged 65 years or older and to qualified disabled people.

DIF: Cognitive Level: Application REF: N/A for Application and above
OBJ: Learning Outcome 1
TOP: Client Needs Category: Safe and Effective Care Environment (Management of Care)
MSC: Integrated Process: Nursing Process (Planning)

MULTIPLE RESPONSE

1. What conditions predispose a client to acute confusion or delirium? *(Select all that apply.)*
   a. Alcoholism
   b. Chronic pain
   c. Acute infection
   d. Major loss
   e. Multi-infarct cerebrovascular disease
   f. Change in drug regimen

   ANS: C, D, F
   Alcoholism and increased pain and disability more commonly lead to depression. Multi-infarct cerebrovascular disease is associated with progressive dementia. Infection and major loss are likely to cause acute confusion.

   DIF: Cognitive Level: Comprehension REF: p. 21
   OBJ: Learning Outcome 13
   TOP: Client Needs Category: Physiological Integrity (Reduction of Risk Potential)
   MSC: Integrated Process: Nursing Process (Planning)

2. What interventions will help an older adult client adjust to being admitted to a skilled nursing facility following surgery? *(Select all that apply.)*
   a. Make sure that she has her hearing aid and glasses.
   b. Offer her the anxiolytic that her physician has prescribed.
   c. Encourage her family to bring in her favorite pictures.
   d. Ask her where she wants the room furnishings placed.
   e. Encourage her to eat meals in her room.
   f. Invite her to group activities.

   ANS: A, C, D
   An anxiolytic may increase the difficulty that the client has in interpreting her surroundings. Making sure that she can see and hear will help the environmental interpretation, familiar possessions will provide a sense of identity, and having some input into the organization of her immediate surroundings helps develop a sense of control.

   DIF: Cognitive Level: Comprehension REF: p. 18
   OBJ: Learning Outcome 11
   TOP: Client Needs Category: Physiological Integrity (Basic Care and Comfort)

MSC: Integrated Process: Nursing Process (Planning)

3. What condition places the client at an increased risk for falls? *(Select all that apply.)*
   a. Visual impairment
   b. Reluctance to use a cane while walking
   c. Hypertension
   d. Obesity
   e. Difficulty arising from a sitting position
   f. Being male

   ANS: A, E
   Vision, hearing, and mobility difficulties are associated with increased fall risk. Obesity is not a risk factor for falls.

   DIF: Cognitive Level: Comprehension REF: p. 18
   OBJ: Learning Outcome 2
   TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control) MSC: Integrated Process: Nursing Process (Assessment)

4. What interventions can the nurse take to help an older adult client who is having trouble sleeping while in the hospital? *(Select all that apply.)*
   a. Changing the client's sheets each night prior to sleep
   b. Dimming the lights to make the client's area as dark as possible
   c. Attempting to keep the client awake during the daytime
   d. Keeping staff conversations as quiet as possible and away from the client's room
   e. Administering sleeping pills instead of regular medication at night
   f. Administering pain medication prior to bedtime
   g. Asking the client if he or she would like to pray

   ANS: B, C, D, F
   Sleep disorders are common in hospitalized clients, especially older adults. The primary contributing factors for clients who have trouble sleeping are pain, chronic disease, environmental noise and lighting, and staff conversations. To help clients get adequate rest, the nurse should try to keep the client awake in the daytime to ensure that she or he is tired at night. Dimming the lights and keeping conversations quiet and further from their rooms will help eliminate some of the environmental factors, and administering pain medication at bedtime will help the client's ability to fall asleep without pain.

   DIF: Cognitive Level: Comprehension REF: p. 23
   OBJ: Learning Outcome 14
   TOP: Client Needs Category: Physiological Integrity (Physiological Adaptation)
   MSC: Integrated Process: Nursing Process (Planning)

5. Which outcomes can be achieved through early detection and treatment of depression in an older adult client? *(Select all that apply.)*
   a. Shortened hospital stay
   b. Suicide

c. Decreased pain
d. Alcoholism
e. Increased physical illness

ANS: A, C
Depression is the most common mental health/behavioral health problem among older adults in the community. Early detection can prevent the effects of depression, including worsening of medical conditions, increased pain and disability, and delayed recovery from illness. Failure to diagnose and treat depression can result in a risk of physical illness, alcoholism, and suicide.

DIF: Cognitive Level: Comprehension REF: p. 20
OBJ: Learning Outcome 8
TOP: Client Needs Category: Physiological Integrity (Reduction of Risk Potential)
MSC: Integrated Process: Nursing Process (Planning)