Aging is *Experiencing* Life’s Journey
Using Exploration & Adaptation

**Exploration ~ Panama City 2005**

**Metamorphosis ~ Aruba 2005**

**Adaptation ~ Hawaii 2008**

**NURS 117**
Concepts & Practices of Gerontological Nursing

**Syllabus & WorkBook**

*Fall 2012*
Dr. Cheryl Osborne
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NURS 117

COURSE OVERVIEW

COURSE NUMBER: NURS 117

COURSE TITLE: Concepts and Practices of Gerontological Nursing

COURSE CREDIT AND CLOCK HOURS: 2 Units, 2 hours/week

PLACEMENT IN CURRICULUM: Junior Year, second semester in the nursing major courses.

PREQUISITES: NURS 11, 12, 14, 15 and 16 or permission of professor.

FACULTY: Cheryl Osborne EdD, MSN, RN
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osbornec@csus.edu
Office Hours: Call for Appointment – Benicia Hall 1020

CATALOG DESCRIPTION: Designed to explore current theories and practices in gerontological nursing. The primary focus of the course is on the role of the nurse in assessing and managing the aging individual and family adaptation to the aging process. Lecture two hours. Prerequisite: Admission to Clinical Nursing program. Graded: Graded Student. Units: 2.0

COURSE OBJECTIVES
These Student Learning Outcomes incorporate outcomes, competencies and professional standards from the following sources: California BRN, ANA, CCNE Essentials, AACN Baccalaureate Geriatric Nursing Competencies (# noted), CSUS Division of Nursing Summative and Level Outcomes, and University Learning Outcomes.

SO 1: Synthesizes theories and concepts from the sciences, the arts, and nursing and integrates these into nursing practice.

Level I:
Applies theories and concepts from the sciences, the arts, and nursing and integrates these into nursing practice.

1.1 Apply common biological, psychosocial, cultural, spiritual, gender, generational, and environmental (holistic) influences and reactions to the aging process using Nursing Process as a framework.
1.2 Use an evidence-based, holistic approach when formulating nursing interventions for older adults and their families.
1.3 Discuss how current theories from a variety of disciplines may be used to explain responses to the aging process.
1.4 Incorporate understanding of teaching-learning principles when developing plans of care for older adults and their families.
1.5 Discuss the effects of disease processes on adaptation abilities of older adult’s and their families.(14, 15)
1.6 Use interpersonal, group, crisis, and coping theories when assisting families to access coping strategies needed when dealing with intergenerational issues in various settings.

Essential 1 - Liberal Education for Baccalaureate Generalist Nursing Practice

SO II: Utilizes the nursing process to facilitate optimal health, integrating knowledge and skills with individuals and groups across the lifespan and in a variety of settings.
Level II:
Utilizes the nursing process and clinical reasoning to diagnose and formulate alternative solutions to health problems across increasingly unpredictable and complex health care settings.

2.1 Demonstrate the use of the nursing process when analyzing the needs of older adults and their families.
2.2 Explain how holistic adaptation to typical age related changes affects the functioning of older adults, their families, and communities at large.
2.3 Synthesize knowledge of the aging process to predict older adults’ affinity for at risk situations.
2.4 Adopt the concept of individualized care as the standard of practice with older adults.
2.5 Recognize that sensation and perception in older adults are mediated by functional, physical, cognitive, psychological, and social changes common in old age.
2.6 Incorporate into daily practice, valid and reliable tools to assess the functional, physical, cognitive, psychological, social, and spiritual status of older adults.
2.7 Correctly perform Functional Assessment, Fall Risk Assessment and Mini Mental Exam on a minimum of one elder individual.
2.8 Correctly use supplied assessment screening tools with selected elders.
2.9 Assess older adults’ living environments with special awareness of the functional, physical, cognitive, psychological, and social changes common in old age.
2.10 Adapt technical skills to meet the functional, physical, cognitive, psychological, social, and endurance capacities of older adults.
2.11 Recognize and manage geriatric syndromes common to older adults.
2.12 Recognize the complex interaction of acute and chronic co-morbid conditions common to older adults.
2.13 Use various theories and frameworks for analysis of adaptation by older adults and their families.
2.14 Hypothesize ways in which the older adult’s adaptive responses can be used to promote optimal functioning within their total environment.
2.15 Discuss older adult’s resources for access to various levels of health and illness care.
2.16 Evaluate and correctly applies evidence based research findings to care of older adult and their families.

Essential 9 - Baccalaureate Generalist Nursing Practice

SO III: Synthesizes leadership and management theories and principles of quality improvement in the delivery of safe and efficient health care to individuals, families, groups, and communities.

Level I:
Describes the unique role of the nurse working within the organizational structure of the health care environment.

3.1 Incorporate decision making theories when using the nursing process to assist older adult and their families in adapting to changes experienced during the aging process.
3.2 Relate roles of various HCT members and how they interact with nursing in promoting optimal level wellness for elders and their families.
3.3 Discuss care management of older adults and their families.
3.4 Compare and contrasts nursing roles in various levels settings in regard to facilitating adaptation of older adults and their families.
3.5 Analyze the effectiveness of community resources in assisting older adults and their families to retain personal goals, maximize function, maintain independence, and live in the least restrictive environment.
3.6 Appreciate the influence of attitudes, roles, language, culture, race, religion, gender, and lifestyle on how families and assistive personnel provide long-term care to older adults.
3.7 Recognize the benefits of interdisciplinary team participation in the care of older adults.
3.8 Involve, educate, and when appropriate, supervise family, friends, and assistive personnel in implementing best practices for older adults.
3.9 Insure quality of care commensurate with older adults’ vulnerability and frequency and intensity of care needs.
**Essential 2 - Basic Organizational and Systems Leadership for Quality Care and Patient Safety**

**SO IV:** Employs effective inter and intra-professional communication and collaborative strategies to foster an optimal level of health.

**Level II:** Demonstrates effective inter and intra-professional communication techniques with individuals, families, and groups as a collaborative member of the healthcare team to strengthen positive working relationships and patient-centered care.

4.1 Recognize one’s own and others’ attitudes, values, stereotypes and expectations about aging and their impact on care of older adults and their families. (1)

4.2 Communicate effectively, respectively, and compassionately with older adults and their families. (3)

4.3 Communicate awareness of own interdependent and collaborative roles when working with older adults, their families, and staff within various practice settings.

4.4 Communicate effectively, respectively, and knowledgeably with agency staff and community members.

4.5 Complete Elder interview and any agency visit in a knowledgeable, respectful, professional manner.

**Essential 6 – Inter-professional Communication and Collaboration for Improving Patient Health Outcomes**

**SO V:** Exemplifies the values and beliefs of professional nursing and articulates the importance of lifelong learning.

**Level II:** Exhibits and promotes professional and academic attitudes and behaviors consistent with the ANA Code of Ethics, professional nursing practice, and Division of Nursing and University policy.

5.1 Actively participate in own learning by thoroughly completing assignments on time.

5.2 Discover elements of compassion when relating to older adults and their families.

5.3 Demonstrate sensitivity for human dignity when facilitating older adults’ and their families’ adaptation to typical age related changes.

5.4 Articulate own ethical decision making process in common situations faced by older adults and their families.

5.5 Discuss nurses’ legal roles as they relate to facilitating adaptation for older adults and their families.

5.6 Establish and follow standards of care to recognize and report elder mistreatment. (13)

5.7 Apply ethical and legal principles to the complex issues that arise in care of older adults. (19)

5.8 Promote the desirability of quality end-of-life care for older adults, including pain and symptom management, as essential, desirable, and integral components of nursing practice. (30)

**Essential 8 - Professionalism and Professional Values**

**SO VI:** Synthesizes knowledge and skills in the utilization of patient care technologies and information management systems to support ethical nursing practice and promote safe, quality care delivery.

**Level I:** Demonstrates the ability to responsibly access, utilize, and evaluate patient care technologies and information management systems in the delivery of safe, quality care.

6.1 Use technology to enhance older adults’ function, independence, and safety. (16)

6.2 Facilitate communication as older adults transition across and between home, hospital, and nursing home, with a particular focus on the use of technology. (17)

**Essential 4 – Information Management and Application of Patient Care Technology**

**SO VII:** Integrates and disseminates theory and research to inform and improve patient outcomes through evidence-based practice.
Level II:
Applies the basic elements of research in order to critique and appraise evidence related to practice outcomes.

7.1 Critically appraise validity and applicability of evidence based research when developing plans of care for older adults and their families.

7.2 Critically appraise validity and applicability of evidence-based research when creating theory to Practice Fact Sheet for older adults and their families.

**Essential 3 – Scholarship for Evidence based Practice**

**SO: VIII:** Integrates knowledge of healthcare policy, finance, and regulation to inform and influence professional nursing practice as an advocate and leader promoting equity and quality in healthcare delivery.

**Level I:**
Demonstrates basic knowledge of concepts related to health care policy, finance, and regulation.

8.1 Evaluate differing international models of geriatric care. (21)

8.2 Analyze the impact of an aging society on the health care system. (22)

8.3 Evaluate the influence of payer systems on access, availability, and affordability of health care for older adults. (23)

8.4 Contrast the opportunities and constraints of supportive living arrangements on the function and independence of older adults and their families. (24)

8.5 Facilitate older adults’ active participation in all aspects of their own health care. (27)

8.6 Discuss profession’s efforts to become involved in policy issues related to older adults.

**Essential 5 - Health Care Policy, Finance, and Regulatory Environments**

**SO: IX** Utilizes principles of health promotion and disease prevention to improve population health across the lifespan in individuals, families, groups, and communities.

**Level I:**
Identifies protective and predictive factors including cultural, psychosocial, and spiritual influences on the health of individuals and families.

9.1 Discuss strategies for evidence-based health promotion and maintenance in relation to expected life experiences for older adults and their families.

9.2 Explore global health care models that address needs of older adults and their families.

9.3 Explore available community resources for older adults and their families.

9.4 Assess family knowledge of skills necessary to deliver care to older adults. (8)

9.5 Individualize care and prevent morbidity and mortality associated with the use of physical and chemical restraints in older adults. (10)

9.6 Prevent or reduce common risk factors that contribute to functional decline, impaired quality of life, and excess disability in older adults. (11)

9.7 Apply evidence-based standards to screen, immunize, and promote healthy activities in older adults. (13)

9.8 Assist older adults, families, and caregivers to understand and balance “everyday” autonomy and safety decisions. (18)

9.9 Evaluate utility of complementary and integrative health care practices on health promotion and symptom management for older adults. (26)

**Essential 7 – Clinical Prevention and Population Health**

**SO: X:** Demonstrates information competence relevant to nursing practice

**Level II:**
Determines the extent of information needed and appropriately accesses, critically evaluates, and efficiently utilizes and communicates information relevant to nursing practice.

10.1 Explore aging websites to determine valid ones for older adults and their families.

10.2 Access and correctly use information from a variety of sources when assisting older adults and their families in determining care needs and interventions. (7, 12)

*University Information Competency Outcome (CSUS reference: http://library.csus.edu/content2.asp?pageID=363)*
TEACHING STRATEGIES
Discussion, individual and group classroom experiential application exercises, case studies, reflective writing assignments, video analysis, SacCT, and lecture.

EVALUATION METHODS
Written examinations, evaluation of written assignments by established rubrics, & active class participation.

TEXTS:
Required Readings in:

Self-Selected Journal Readings
Recommended Texts:

Frequently used Websites:
SacCT
www.consultgerirn.org (to use throughout the course and after 😊)
www.healthyagingprograms.org (for #3 Virtual Class)
www.elsevier.com (website for Student Resources from your Book)

SERVICES FOR STUDENTS WITH DISABILITIES http://www.csus.edu/sswd/
It is the responsibility of students with disabilities to self-identify and request needed disability-related accommodations in a timely manner by contacting the SSWD office. The office is open Monday to Friday from 8:00 a.m. - 5:00 p.m. All matters related to students with disabilities are treated as CONFIDENTIAL. Students are strongly encouraged to request accommodations as early as possible since it can take several weeks or more to facilitate requests. Students should communicate with professors regarding approved accommodations early to help contribute to success in their courses.
Location: Lassen Hall Room 1008 ~ Phone: (916) 278-6955 / (916) 278-7239 TTY

INTERNET ETIQUETTE
Written words in emails and online communication can be interpreted differently than the author’s intended message. Please be respectful in your written communication. Further information on internet communication can be found at http://imet.csus.edu/imet3/lori/iknow/email.html

SacCT/Blackboard
SacCT/Blackboard (Internet web-enhanced system) is used for portions of the course. To access SacCT, go to the CSUS home page (www.csus.edu). You will need your Saclink ID and password to access SacCT. Tutorials are available on the course site. Students are expected to complete assignments on SacCT according to assignment directions and turn in no later than the required date/time.
ONLINE AND OUT-OF-CLASS PARTICIPATION

There are 3 "Virtual" classes during the semester that will not be held on campus (check out Week-at-a-Glance for dates). In addition to the usual required readings; Virtual class #3 has graded online activities (turned in the following class). Personal Reflections will be turned in the following week in class.

DEFINITIONS OF ACADEMIC DISHONESTY. Also please refer to University Website: www.csus.edu/umanual/AcademicHonestyPolicyandProcedures.htm & also check Student Code of conduct in CSUS Nursing Student Handbook.

CHEATING. At CSUS, cheating is the act of obtaining or attempting to obtain credit for academic work through the use of any dishonest, deceptive, or fraudulent means. Cheating at CSUS includes but is not limited to:

1. Copying, in part or in whole, from another’s test or other evaluation instrument;
2. Using crib notes, "cheat sheets," or any other device, including electronic devices, in aid of writing the exam not permitted by the instructor;
3. Submitting work previously graded in another course unless doing so has been approved by the course instructor or by department policy.
4. Submitting work simultaneously presented in more than one course, unless doing so has been approved by the respective course instructors or by the department policies of the respective departments.
5. Altering or interfering with grading or grading instructions;
6. Sitting for an examination by a surrogate, or as a surrogate;
7. Any other act committed by a student in the course of his or her academic work that defrauds or misrepresents, including aiding or abetting in any of the actions defined above.

PLAGIARISM: Plagiarism is a form of cheating. At CSUS plagiarism is the use of distinctive ideas or works belonging to another person without providing adequate acknowledgement of that person’s contribution. Regardless of the means of appropriation, incorporation of another’s work into one’s own requires adequate identification and acknowledgement. Plagiarism is doubly unethical because it deprives the author of rightful credit and gives credit to someone who has not earned it. Acknowledgement is not necessary when the material used is common knowledge. Plagiarism at CSUS includes but is not limited to:

1. The act of incorporating into one’s own work the ideas, words, sentences, paragraphs, or parts thereof, or the specific substance of another’s work without giving appropriate credit thereby representing the product as entirely one's own. Examples include not only word-for-word copying, but also the "mosaic" (i.e., interspersing a few of one’s own words while, in essence, copying another’s work), the paraphrase (i.e., rewriting another’s work while still using the other’s fundamental idea or theory); fabrication (i.e., inventing or counterfeiting sources), ghost-writing (i.e., submitting another’s work as one’s own) and failure to include quotation marks on material that is otherwise acknowledged; and
2. Representing as one’s own another’s artistic or scholarly works such as musical compositions, computer programs, photographs, paintings, drawing, sculptures, or similar works.
WRITING STANDARD GUIDELINES AND RUBRIC
Most CSUS courses use the CSU Sacramento Advisory Standards for Writing. Please check out this helpful website (www.csus.edu/wac/rubric.stm) before, during and after you have written papers (following assignment requirements of course) in your courses. It will help you decide if you have written the level of paper you want to turn in. It is used along with any course grading rubrics to analyze your papers.

PAPER FORMATTING
Most professional courses use APA writing style for written research papers. It is similar to MLA but there are some key differences. All papers (except in-class papers) must be typed and in APA format - Publication Manual of the American Psychological Association 6th ed (APA) in the book store or online and check out website www.apastyle.org click on Style Tips. You can also check the CSUS library site (www.library.csus.edu) or Gerontology Program site (www.csus.edu/gero). If in-class papers are unreadable, they will not receive credit. A sample APA paper is available from Dr. O for review.

Key Components of APA format to be used when typing your papers include:
- Double-spaced; 12 font-Arial or Times New Roman font
- 1” margins on all sides
- Number all pages except Title Page -upper right-hand corner (please use proper APA formatting for Title Page)
- Indent 5 spaces-first line of every paragraph
- Sources must be referenced (example: Hoyer & Roodin, 2003) in the text of the paper, with a Reference list at the conclusion of the paper. All direct quotes must be referenced with source and page number.
- If the source is from the Internet, please refer to the APA Website: http://www.apastyle.org/elecref.html or refer to the APA Manual 6th edition for examples

CHHS SUPPORT FOR WRITING ASSIGNMENTS
The College of Health and Human Services Writing Center, located in Solano Hall 5000, is a program designed to assist students with all stages of writing from pre-writing through editing a text utilizing a peer-tutoring environment. The Center is staffed by graduate students from the English Department. Hours will be posted at the beginning of the Fall 2008 semester. If you have questions about the Center, please call (916) 278-7255.

USE OF TECHNOLOGY IN THE CLASSROOM
Students may use audio/video recording devices for the purpose of recording lectures ONLY with specific permission of each individual faculty member in the course. Faculty reserve the right to refuse permission to audio/video record. Students who are permitted to audio/video record lectures may only do so for personal use in study and preparation related to the class and must destroy any audio/videotapes when no longer needed for academic work, or at the end of this academic semester, whichever comes first. The audio/videotapes are recognized as sources, the use of which in any academic work is governed by rules of academic conduct delineated by the Program and University. Audio/videotapes of lectures are to be treated as (HIPPA protected) confidential material and may only be played in a secure private environment. Students who require audio/videtaping accommodations as a result of an educational plan set forth by the Services to Students with disabilities (SSWD) office must provide faculty with written documentation at the start of the semester per University policy.

Students may use computers in the classroom for note-taking purposes with the specific permission of each individual faculty member in the course. Faculty reserve the right to refuse permission to use computers in the classroom if such use becomes disruptive for other students or the faculty member.
OUTCOME EVALUATION/GRADING METHODS
The following assignments will be evaluated by established objectives and based on identified rubrics and will determine the student’s final grade. The individual assignment percentages are shown to the right of the assignments.

(9) Personal Reflections + Lessons Learned & points on any turned-in Class Worksheets  15%
Health Promotion Project  10%
Elder Project Fact Sheet (25%); Presentation (10%)  35%
Exams (2) (each 20%)  40%

University Standards for Course grades:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>A</td>
<td>93 - 100%</td>
</tr>
<tr>
<td>A-</td>
<td>90 - 92%</td>
</tr>
<tr>
<td>B+</td>
<td>87 - 89%</td>
</tr>
<tr>
<td>B</td>
<td>83 - 86%</td>
</tr>
<tr>
<td>B-</td>
<td>80 - 82%</td>
</tr>
<tr>
<td>C+</td>
<td>77 - 79%</td>
</tr>
<tr>
<td>C</td>
<td>73 - 76%</td>
</tr>
<tr>
<td>C-</td>
<td>70 - 72%</td>
</tr>
<tr>
<td>D+</td>
<td>67 - 69%</td>
</tr>
<tr>
<td>D</td>
<td>63 - 66%</td>
</tr>
<tr>
<td>D-</td>
<td>60 - 62%</td>
</tr>
<tr>
<td>F</td>
<td>59% and below</td>
</tr>
</tbody>
</table>

** 73% or better is required for passing in all Nursing Major courses. An average of 73% or higher on the two Exams is also required for passing.

** Assignments are due and must be turned in at the beginning of class or before (to my mailbox - have front desk secretary date/time stamp it and put it in my box. 5 points will be taken off for each day papers are late (including weekends). The first 5 points will be taken off after class has started.

** All papers except weekly in class Personal Reflections must be typed and in APA format. If Personal Reflections are unreadable you will not receive credit.

** All assignments are due according to Week-at-a-Glance dates/times (includes SacCT ones also).

** Points for In-class, weekly papers (Personal Reflections) will only be given if turned in during the class.
California State University Sacramento  
*Nursing 17*  
Extra Credit Description Summary Criteria

Please type your Event Description Summary *using the criteria and format below*. It should long enough to clearly answer the required criteria (below) but no more than 3 pages. It should be written in correct paper format - with an introduction, body, and a conclusion. Please use APA format (title page and reference page if you cite any references – I recommend you do to more clearly tie to all you are learning and the more you practice, and the more you do this, the easier it gets). Points vary based on completeness of description and time spent participating in the event (1 point/hour of participation possible). These will be added to your Elder Project score at the end of the semester. **Attach proof of participation.** No more than 10 points may be credited. You must be passing the course to have Extra Credit points added into your final grade. Your summaries must be turned in no later than the week before finals to receive credit.

Name: ________________________________       Date: ____________  
Name/Location of Elder Experience/Event/Conference _____________________________  
How much did the event cost? _________  
How long did you attend? ___________  

*Be sure to connect lessons learned from this experience to what you are learning in this aging class.*

1. What motivated you to participate this event/conference:  

2. Describe what you learned:  

3. How will you apply this information to your *personal life*?  
   a. How do you think differently after participating in this event?  
   b. What will you do differently in your life because of participating in this event?  

4. How does the information presented apply to your *nursing practice*?  
   a. How do you think differently after participating in this event?  
   b. What will you do differently in your nursing practice because of participating in this event?
COURSE ASSIGNMENTS
Personal Reflections Worksheet Guidelines

**Purpose:**
1. To facilitate HOLISTIC analysis of acquired knowledge and beliefs regarding aging throughout the semester.
2. To provide the opportunity for learners to practice developing interventions and outcomes related to learned content that they can implement and evaluate in clinical practice.
3. To provide a vehicle for the student and faculty to track changes in knowledge and attitudes toward aging and the aging population.

**Process:**
This is a chance for you to briefly demonstrate your holistic understanding of class content - readings, class discussions, class assignments, etc, from your perspective. The Reflections sheets are in your Workbook for the classes indicated on the Assignments at a Glance. Your entry must include your reflections on concepts – (read and discussed in class), Surprises/Myths busted, Overall conclusions on the topic, at least two BPNI, and two measurable Outcomes. Completing these will also help you to organize all the information you are learning and help you study for exams!!

**Grading:**
Each Personal Reflection worksheet is worth 3 points if turned in (completed) at the asked for time during class. Full credit will be given if turned in during the class. If not turned in class, I am interested and happy to read them. You will receive CR, but no points. The total number of possible points is equal to the total number of Personal Reflections turned in for the semester. These worksheets, along with your Lessons Learned Summary/Speed Networking Exercise (see following) are worth 15% of your grade.

*(In Class Personal Reflection & Holistic Intervention Assignment)*
Evidenced Based Best Practices Nursing Interventions (BPNI)

**Purpose:**
To assist learners in applying theory/learned facts about the aging process to life and nursing practice.

**Process:**
Best Practice Nursing Interventions (BPNI) are actions you do “with, to, OR for” patients and families in your care, based on your knowledge and experience. These actions may also be implemented for your self, friends, and family. Creating and applying these BPNIs demonstrate your understanding of the concepts you are learning about. BPNIs are best written as action nurse-intervention statements. They describe what you will do. Begin the intervention statement with an action word, a verb. Some examples are: Rehearse, practice, apply, execute, talk about, implement, offer, supply, present, provide, teach, explain, instruct, coach etc. Outcomes are also action statements and describe what you expect will happen to the person because of your intervention. Think of these together! Evaluations are what happens because the intervention – was the outcome reached or not. I recommend you try these out on your patients/families when you are in clinical – let me know how they all work (we'll talk about them briefly in class).
Some examples of BPNIs, Outcomes, and Evaluations are:

**Patients/families**

1.) **BPNI:** Discuss patient’s expectations for the surgery.  
   **Outcome:** Patient talks about expectations and fears regarding surgery.  
   **Evaluation:** Talking with Mr. J. about his expectations & fears was easier than I thought! What I found out was that he had talked with several of his neighbors and had incorrect information about what the surgery entailed. I checked with my instructor and my charge nurse and got some pamphlets that gave him more information about his surgery. We discussed them & he said I had really helped him! 😊

**Self**

1.) **BPNI:** Identify ways to improve my chances for longevity.  
   **Outcome:** Student lists 3 three things he will do during to reduce stress throughout semester.  
   **Evaluation:** One of the things on my list was to start a walking program 3 times per week. It has only been two weeks but I already feel less stressed and the days I don’t walk I feel more stress! I will continue to do this and see how I am at the end of the semester and let you know! 😊 The other two are get more sleep and hug my children more. The hugging has been easy (and great!) but I’m still working on getting more sleep.

**Friends/family**

1.) **BPNI** Assess Grandpa's feelings about challenges that impact elders' driving.  
   **Outcome:** Grandpa discusses his thoughts and is open to gaining more information by reading the AARP website on driving.  
   **Evaluation:** At first Grandpa didn’t want to talk about not driving – he said “I’m a good driver – though some old people aren’t. I plan on driving until I die!!” I listened to what he said and his tone and I realized he had given this a lot of thought – he was just afraid of not being independent. He did agree to look at the website so I’ll check with him next week and see what he learned – I’ll let you know!

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**Aging & Longevity Lessons Learned Summary & “Speed Networking” ~ Say it in 90 Seconds:**

**Purpose:**

1.) To afford learners the opportunity to reflect on and analyze their learning from the beginning to the end of this course.

2.) To practice communicating your key thoughts (in 90 seconds) – so others will be intrigued and want to know more!!

**Process:**

- Keep your Personal Reflections and any paper-pencil exercises so you’ll be able to review them (for tests, this summary, and your Speed Networking Exercise) there is a lot of information on them that will help you studying for ATIs and Boards too!!

- At the end of the semester, review and analyze your Reflections & answers to exercises. This will help in studying for the exam too! After your analysis, complete the following "Aging & Longevity Lessons Learned Template" summarizing what you have learned during the semester from readings and class experiences.

- Turn in your Lessons Learned Template and Grading Rubric after you present in class (see Week at a Glance for date). This Summary is worth 30 points. These points will be factored into your Personal Reflections points with the total being worth 15% of your grade. Points will be given if turned in at the specified time, all areas (see grading rubric) are addressed, and you participate in the Speed Networking exercise in class. Your Summary will be returned during the last class on the day of the Wisdom Panel.
Aging & Longevity Lessons Learned Summary &
“Speed Networking” ~ Say it in 90 Seconds:

The reading assignment that had the greatest impact on me and why .....  

Recurring themes I noticed in my learning

How I am doing on My Health Promotion Goal(s):
How my perception/attitude towards aging expanded

How I will use information learned in my life and to guide my Practice
Lessons Learned Summary Grading Rubric

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discusses the reading assignment had the greatest impact on you &amp; why</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Describes any recurring themes noticed in your learning</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Describes Progress on Health Promotion Contract</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Describes how your perception/attitude towards aging has expanded</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Explains how you will use information gained in your life &amp; nursing practice</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Actively participated in Speed Networking Exercise</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

Health Promotion Plan/Contract Assignment

(55 points - 10% of total grade)

**Sept 20**
1. Go to the National Council on aging website ([www.ncoa.org](http://www.ncoa.org)) ➔
2. Click on Center for Healthy Aging in the center of the home page ➔
3. Click on tab “About Evidence Based Programs” – read through both sub tabs ➔ Click on [Chronic Disease](http://www.ncoa.org) on left of page – “read and click on Get More Facts”; read about [Community Programs](http://www.ncoa.org) – find the closest one to you and explore the online options ➔
4. Click on [Community Programs](http://www.ncoa.org) - under [Chronic Disease](http://www.ncoa.org) – read through – checking links ➔
5. Click on [Tools and Resources](http://www.ncoa.org) – under [Chronic Disease](http://www.ncoa.org) - read through and click on and read [Better Choices, Better Health](http://www.ncoa.org) ➔
6. Click and view “Health for a Lifetime” video

Choose one of the other Healthy Aging Programs (Falls, Physical Activity or Behavioral Health) – and go through the site to learn about what is being done in this area.

Write two paragraphs - one for each of the following:
1. What you learned about Evidence-based Health Promotion (general) &
2. the Aging Program you chose above (specific)
   At the end
3. List 2 ways you will use what you learned with your patients/families.

Create and complete your own [Personal Health Promotion Contract](http://www.ncoa.org) (p. 18 in Workbook) & make an [Activity Calendar](http://www.ncoa.org) (through the end of this semester) to show how you plan to meet your Health Goal(s).

**Nov 15**
Evaluate your Health Promotion Plan in your Lessons Learned Assignment (graded there)

Health Promotion Contract Assignment Grading Rubric

| Clearly discusses what you learned about Health Promotion (in general) | 15 |
| Clearly discusses what you learned from the specific Health Promotion Program you reviewed | 15 |
| Lists at least two (2) ways you will use what you learned            | 6  |
| Thoroughly completes own Health Promotion Contract from Workbook     | 15 |
| Identifies dates/times etc. of Health Promotion activities on Personal Calendar | 4  |
| Total                                                                  | /55|
## Health Contract

**My Health Goal is** (include date range):

________________________________________________________________________________________

**The Projected Outcome is**:

________________________________________________________________________________________

**Motivators that help me reach my Health Goal are**:

1.  
2.  
3.  
4.  

**Barriers that may interfere with reaching my health goals & solutions are**:

1.  
2.  
3.  
4.  

**For social or emotional support in reaching my health goals & objectives I will**:

1.  
2.  
3.  
4.  

---

**My Plan of Action for reaching my goals**:

1.  
2.  
3.  

4. **Evaluation Date:** ___________

(Attach calendar for planning & implementation viewing)

<table>
<thead>
<tr>
<th>My signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Support Person’s</th>
<th>Date</th>
</tr>
</thead>
</table>
Elder Project
Evidenced-Based Fact Sheet for Elders & Their Families
& Group Presentation

This Elder Project Experience combines individual and group evidence-based research, communication, and collaboration, and data analysis. The project CONNECTS nursing practice in two SECOND SEMESTER COURSES (Nurs 117 & Nurs 123). The Project culminates in producing an evidenced-based Fact Sheet on a relevant aging topic research and presenting it to your classmates.

Purpose:
1. To facilitate students’ in depth study of adaptation and aging (both courses).
2. To provide the opportunity for students to combine assessment, interview, and literature data when drawing conclusions and planning interventions regarding a selected topic pertinent for elders and their families (both courses).
3. To provide students with information for clinical assessment of ill elders (Nurs 123).
4. To afford students opportunities to explore available community based services related to their chosen older adult topic (Nurs 117).
5. To direct students’ efforts at collaborating with other students to produce a well-written, professional, evidence-based Fact Sheet and presentation. (Nurs 117).
6. To afford students opportunities to contribute to an extensive web-based list of available community older adult agencies (Nurs 117).

Format:
1. APA (6th ed) format (Get APA Book in bookstore and check out library website on APA).
2. Samples are available from Dr. O.
3. Use Publisher or Word (or Mac correlate) to develop creative Fact Sheet template.

Process:
1. During the week after the first class, choose an aging topic you are interested in researching in-depth. It’s even better if you have a personal “tie” to or passion about the topic, so you REALLY want and NEED to know more! Your topic must relate to older adults (70+) – of course, the older the better!
2. Then choose four (4) other student partners who are also interested in this topic (total of five/group). Smaller or larger Groups will only be considered after groups of five are complete. You can use SacCT to let others know your topic and if you need more group members. You will work together to complete the Fact Sheet.
3. You will sign up with your group members during the second Nurs 117 class.
4. After your group is formed, divide up the research work evenly for each group member. Each group member is responsible for researching a minimum of 4 evidence-based research articles (from professional journals) on your topic (total of at least 20/fact sheet), visiting one (1) community agency, and finding one (1) valid website that you would refer clients/family members to (a total of five (5) agencies and five (5) separate websites for each Fact Sheet). Be sure to thoroughly investigate the agency and website before recommending it!! You may use information from books or validated websites but those sources are in addition to the primary EB research articles.
5. You may want to email or copy each of the articles to your group members so they will have them. These articles form the basis for your Fact Sheet and presentation.
6. Check Assignments at a Glance for the due date of your Fact. Organize your Fact Sheet using the identified paper components (and be sure to check the Grading Rubric). ☺

Evidence-Based Fact Sheet Components

1. Use all 20 of the research journal articles read by your group members.
   1. The Fact Sheet should be no more than 7-8 pages (back-to-back makes it 3-4 pages, not counting your reference page).
2. It should be written to inform the consumer audience (use regular non nursing/medical language 😊) but cite all your sources!!

c. I’ll bring some samples so you can get an idea of what these look like – or you can come to my office to see some samples. Just remember ~~ easy to read and understand are the keys!! You want to use this in your nursing practice with patients and families, long after your finish this course!!

d. After all your research & study, you are now an expert on this topic, so create a Fact Sheet that highlights the MOST IMPORTANT concepts ~ prioritize – most → least important. Using bullets is often an easy way to do this but if you write short paragraphs then be sure they are easy to follow.

2. Your Fact Sheet needs to be evidenced-based (with citations for all of the following areas (except f, h, & i). Set up section e (below) as a table so readers can see exactly what they can do 😊

a. Introduction ¶ about the topic and the group addressed

b. Definition of Concern/Issue ~ Generally accepted definitions surrounding the topic/issue

c. Background facts ~ statistics, risk factors, costs, and any common pertinent facts you identify.

d. Ethical/Legal/regulatory issues ~ ethical issues, state/federal laws & licensing parameters etc, elders and/or families should consider surrounding this topic.

e. Minimum of at least four (4) Primary Patient/Family Holistic Needs & corresponding Care Interventions (columns match needs with the best Care Interventions for the identified concern/need) ~ Make this Table so this section is easy to understand. An example is:

<table>
<thead>
<tr>
<th>Patient/Family Holistic Needs/Concerns</th>
<th>Care Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2. for each need</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3. **</td>
</tr>
<tr>
<td>Social</td>
<td></td>
</tr>
<tr>
<td>1. for each need</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3. **</td>
</tr>
<tr>
<td>Etc</td>
<td></td>
</tr>
</tbody>
</table>

First: Identify & Prioritize the eight (8) most common patient/client & family needs or concerns – think holistically! (you must include & address at least four (4) of the eight (8) holistic parameters – give a brief statement at the beginning of the Table that gives the rationale why you are prioritizing them in this order). Then: Describe the best interventions noting who is should do it (patient, family, HCTM – include the levels/types of personnel needed, types of environment (home, assisted living, acute/LTC, etc.) that are needed to provide/address the care needs/concerns so the readers of your Fact Sheet know what to do and where to go!!

f. Community Agency/Service Resources ~ Include for all necessary contact information and a 1 - 2 sentence description of services provided for all 5 of the Community Agencies. List the 5 additional websites in the Fact Sheet after the agencies.

g. Conclude with a Fact Sheet Summary ¶ to highlight key findings from the entire Fact Sheet.

h. Include all your references at the end your Fact Sheet (can be smaller print).

i. Complete and email one Group Community Agency Template (available in SacCT) with each group member’s agencies and separate websites that are valid & available for the population addressed in your paper to Dr. O (at osbornec@csus.edu) by class time on the day your Fact Sheet is Due.

3. Turn in two (2) Fact Sheets - one with the Grading Rubric (the group gets it back), and another for me to Give to the School of Nursing.
4. I recommend that each student keep a copy of the final Fact Sheet – both electronic and hard copy for future use. Don't forget – the final product should also be referenced on your Resume!! 😊

Please remember Group Process concepts and **collaborate, negotiate, and agree** on all aspects of your Fact Sheet. Decide ahead of time on the final date you will have it all together so no one ends up having to do the bulk of the work putting the final product together at the last minute – this will definitely **decrease** STRESS! You might want to check out Bruce Tuckman’s (1984) Group Process work at [www.cedanet.com/metagroup_process.htm](http://www.cedanet.com/metagroup_process.htm) for help in managing groups!! 😊

If you have issues please see Dr. O **early** in the process!!

**Overall Hints for Elder Project Success**

If you’re having trouble, talk with Dr. O. I have samples of papers from last semester so come by my office (BNC 1020) and look at them!! Models always are helpful!!

**Plan** dates to work with/talk with your group members AHEAD OF TIME so you will have time to research, write, compile, review and edit your work!! ☺

**Start EARLY!!!** This assignment is all inclusive and takes time up front to plan so everyone’s schedules can be taken into account. DON’T think you can do it all the week before it’s due! – You’ll make yourself Stressed and not get all you can out of the experience!!

**Use** correct grammar, punctuation, spelling, writing clarity & conciseness, research paper development (introduction, body, and conclusion should be used in the last assignment).

**Refer to** composition/writing guidelines your Syllabus for help in evaluating your writing and the APA book and [www.csus.edu/gero](http://www.csus.edu/gero) (look under current students and Paper Help: APA, for format).

**Have a friend proof-read your paper** – they will see things you won’t!

**Cite all** references (20 research articles, 5 websites, and any personal communications) every time you use them. Your Fact Sheet must reflect all the references!

**Check** Decision Chart – in Syllabus Appendix. Article currency (last 5-10 years) must be considered related to your topic. **Remember** they must be evidence-based research articles and valid websites. If you use classic research (very old) or articles that are older than 10 years, then somewhere – like your introduction to that section - state this or why you’re using it. Cite and reference all web information needed to allow someone to access it (check APA formatting for this also).

**Check** the Grading Sheet to be sure you have included all you need to, to get a great grade and attach it to one of your Fact Sheets!!
**NURS 117 Elder Fact Sheet Evaluation Criteria Rubric**
180 points (25%)

<table>
<thead>
<tr>
<th>Fact Sheet (all areas require variety of citations)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of topic/group addressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defines topic/issue (based on your research)</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Identifies background facts (stats, risks, costs etc)</td>
<td>13</td>
<td>15</td>
<td>18</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Highlights Legal/regulatory issues (ethical issues, state/federal laws &amp; licensing parameters etc.)</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Prioritizes Primary Patient/Family Holistic Needs Care Intervention Table - (8 most common patient/client &amp; family needs or concerns (must address at least 4 of the 8 holistic parameters)</td>
<td>13</td>
<td>16</td>
<td>18</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Defines/explains Care Interventions &amp; includes levels/types of personnel needed, types of environment – home, assisted living, acute/LTC, etc. (Combined Table)</td>
<td>13</td>
<td>16</td>
<td>18</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Includes at least 5 Community Service/Agency Resources &amp; (5) websites</td>
<td>8</td>
<td>9</td>
<td>11</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Concludes with Fact Sheet Conclusion/Summary</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Assignment Requirements**

<table>
<thead>
<tr>
<th>Correct grammar, punctuation, writing clarity, spelling; appropriate language level</th>
<th>13</th>
<th>16</th>
<th>18</th>
<th>20</th>
<th>25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct APA format (citations, reference list)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Cites all 20 references in Fact Sheet; all citations are referenced</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Presents in a professional manner; Attaches Grading Rubric</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Follows all Project Directions; Turns in extra Fact Sheet for Resource Center</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td><strong>Group Community Agency Info Sheet All components Completed &amp; Emailed before class on due date</strong></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

**Comments:**

Total: 180
ELDER PROJECT Fact Sheet Round Table Presentation

Professional Nursing Conferences often have Round Table Presentations. So, for this assignment you will get to experience this format so you are prepared when you attend a professional conference!

During the November 29th class you and your Fact Sheet group will present your Fact Sheet to other class members in a Round Table Format. This means you will have a set amount of time to share information with your classmates in small groups. Before class be sure to review your Fact Sheet as a group so you are prepared to talk about the following: 1.) key points - highlights from your Fact Sheets (teach your classmates), 2.) thoughts on ways to make your group process even better, and 3.) some examples of how you will use your Fact Sheet in your nursing practice.

You will participate in three (3) 20-minute Round Tables where each of the 4 participating groups will take turns discussing their group’s Fact Sheet (5 minutes/group). Then you will switch groups and repeat the process (X2). All group members are expected to participate in the Round Tables. Faculty and visiting students will circulate among Round Tables to evaluate the above required presentation elements. Credit will be given based on these elements. This experience is CR or NC and is worth 10% of your grade. Credit = 50 points; NC = 0 points.

Enjoy the Process!!
N117 COURSE EVALUATION  
Semester F: Sp____

NOTE: You are evaluating the course, not the instructor. PLEASE BRING TO FINAL

INSTRUCTIONS:
Please rate the following items for effectiveness in assisting your learning and achieving the course objectives. Indicate your by scoring the items, next to each number, on a scale of 1-5 as defined below:

1 -- Very ineffective  
2 -- Minimally ineffective  
3 -- Moderately effective  
4 -- Very effective  
5 -- Outstanding, highly effective

Please add any comments that might help me to know how these assisted your learning for Life and Nursing.

READINGS:

___ 1. Course Text  
Comments:

___ 2. Course Syllabus/WorkBook  
Comments:

___ 3. Recommended Texts (Any you may have read)  
Comments:

COURSE ASSIGNMENTS:

___ 4. Personal Reflections  
Comments:

___ 5. Fact Sheet  
Comments:

___ 6. Elder Project Assessment Analysis Summary  
Comments:

Please describe the strengths of the course:

What suggestions do you have to improve the course?

Thank you for your input!!
CLASS DISCUSSION MATERIALS
Overview

Beginning the Journey
Personal Reflections ~ #1
Describe some examples of *ageism* have you seen in life/practice. List two things will you do to avoid discrimination against elders.

Conclusions

Surprise!!
Myths Busted or ...
I didn't know That!!
When do you think someone is old? ........Why then?

What do you do to show your respect toward elders? Are these behaviors different from how you treat others? Why/Why not?

List the transitions you expect to make/have made during your life
Elder: ___________________
Due 2nd Class

When do you think someone is old? ......... Why then?

Should others respect you because of your age? What things do people do that show you they respect you?

List the transitions you expect to make/have made during your life

Conclusions: How did your answers compare with your elder’s?
STANDARDS OF GERONTOLOGICAL NURSING PRACTICE
ANA, 1987

I. All gerontological nursing services are planned, organized and directed by a nurse executive who is Baccalaureate or Master’s prepared and experienced in gerontological nursing and administration of services for older adults.

II. The nurse participates in the generation and testing of theory and uses theoretical concepts to guide the effective practice of gerontological nursing.

III. The older person’s health status is regularly assessed in a comprehensive, accurate, and systematic manner. Information is shared with appropriate members of interdisciplinary team, including the older person and the family.

IV. The nurse uses health assessment data to determine nursing diagnosis.

V. The nurse develops the plan of care in conjunction with the older person and appropriate others. Mutual goals, priorities, approaches, and interventions address the therapeutic, preventative, restorative and rehabilitative needs of the older person.

VI. The nurse intervenes to provide care to restore the older person’s functional capabilities and to prevent complication and excess disability.

VII. The nurse continually evaluates the client’s and family’s responses to interventions in order to determine progress toward goal attainment and to revise the data base, nursing diagnosis, and plan of care.

VIII. The nurse collaborates with other members of the health care team, which meets regularly to evaluate the care plan and adjust it to meet the client’s and family’s changing needs.

IX. The nurse participates in research, and uses and disseminates research findings.

X. The nurse uses the ANA code as a guide for ethical decision making in practice.

XI. The nurse assumes responsibility for professional development and contributes to the professional growth for interdisciplinary team members.
AACN Baccalaureate Competencies & Curricular Guidelines for Geriatric Nursing Care (2000)

1. Recognize one’s own and others’ attitudes, values, and expectations about aging and their impact on care of older adults and their families.
2. Adopt the concept of individualized care as the standard of practice with older adults.
3. Communicate effectively, respectfully, and compassionately with older adults and their families.
4. Recognize that sensation and perception in older adults are mediated by functional, physical, cognitive, psychological, and social changes common in old age.
5. Incorporate into daily practice valid and reliable tools to assess the functional, physical, cognitive, psychological, social, and spiritual status of older adults.
6. Assess older adults’ living environment with special awareness of the functional, physical, cognitive, psychological, and social changes common in old age.
7. Analyze the effectiveness of community resources in assisting older adults and their families to retain personal goals, maximize function, maintain independence, and live in the least restrictive environment.
8. Assess family knowledge of skills necessary to deliver care to older adults.
9. Adapt technical skills to meet the functional, physical, cognitive, psychological, social, and endurance capacities of older adults.
10. Prevent or reduce common risk factors that contribute to functional decline, impaired quality of life, and excess disability in older adults.
11. Establish and follow standards of care to recognize and report elder mistreatment.
12. Apply evidence-based standards to screen, immunize, and promote healthy activities in older adults.
13. Recognize and manage geriatric syndromes common to older adults.
14. Recognize the complex interaction of acute and chronic co-morbid conditions common to older adults.
15. Use technology to enhance older adults’ function, independence, and safety.
16. Facilitate communication as older adults transition across and between home, hospital, and nursing home, with a particular focus on the use of technology.
17. Assist older adults, families, and caregivers to understand and balance “everyday” autonomy and safety decisions.
18. Apply ethical and legal principles to the complex issues that arise in care of older adults.
19. Appreciate the influence of attitudes, roles, language, culture, race, religion, gender, and lifestyle on how families and assistive personnel provide long-term care to older adults.
20. Evaluate differing international models of geriatric care.
21. Analyze the impact of an aging society on the health care system.
22. Evaluate the influence of payer systems on access, availability, and affordability of health care for older adults.
23. Contrast the opportunities and constraints of supportive living arrangements on the function and independence of older adults and on their families.
24. Recognize the benefits of interdisciplinary team participation in care of older adults.
25. Evaluate the utility of complementary and integrative health care practices on health promotion and symptom management for older adults.
26. Facilitate older adults’ active participation in all aspects of their own health care.
27. Involve, educate, and when appropriate, supervise family, friends, and assistive personnel in implementing best practices for older adults.
28. Ensure quality of care commensurate with older adults’ vulnerability and frequency and intensity of care needs.
29. Promote the desirability of quality end-of-life care for older adults, including pain and symptom management, as essential, desirable, and integral components of nursing practice.
International/National Agendas for Health Care Delivery
for current Healthy People 2010

Historically:
Healthy People 2010: National Health Promotion and Disease Prevention Objectives Specific goals to be achieved by the year 2010:
1.) Increase the span of healthy life for Americans
2.) Reduce health disparities among Americans.
3.) Achieve access to preventative services for all Americans.

Health Status
Reduce:
- Suicide among white males
- Death by motor vehicle accidents (age 70+)
- Death from falls and fall-related injury particularly in ages 85+
- Death from residential fire
- Number of persons who have difficulty performing two or more personal care activities so as to enhance independence
- Significant visual impairment
- Epidemic related pneumonia and influenza deaths
- Pneumonia-related days of restricted activity

Increase:
- Years of healthy life to at least 65 among Blacks and Hispanics

Risk Reduction
Increase:
- Percentage of individuals who regularly participate in light to moderate activity for at least 30 minutes/day.
- Immunization levels for pneumococcal influenza among the chronically ill older population.
- The percentage of older persons who receive, within appropriate intervals, screening and immunization services at least one counseling service.

Services and Protection
Increase:
- Percentage of recipients of home food service.
- Percentage of older adults who have the opportunity to participate yearly in at least one organized health promotion program through senior centers, life care facility, or community-based setting serving the older adult.
- Percentage of states in the United States that have design standards for signs, signals, marking, lighting, and other roadway environmental improvements to enhance visual stimuli and protect the safety of older drivers and pedestrians
- The proportion of primary care providers who routinely review with their patients prescribe and over-the-counter medications each time a new medication is prescribed
- The usage of the oral care system
- The proportion who receive clinical breast examinations and mammograms
- The number of women age 70+ who receive Pap tests

Extend:
- Long-term institutional facilities, the requirement of oral exams, and service provided to new admissions no later than 90 days after admission.
WHAT DO YOU SEE NURSE?

What do you see, nurse, what do you see?
Are you thinking when you are looking at me,
A crabby old woman, not very wise
Uncertain of habit, with faraway eyes.
Who dribbles her food and makes no reply,
When you say in a loud voice, "I do wish you'd try";
Who seems but to notice the things that you do,
And forever is losing a stocking or shoe.
Who uninteresting or not, lets you do as you will
With bathing and feeding the long day to fill.
Is that what you're thinking, is that what you see?
The open your eyes nurse, you're not looking at me.
I'll tell you who I am as I sit here so till,
As I rise to your bidding, as I eat at your will.

I'm a small child of ten with a father and mother,
Brothers and sisters who love one another
A young girl of sixteen with wings on her feet,
Dreaming that soon now a lover she'll meet;
A bride soon at twenty, my heart gives a leap,
Remembering the vows I promised to keep.
At twenty-five now I have young of my own
Who need me to build a secure happy home.
A woman of thirty my young now grow fast,
Bound to each other with ties that should last.
At forty my young sons have grown and are gone.
But my man's beside me to see I don't mourn.

At fifty once more babies at my knee,
Again we know children, my loved one and me.
Dark days are upon me, my husband is dead.
I look at the future--I shudder with dread.
For my young are all rearing young of their own,
And I think of the years and the love I've known.

I'm and old woman now, and nature is cruel;
'Tis her jest to make old people look like a fool.
The body ii crumbles, race and vigor depart,
There is now a stone where I once had a heart.
But inside this old carcass a young girl still dwells,
And now and again my battered heart swells,
I remember the joys, I remember the pain,
And I'm loving and living life over again.
I think of the years all too few, gone too fast;
And accept the stark fact that nothing can last.

So open your eyes nurse--open and see,
Not a crabby old woman, LOOK CLOSER AT ME !!

Note: This poem (circa 1970) came from a nurse who works in a geriatric ward at Ashludie Hospital near Yorkshire, England. An old lady died in the ward, she explained, and another nurse going through her possessions found a poem the lady had written. The verses so impressed the staff that copies were duplicated and distributed to every nurse in the hospital.
Course Frameworks:

Holistic Parameters

Physical – promotes participation activities despite limitations
Psychological – awareness and acceptance of one’s feelings; encourages mental activity; encourages achievement of interests
Social – emphasizes healthy relationships – some individual, some group
Cultural – uses traditions for strength and coping abilities
Spiritual – encourages quest for meaning & purpose in life
Gender – understands role gender plays in individual response to the world
Environmental – understands how surroundings impact responses and relationships
Generational – acknowledges & draws on age cohort differences

Modified by Osborne, C. (2008) from Halbert Dunn (1950s)

Miller’s Functional Consequences Theory

Age Related Changes
Risk Factors
Negative Functional Consequences

Nursing Assessment:
Interview Questions
Observations
Interventions

Positive Functional Consequences
Evidence-based Health Promotion

**Imperative**: Only 30% of physical aging is attributable to genetic heritage!!!

While the majority of older adults have one or more chronic conditions, illness and disability are not inevitable parts of the aging process, and can be prevented or delayed. There is overwhelming evidence that older persons do indeed benefit from health promotion interventions. Key health risk behaviors that can be targeted through health promotion include: physical inactivity, poor diet, smoking, and substance abuse.

The Center for Healthy Aging provides a number of resources for those interested in healthy aging programs that deal with general health promotion issues. [www.healthyagingprograms.org](http://www.healthyagingprograms.org)

**Health promotion and disease prevention works for older adults**

Never too late to start – always too early to stop!!

Longer life

Reduced disability

Later onset

Fewer years of disability prior to death

Fewer falls

Improved mental health

Positive effect on depressive symptoms, social connectedness

Lower health care costs

[www.healthyagingprograms.org/content.asp?sectionid=85&ElementID=304](http://www.healthyagingprograms.org/content.asp?sectionid=85&ElementID=304)

**One Day at a Time**

Ida Scott Taylor (Guest Panelist Sp 95)

One day at a time

this is enough.

Do not look back and grieve over

the past,

for it is gone;

and do not be troubled about the future,

for it has not yet come.

Live in the present,

and make it so beautiful that it will be worth remembering.
Experiencing Older Adults: Myths & Resiliency
Personal Reflections ~ #2
What is healthful living?
How will you promote healthful living as you care for ill patients?

Conclusions

Surprise!!
Myths Busted or ...
I didn’t know That!!

BPNI

Outcome
Do Along with PPT in Class

Answer True or False in the margin as soon as you read the statement.

1. Eight out of ten older Americans have one or more chronic disease.
2. Physical strength declines with age.
3. The majority of older adults retain basic health at least though their 60s.
4. All five senses decline with age.
5. Constipation increases in more people when they get older.
6. Bladder capacity decreases with age, which leads to frequent urination.
7. Most older adults consider their health to be good.
8. Memory loss is a normal part of aging.
9. The majority of old people (65+) have Alzheimer’s disease.
10. It is very difficult for older adults to learn new things.
11. Old people are demanding, fault finding, and crankier than younger people.
12. Clinical depression occurs more frequently in older than younger people.
13. Old people are set in their ways and unable to change.
15. Abuse of older adults is not a significant problem in the U.S.
16. Older adults (65+) are more fearful of crime than are persons under 65. In general, most old people are alike.
17. The modern family no longer takes care of its elders.
18. Abuse occurs in all cultural groups.
19. Retirement is often detrimental to health – ie people frequently seem to become ill or die soon after retirement.
20. Older people tend to become more religious as they grow older.
21. Older adults are less anxious about death than are younger and middle-aged adults.
22. The majority of older adults are bored.
23. Older females exhibit better health are practices than older males.
24. All women develop osteoporosis as they age.
25. Most old people lose interest in and capacity for sexual relations.
26. Personality changes with age.
27. Older people do not adapt as well as younger age groups when they relocate to a new environment.
28. Most older drivers are quite capable of safely operating a motor vehicle.
29. Most older adults are living in nursing homes.
30. Older people perspire less, so they are more likely to suffer from hyperthermia.
31. Research has shown that old age truly begins at 65.
32. Grandparents today take less responsibility for rearing grandchildren than ever before.
33. Living below or near the poverty level is no longer a significant problem for most older Americans.
34. Older workers cannot work as effectively as younger workers.
35. All older people recognize they are old.

Common Transitions in the Second Half of Life
Children leaving home
Changing body
Retirement
Widowhood
Serious illness/disability
Changing where you live

Transition Goals in the Second Half of Life

**Mid-forties-mid-sixties**
Reevaluate, explore and transition

**Mid fifties-mid-seventies**
Liberation, experimentation, & innovation

**Late sixties - nineties**
Recapitulation, resolution & contribution

**Late seventies – end of life**
Encore: Continuation, reflection & celebration
Elder Survivor Skills: Tapping into Resiliency to Enhance Longevity
Cheryl Osborne EdD, MSN, RN
Director of Gerontology &
Professor of Nursing & Gerontology
California State University, Sacramento

Objectives
- Identify common life changes
- Define resiliency & why it is important to longevity
- Assess own resiliency own levels
- Recognize examples of resiliency characteristics
- Identify ways to protect and enhance own resiliency
- Identify ways to help families, communities, & organizations protect & enhance resiliency
- Apply resiliency characteristics to own life changes

Resiliency and Aging

What is Resiliency?
Resiliency is about when people encounter disruptive and stressful challenges, individuals use or learn coping skills, thus becoming more effective in dealing with life events.

Definitions:
The process of coping with disruptive, stressful, or challenging life events in a way that provides the individual with additional protective coping skills.” (Richardson, Neiger, Jensen & Krumpfer, 1990)

“The capacity to bounce back, withstand hardship, and to repair yourself.” (Wolin & Wolin, 1993)


Why is it Important?
Promoting resiliency during aging is relevant because it can contribute to wellness, productivity, and growth. Without this support, many elders may be at risk and, as a result, more likely be susceptible to disease and decline.

How Does Resiliency Orientation Work?
Resilient aging emphasizes potentials and possibilities rather than shortcomings and limitations. It focuses on
adaptability, strengths,
development of solutions
to problems, and a “can do” attitude.

Resiliency Characteristics (Warschaw & Barlow, 1995)
Adaptability
* Modifies habits to work with others.
* Cooperative and often champion the rights of others.

Resourcefulness
* Knows where resources are, when to turn to them & how to find help.
* Has more than one friend & career interest.

Unambiguous Commitment to Life
* Doesn’t waste time agonizing over whether life is worth living - They Know It Is!

Resiliency Characteristics

Self Confidence
* Believes they can understand the world around them.
* Sets realistic goals to achieve in that world and develops required skills to do it.
* Has needed strength to strive for aspirations while retaining integrity.
* Has a positive attitude - problems are challenges for growth & learning rather than threats or burdens.
Willingness to Risk
* Doesn’t always “play it safe”, but takes intelligent risks that are grounded in real possibilities for success.

Acceptance of Personal Responsibility
• Has strong spiritual/religious or philosophical beliefs in self-determination.
• Is unwilling to claim victim status.
• Turns mistakes into positive learning experiences.

Perspective
* Knows what is important and what isn’t.
* Gives energy to serious core issues & activities and dismisses or enjoys the inconsequential ones.
* Has a good sense of humor & often uses it to reduce stress or pain.

Openness to New Ideas
* Listens to new ideas eagerly & without prejudgment.
* Is free of rigidity that comes with a narrow life view.
* Investigates & evaluates new information.
* Is always looking for new ways to learn about the world.

Willingness to Be Proactive
* Meets challenges with positive actions - not reactions.
* Isn’t stopped by confusion, inflexible beliefs, fear of the unknown, or the conviction that “nothing can be done”.

Attentiveness
* Pays attention to the world around them.
* Listens.
* Takes others’ perspectives (not only own reality) into account when making plans.

Internal Protective Factors Promoting RESILIENCY (Milstein & Henry, 2000)
- Give of self in service to others or a cause or both.
- Use life skills (good decision making, assertiveness, impulse control & problem solving).
- Are sociable & have ability to be a friend & form positive relationships.
- Are self motivated.
- Have a sense of humor.
- Exhibit internal LOC (belief in own ability to influence one’s environment).
- Act autonomously & independently
- Be flexible.
- Have spirituality (looking for meaning in the deepest sense).
- Have a positive view of own personal future.
- Have the capacity for connection to learning.
- Are “good at something”, have personal competence.
- Have feelings of self worth/confidence.

Environmental (Characteristics of Families, Communities & Organizations) Promoting RESILIENCY (Milstein & Henry, 2000)
- Promotes close bonds.
- Values & encourages education.
- Uses high warmth, low criticism interaction style.
- Sets and enforces clear boundaries (rules, norms, & laws).
- Promotes sharing of responsibilities, service to others, “requires helpfulness”.

Provides access to resources for meeting basic needs (housing, employment, health care, & recreation).
Expresses high and realistic expectations for success.
Encourages goal setting and mastery.
Encourages development of values (ie: altruism) and life skills (ie: cooperation).
Provide leadership, decision making, & other opportunities for meaningful participation.
Appreciate the unique talents of each individual.

Celebrate Your Resiliency !!!!

Resiliency Quotient Questionnaire

Circle the closest description as to how you respond. Total your responses at the end and bring to class.

1. Do you have a problem-solving style that is mostly:
   a. proactive
   b. interactive
   c. reactive

2. Is your usual relationship style mostly:
   a. independent
   b. interdependent
   c. dependent

3. Most of the time, is your style of response:
   a. aggressive
   b. collaborative
   c. passive

4. In a serious crunch, do you:
   a. fight
   b. turn to group support
   c. withdraw

5. When a change of direction is needed, do you see it as:
   a. an interesting challenge
   b. another problem to solve
   c. indication that your life is a problem

6. Do you basically see yourself as a person who is:
   a. positive and optimistic
   b. a realist
   c. worried and pessimistic

7. Do you believe that you are generally:
   a. goal oriented
   b. here and now oriented
   c. past oriented

8. Do you tend to see life as:
   a. meaningful and purposeful
   b. “just life”, just the way it is
   c. rather meaningless and futile

9. Do you feel, most of the time:
   a. in charge of your life
   b. the need to handle life to the best of your ability
   c. out of control and overwhelmed
10. In your darkest moments, do you mostly turn to:
   a. work and learning aids
   b. people and/or support groups
   c. your own thought processes

11. When you hit tough problems, do you find that your overall perspective is grounded in:
   a. your inner resources or “God within”
   b. the human community
   c. fate, destiny, luck, past experiences

12. When you are faced with a new challenge:
   a. you get to it
   b. you get to it in good time
   c. you procrastinate a lot

13. Once you begin to tackle a problem:
   a. you assault it until it’s over
   b. you approach it methodically
   c. you give up soon

14. When you finally arrive at a solution to a problem:
   a. you leverage it and take it to the next challenge
   b. you wrap it up and move on
   c. you feel relieved

15. When you see something on your want list that is risky:
   a. you go for it
   b. you weigh the wish against the risk and often go for it
   c. you dump the wish

16. When things go wrong, do you generally:
   a. look at the big picture and tackle the obstacles
   b. reassess to find something you could do differently
   c. look for people to blame or blame yourself

17. When you celebrate a victory, do you usually;
   a. feel like you deserve every bit of it
   b. feel like it was the team that pulled things together
   c. feel like a fraud

18. When you suffer a defeat, do you usually:
   a. absorb it without much loss of self-esteem
   b. examine your limitations carefully so it doesn’t happen again
   c. get depressed and begin to doubt yourself

19. Do people turn to you as a resource because:
   a. you immediately help them tackle their problems
   b. they know you would help them if they asked
   c. you would support any decision they made

20. All things considered, do you see yourself as:
   a. unusually resilient
   b. resilient enough
   c. just limping along

   # of As = _____
   # of Bs = _____
   # of Cs = _____
Possible Questions When Interviewing a Grandparent or Other Older Adult

1. Where were you born?
2. What were your parent’s names?
3. Brothers/sister?
4. Where was the first home you remember?
5. Do you still have any favorite things that you had as a child?
6. Did you have a nickname? How did you get it?
7. Names, locations and memories you have of your elementary, jr. high, or high school?
8. Who were your closest friends?
9. In high school, what were your favorite subjects?
10. What clubs, sports and activities did you participate in?
11. Did you win any academic, social, or athletic awards or prizes?
12. What person has influenced you the most?
13. When was your first date and with whom?
14. Tell me about your part time jobs.
15. How much money did you earn?
16. What was the first movie you saw?
17. What were your favorite books?
18. What were the most popular songs?
19. What were the major clothing fads?
20. Which childhood trip do you remember most vividly? Why?
21. Tell me about transportation over the years.
22. Who taught you how to drive? What kind of car did you drive?
23. Did you go to college? Where? What was your major?
24. What friends have you stayed in touch with since childhood?
25. What is the favorite story about any of your friends?
26. How did you meet your spouse?
   How old were each of you?
   How long did you know each other before you discussed marriage?
   What attracted you to each other?
   How long were you engaged?
27. When and where were you married?
   What do you remember best about the ceremony?
   Did you go on a honeymoon? Where?
28. What is your favorite story about your spouse?
29. Tell me about the early years of your married life.
30. Tell me about the birth of your first child.
31. Is there one special early memory you have of my mother/father.
32. Tell me about raising a family.
33. Tell me about when the children left home.
34. What was your first full time job.
   What were your responsibilities?
   How much did you earn?
35. What has been your main occupation? How did you choose it
36. What is the most extravagant thing you’ve ever done?
37. What do you think is the soundest investment one can make?
38. What were your grandparents’ names?
   Where did they come from?
   What memories do you have of them?
39. Are there any medical problems that seem to run in the family?
40. What are the most important things you have learned from your mother/father?
41. What family traditions have we always followed?
42. Are there any favorite family stories that are told and retold?
43. What is the best gift you have ever received?
44. What holiday traditions do you hope I give to my own children?
45. What inventions or technological advances have most changed your life? How?
46. What national events have most affected your life?
47. Tell me about your political interests.
48. Was there a major turning point in your life?
49. What are you most proud of doing?
50. What was your happiest experience?
51. What was your saddest experience?
52. When you look back, you wish you had …
53. As you look ahead, you plan to …
54. What do you hope the future holds for me?
55. Whom do you love?
56. What do you love?
57. What would you like to tell me that I haven’t asked?

I have good news for you. The first 80 years are the hardest. The second 80 years are a succession of birthdays parties.

Once you reach 80, everyone wants to carry your baggage and help you up the steps. If you forget your name or anybody else's name, or an appointment, or your own telephone number, or promise to be three places at the same time, or can't remember how many grandchildren you have, you need only explain that you are 80.

Being 80 is a lot better than being 70. At 70, people are mad at you for everything. At 80 you have a perfect excuse now matter what you do. If you act foolishly, it's your second childhood. Everybody is looking for symptoms of softening brain.

Being 70 is no fun at all. At that age, they expect you to retire to a house in Florida and complain about your arthritis (they used to call it lumbago), and you ask everybody to stop mumbling because you can't understand them. Actually your hearing is about 50% gone.

If you survive until you are 80, everybody is surprised that your are still alive. They treat you with respect just for having lived so long. Actually they seem surprised that you can walk and talk sensibly. So please, folks, try to make it to 80. It's the best time of life. People forgive you for anything.

If you ask me, life begins at 80!
MYTHS & FACTS ABOUT SEXUALITY AND AGING
Test What You Believe!

1. True False  Elderly people do not have sexual desires.
2. True False  Elderly people are unable to engage in sexual intercourse, even if they want to.
3. True False  Elderly people are physically unattractive, and therefore sexually undesirable.
4. True False  Sexual activity can lead to a heart attack in an older person.
5. True False  Sex is no longer pleasurable after menopause.
6. True False  The quality of a person’s sex life drastically declines as they age.
7. True False  The elderly are physically fragile and might harm themselves by sexual activity.
8. True False  Sex is only for the young.
9. True False  Sexual activity in old age is perverse.
10. True False  Elderly men become impotent.
MYTHS & FACTS ABOUT SEXUALITY AND AGING -- ANSWERS

MYTH: Elderly people do not have sexual desires.
FACT: Sexual desire can, and more often does, survive into advanced age.

MYTH: Elderly people are unable to engage in sexual intercourse, even if they want to.
FACT: Studies reveal that men and women in general good health are physiologically able to have a satisfying sex life well into their eighties and beyond, and that individuals who were most active sexually during their youth and middle age usually retain the vigor and interest longer into old age.

MYTH: Elderly people are physically unattractive, and therefore sexually undesirable.
FACT: Sexual attractiveness has little to do with age and the appearance of a partner. Most contend that attractiveness is the outward and visible sign of inward and spiritual self esteem. Inner self-esteem can make a person sexually desirable.

MYTH: Sexual activity can lead to a heart attack in an older person.
FACT: Except in cases of unusual severity, the danger of a coronary attack during sexual activity is slight. It is estimated that less than 1% of sudden coronary deaths occur during intercourse. In fact, anxiety and tension caused by restricting sex are considered to be greater risks than is the physical risk from participating in intercourse.

MYTH: Sex is no longer pleasurable after menopause.
FACT: It is true that menopause, because of changes in the walls of the vagina, it takes longer for a woman to lubricate. This may call for the use of a lubricant, but enjoyment of sex comes primarily from stimulation focused on the clitoris, so sexual pleasure still continues.

MYTH: The quality of a person’s sex life drastically declines as they age.
FACT: Most older people contend that sex actually gets better in the later years. Many believe this is because over the years they have gained a better understanding of how men and women respond to sexual stimuli and have a keener appreciation of intimate sharing and caring.

MYTH: The elderly are physically fragile and might harm themselves by sexual activity.
FACT: Sex is a highly non-dangerous activity. Most elders are able-bodied and not as physically fragile as many think. They are not limited in a major way by weakness or physical impairments. Sexual activity is a good form of exercise that helps maintain flexibility and stamina.

MYTH: Sex is only for the young.
FACT: Research literature demonstrates this belief is not factual. Physiological, psychological, and sociological data indicate that aging individuals have the potential to be sexual and are indeed sexual beings.

MYTH: Sexual activity in old age is perverse.
FACT: Older adults have a strong interest in sexual activity and such activity helps physical and mental well-being. Older adults should be encouraged to continue their sexual interests without feeling guilty.

MYTH: Elderly men become impotent.
FACT: Men over 60 who are in reasonably good health and who have a willing and interested partner can continue to attain erections and have intercourse into their 70s, 80s and beyond.
SEXUALITY BARRIERS
LOSS OF SEXUAL RESPONSIVENESS

MONOTONY OF A REPETITIVE
SEXUAL RELATIONSHIP

MENTAL OR PHYSICAL FATIGUE

OVERINDULGENCE IN FOOD OR DRINK

PREOCCUPATION WITH CAREER
OR ECONOMIC PURSUITS

PHYSICAL OR MENTAL INFIRMITIES
OF EITHER PARTNER

PERFORMANCE ANXIETY RELATED TO
ANY OF THE ABOVE

AGING SEX CHANGES

HORMONAL:
TESTOSTERONE, ESTROGEN, PROGESTERONE CHANGES

DECREASED MUSCLE TONE AND ELASTICITY

PROSTATE HYPERTROPHY

SCLEROSING ARTERIES AND VEINS

INCREASED TIME FACTORS: AROUSAL AND REAROUSAL

MOST COMMON PROBLEMS IN MALES ARE R/T DRUGS & SURGERY

MOST COMMON PROBLEMS IN FEMALES ARE R/T RESPONSES TO MENOPAUSE

DEMOGRAPHICS:
MORE AVAILABLE WOMEN THAN MEN

CULTURE:
SENIORS GREW UP IN AN ERA WHERE MEN TOOK THE SEXUAL INITIATIVE,
WHERE THERE WERE LESS SEXUAL FREEDOMS FOR WOMEN, AND
WOMEN WERE LESS LIKELY TO MARRY YOUNGER MEN
SEXUAL NEGLECT OF THE ELDERLY
by Donna Swanson

God, My hands are old.
I’ve never said they out loud before but they are.
I was so proud of them once.
They were soft like the velvet smoothness of a firm, ripe peach.
Now the softness is more like worn-out sheets or withered leaves.
When did these slender, graceful hands become gnarled, shrunken claws?
When, God?
They lie here in my lap, naked reminders of this worn-out body that has served me too well!

How long has it been since someone touched me?
Twenty years?
Twenty years I’ve been a widow.
Respected.
Smiled at.
But never touched.
Never held so close that loneliness was blotted out.
I remember how my mother used to hold me, God.
When I was hurt in spirit or flesh, she would gather me close, stroke my silky hair, and caress my back with her warm hands.

I remember the first boy who ever kissed me.
We were both so new at that!
The taste of young lips and popcorn.
The feeling inside of mysteries to come.

I remember Hank and the babies.
How else can I remember them but together?
Out of the fumbling, awkward attempts of new lovers came the babies.
And as they grew, so did our love.
And, God, Hank didn’t seem to mind if my body thickened and faded a little.
He still loved it. And touched it.
And we didn’t mind if we were no longer beautiful.
And the children hugged me a lot.
O God, I’m lonely!

God, why didn’t we raise the kids to be silly and affectionate as well as dignified and proper?
You see, they do their duty.
They drive up in their fine cars;
They come to my room to pay their respects.

They chatter brightly, and reminisce.
But they don’t touch me.
They call me “Mom” or “Mother” or “Grandma.”

Never Minnie.
My mother called me Minnie.
So did my friends.
Hank called me Minnie, too.
But they’re gone.
And so is Minnie.
Only Grandma is here.
And God! She’s lonely!
RIPENING
Joanne McCarthy

It is sad to grow old but nice to ripen - Brigitte Bardot

What she regretted was her skin, folding in

on itself like fabric, elasticity gone.

Life-juices that plumped her cheeks disappeared,

wrinkles cast their fine net across her face, laugh-lined her mouth.

Her eyes deepened.

The hairdresser warned her about the gray.

Leave it, she said, I want to see what Nature will do.

What Nature did was remind her that ripeness is all,

that autumn is the richest season,

that preparing for snow means building a shelter,

that warmth within withstands whatever winter howls without.

When the baby laughed, reached for her breast

even though milk had been gone for years,

she remembered sweet burdens of motherhood,

relinquished them gladly,

her destiny now another –

grandmother,

wise woman, matriarch.

The brain holds what I am, she said,

knowing then that body was always hers.

The heart holds what I would be, the womb can rest.

She saw her life, and knew that it was good.
Virtual Class #1
Atypical Presentations in Older Adults & Holistic Multidimensional Assessment
Check SacCT for
PowerPoint & Case Study materials.
Complete as Instructed and
No Personal Reflections for this Class
N117 Virtual Class
Case Study #1 Answer Sheet

1.) Name at least 3 Atypical Presentations you identified in this case;
   1. 
   2. 
   3. 

2.) Summarize 3 “lessons learned” from the:
   Nurse’s standpoint:
   1. 
   2. 
   3. 
   Patient/Family member’s standpoint:
   1. 
   2. 
   3. 

3.) Identify 3 Interventions: one for each of the above Lesson Learned:
   Nurse:
   1. 
   2. 
   3. 
   Patient/Family member:
   1. 
   2. 
   3. 

4.) List two Community Agencies/Services you would refer your patient/family to and why (include contact information):
   1. 
   2. 

5.) Name at least one assessment tool (from consultgeri.org) you would use to assist you in caring for this patient/family, and your reasoning about why this tool would be beneficial.
   1. 
   2.
Generational Identity; Health Promotion & Sensory Changes
Personal Reflections ~ #3

How does understanding generational differences/similarities impact your nursing care?

How can you promote Health in self & Others? What difficulties do you anticipate experiencing when working with elders with sensory deficits?

What are some alternative communication modes you might use?

Surprise!!
Myths Busted or ... I didn't know That!

Conclusions

BPNI

Outcome
**Generational Faces - PowerPoint**

The World Through Four Generational Lenses: Where Do **You** “fit”?  
Why Do **THEY** Think that Way?

**Goal:** Understand four generational lenses and how to reduce clash-points  
When you leave you will be able to:  
1.) View the world through four generational perspectives.  
2.) Facilitate communication across generations.

Think of some ways you can get into “their perspective” to increase understanding and communication.

**Traditionalists ~ 1900 - 1945**  
(75 million ~ two generations)  
**Loyal:** put aside individual needs and work for the whole;  
**Partner** with larger groups to get things done;  
**Faith in institutions:**  
No social safety nets → **value of $$**;  
**Patriotic →** military experiences → **Top down** approach is **most efficient** way to get things done  
Traditionalist’s Defining Events: Flu Epidemic 1918; WWI; Roaring Twenties; Great Depression; New Deal; WWII; Korean War; GI Bill →

**KEY WORDS:**  
Loyal, patriotic, God-fearing, hardworking, group of individuals.

**Traditionalist’s Influences - Things:** (Were scarce) → lots of opportunities to learn to do without → “save for rainy day & waste not want not” = VERY REAL; symbols were very imp’t: swastikas to sputnik, flappers to flattops they drove roadsters to drive-ins, smoked, drank Coca Cola, played 45s and did the Twist.

**Traditionalist’s Retirement Behaviors:** Healthiest, wealthiest, best educated generation to retire! **Do, enjoy, give back, appreciate:** Ready to treat themselves. 72% also plan to work PT! 30% are in school; make up 80% of luxury travel – walking/biking tours; volunteering at home & foreign countries.

**Baby Boomer ~ 1946 - 1964**  
(80 million)  
* **Optimistic** – booming post war economy, jobs, education, → anything is possible; traditionalist parents encouraged kids to pursue their dreams – big correlation with “work” & dreams; energy was turned inward toward  
* fixing what was “wrong” with America → **Idealistic**;  
* **Questioned** status quo & pushed for  
* **Change/challenged authority;** focused on interpersonal **Communication**  
* **ME generation** – privileged to be able to focus on themselves AND the deep identification/correlation Boomers feel with who they are and what they achieve at work **Boomer’s Defining Events:** TV: different reference points from parents (TV shows, characters, plots etc); media changes though TV “see it almost in real time (Vietnam War, Watergate, Civil Rights & Women’s rights movements); booming post war economy → anything is possible! World was full of opportunity & education for all/sought after by traditionalists for their kids; interpersonal communication era

**KEY WORDS:**  
Optimistic; idealistic; communicating; pushing for change/challenge authority

**Boomer’s Influences - Things:**  
**Reflected evolving identity & exploding consumer products:** from bellbottoms & mood rings to Brooks Brothers suits & Rolexes, from junk food to junk bonds, from LSD to SEC (securities & exchange commission); Rock’n Roll, country, blues.
Boomer’s Retirement Behaviors:
Viewed with discomfort – have always identified self with professional accomplishments.
Retooling for alternate careers (maybe PT) that provide self-definition; volunteer.

Gen - Xer ~ 1965 - 1980
(46 million)
Skeptical because of more exposure to “real time” portrayal of events through media – loss of innocence;
Resourceful because of having to be independent (latchkey – on own more, single parenting);
Independent – result from being more on own and having to make decisions for self.

Xer’s Defining Events: Much less innocence - 24-hour TV – saw most heroes indicted or exposed; >
violence; Challenger; HIV/AIDS; crack cocaine; > child molesters & DUls > single-parent households;
more latchkey kids; positive = learned to be > resourceful & independent

KEY WORDS;
Skeptical; resourceful; independent

Xer’s Influences - Things:
Cable & digital TV, Satellite, VCRs, personal computers, cell phones, palm pilots (didn’t simplify life tho’)

Millennials ~ 1981 - 1999
(76 million)
Realistic due to real time exposure to events – personally and through media reports;
Expect diversification – because they have seen the world (through internet or family travel)
Confident (expected to be on own)
Communicators – raised by communicative, participation-oriented parents – taking the best from earlier
generations.

Millenial’s Influences - Things:
Access to cell phones, pagers, personal computers since they can remember; visit everywhere via
Internet – virtual & earth malls → information available anytime, anywhere = realistic about challenges of
modern life (directly affected by missing friends)

Millenial’s Defining Events:
So far ….. Columbine, 9/11; illegal drugs; > gangs; Positive = feel empowered to take positive action.
Projected to be next “Greatest Generation” – taking the best from the three previous generations – loyal &
faith in institutions, optimism about ability to make things happen & skepticism --> cautious

KEY WORDS:
Realistic; confident, communicators

Millenial’s Retirement Behaviors: Recycle – expect fun along the way – do it now! Maybe actually
retire the word retire!!

Cuspers
(Positioned between two generations)
(1940-1945)
(1960-1965)
(1975-1980)

Identify strongly with one or other generation or have characteristics of both

Key Words:
Mediating, translating, mentoring - Bridge the generations
**Health Promotion Assignment**
**CHECK Page 17 for directions**

## Hearing Aid Troubleshooting

**SYMPTOMS, CAUSES, TESTS AND REMEDIES CHART**

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>CAUSES, TESTS AND REMEDIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid dead</td>
<td>1, 2, 3, 4, 5, 10</td>
</tr>
<tr>
<td>Working, but weak</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
</tr>
<tr>
<td>Works intermittently</td>
<td>3, 4, 5, 10</td>
</tr>
<tr>
<td>Whistles, continuously or occasionally</td>
<td>6, 9, 11, 12</td>
</tr>
<tr>
<td>Sounds noisy, raspy, shrill</td>
<td>3, 4, 5, 8, 9, 10, 11, 12</td>
</tr>
<tr>
<td>Sounds hollow or mushy</td>
<td>1, 2, 7</td>
</tr>
</tbody>
</table>

**KEY: CAUSES, TEST AND REMEDIES:**

1. Cause: Dead or run down batteries. Test: Check batteries with voltmeter or substituted new batteries.  
   **Remedy:** Replace worn out batteries.

2. Cause: Battery reversed in holder so that + is where - should be. Test: Examine.  
   Hearing Changes in Elders  
   **Remedy:** Replace worn batteries.

3. Cause: Poor contacts in plugs due to dirty pins or springs. Test: With hearing aid turned on, wiggle plug in receptacles and withdraw and reinsert each plug.  
   **Remedy:** Rub accessible contacts briskly with lead pencil eraser, then wipe with clear cloth moistened with Energine or similar cleaning liquid. Inaccessible contacts usually can be cleaned with broom straw dipped in cleaning fluid.

4. Cause: Internal break or near break inside receiver or battery cords. Test: While listening, flex all parts of cord by running fingers along entire length and wiggle cords at terminals. Intermittent or raspy sounds indicate broken wires.  
   **Remedy:** Replace cords with new ones. Worn ones cannot be repaired satisfactorily.

5. Cause: Plugs not fully or firmly inserted in receptacles. Test: While listening, withdraw and firmly reinsert each plug in turn.  
   **Remedy:** Obvious.

6. Cause: Ear tip not properly seated in ear. Test: With the fingers press the receiver firmly into the ear and twist back and forth slightly to make sure that the ear tip is properly positioned.  
   **Remedy:** Obvious.

7. Cause: Ear tip plugger with wax or with drop of water from cleaning. Test: Examine ear tip visually and blow through it to determine whether passage is open.  
   **Remedy:** Disconnect ear tip from receiver, then wash ear tip in lukewarm water and soap using pipe cleaner or long bristle brush to reach down into the canal. Rinse with clear water and dry. A dry pipe cleaner may be used to dry out the canal, or blowing through the canal will remove surplus water.

   **Remedy:** If cap is cemented on or crimped, and has become loose, it can be repaired only by the manufacturer.

9. Cause: Insufficient pressure of bone-receiver on mastoid. Test: While listening, press the bone-receiver more tightly against the hand with the fingers.
Remedy: Bend the bone-receiver headband to provide greater pressure. This is preferable done by your consultant as he is more skilled in maintaining conformation with the head.

10. Cause: Batteries oozing liquid (resulting in poor battery connection). Test: Examine battery and battery holder for evidence of leakage in the form of slimy liquid or corrosion. 
Remedy: Replacement of batteries before they wear out completely will avoid leakage. If leakage does occur, discard the battery and wipe the holder terminals carefully with cloth dampened (not wet) in warm water to remove all battery fluid.

11. Cause: Receiver close to wall or other sound reflecting surfaces. Test: Examine.
Remedy: Avoid sitting with the fitted side of the head near a wall or other surface. Such surfaces close by tend to reflect the sound from the receiver so that it is more readily picked up by the microphone, thus causing whistling.

12. Cause: Microphones worn too close to receiver.
Remedy: Avoid wearing microphone and receiver on same side of body or close together.
Sensory Experiences
What Might Growing Older Really Feel Like?
An Adaptation Strategy

Write 3 ways you feel:
1.
2.
3.

Write 3 things you would do to adapt to the world and compensate for your changes/losses:
1.
2.
3.

Write 3 things someone else can do to help you adapt to your world:
1.
2.
3.

What will you take away from this experience?
Holistic Restorative Care & Geriatric Syndromes
Personal Reflections ~ #4

Restorative Care provides care that capitalizes on a person's strengths. Give examples of how you can use restorative care as a nursing care philosophy to help all patients with pain mgmt, improving sleep, & fall prevention?

Conclusions

Surprise!!
Myths Busted or ...
I didn't know That!!

BPNI

Outcome
Pain – The Resident’s Perspective
Observation Sheet

Descriptions of Pain:

BPNI: Outcome: 
**********************************************

Communicating About Pain:

BPNI: Outcome:
**********************************************

Withdrawing from Life:

BPNI: Outcome:
**********************************************

Reluctance to Talk About Pain:

BPNI: Outcome:
**********************************************

Responding to Pain:

BPNI: Outcome:
**********************************************

Overcoming Pain:

BPNI: Outcome:
**********************************************

Conclusions:
Pain Assessment & Management Notes

Predictors for Severe Pain (ethnically diverse)

- Medicaid recipient
- ≥ 2 co morbidities
- Low educational level
- Psychological Distress

Pain Assessment & Management

People in pain usually seek effective pain relief, 1 in 5 elders however, report taking meds only occasionally during a one-week period — reasons why?

- Under-treatment by providers?
- Financial difficulties?
- Reluctance to take meds?

Clinical Pain Assessment

Goals are same as for younger people

Elders may be hesitant to report pain:
- “normal aging”
- “don’t want to be a nuisance”
- “fear consequences of acknowledging pain like expensive testing, hospitalization etc”

Pain Assessment & Management

Regardless of reasons .... What are the consequences of untreated pain?

- Depression
- Anxiety
- Decreased socialization
- Sleep disturbances
- Impaired ambulation
- Increased healthcare utilization/costs

Clinical Pain Assessment

Detailed History (possible pain sources r/t pathological conditions)

- Peripheral vascular disease (PVD)
- Diabetes
- Poststroke syndrome
- Decubitus ulcers
- Oral/dental problems
- Contractures
- Degenerative joint disease
- Rheumatoid arthritis
- Previous fx
- Osteoporosis

Clinical Pain Assessment

Detailed System History

Ask about Hx of liver, GI and kidney dysfunction

Med Hx —

Include all prescription, OTC, & herbal remedies, & alcohol consumption

(could impact med treatments for pain)

Clinical Pain Assessment

Physical exam
(self report is most reliable source – even with some dementia – may respond more to achy, sore or discomfort than “pain”)

Type
Quality
Location
Intensity
Etiology (skin, bones, muscle, mixed?)
What makes it worse? Better? What Tx used before? Response to Txs?

**Appropriate diagnostic assessment**

**Assessment Tools**

**Numeric** – 0 (no pain) → 10 (worst)

**Verbal Rating** – mild, moderate, severe, agonizing

**FACES Pain Rating** – pick a face (sad/teary → happy)

**Assessing Unconscious or Severely Cognitively Impaired**

**Nonverbal cues** (ie restlessness & guarding)

**Verbal cues** (moaning, crying, groaning)

**Facial expressions** (grimacing, furrowed brow)

**Clinical Pain Assessment**

Changes is usual activity are important to acknowledge

- Combativeness
- Resisting Care
- Decrease Social Interactions
- Increased Wandering
- Difficulty Sleeping
- Refusing to Eat

**Pharmacological**

Start low & go slow!

- Acetaminophen – first line Tx (mild-moderate pain)

  → NSAIDs (short term only b/c → GI toxicity, platelet & renal dysfunction, NA retention

  → Opioids (moderate-severe) tho’ side effects commonly = sedation, N/V, Itching, constipation

**Non-pharmacological**

(individualized & used with other therapies)

- Physical Activity
- Music
- TV
- Massage
- Storytelling
- Relaxation Exercises
- Pet Therapy
SLEEP

Never to allow a patient to be waked, intentionally or accidentally, is a “sine qua non” of all good nursing.

If he is roused out of his first sleep, he is almost certain to have no more sleep.

It is a curious but quite intelligible fact that, if a patient is waked after a few hours instead of a few minutes sleep, he is much more likely to sleep again.

Florence Nightingale (1859)

PARAMETERS OF NURSING ASSESSMENT OF SLEEP
Measured Every Shift By Nurse

SLEEPING ENVIRONMENT
Noise interrupted or prevented sleep.
Light interrupted or prevented sleep.
Cold/hot temperature interrupted or prevented sleep.
Inadequate ventilation interrupted or prevented sleep.
Medical/nursing care interrupted or prevented sleep.

PHYSICAL AND MENTAL FACTORS
Pain interrupted or prevented sleep.
Discomfort interrupted or prevented sleep.
Feeling sad interrupted or prevented sleep.
Worry interrupted or prevented sleep.
Anxiety interrupted or prevented sleep.
Difficulty breathing interrupted or prevented sleep.
Snoring interrupted sleep.
Nightmare interrupted sleep.
SLEEP CARE STRATEGIES

GOAL:
Patient will report that he/she is sleeping well or feeling rested and demonstrate an increased ability to concentrate and a reduction in behaviors indicative of sleep deprivation (e.g. restlessness).

INTERVENTION:
- Develop an individualized sleep protocol. Strategies for promoting sleep include:
  a. Maintain normal sleep pattern (e.g., arrange medications and therapies to minimize sleep interruptions).
  b. Encourage daytime activity (e.g., discourage daytime naps).
  c. Support bedtime routines/rituals (e.g., enable bedtime reading, listening to music, or quiet television).
  d. Promote comfort (e.g., make sure the bed is comfortable, including pillows as requested, wrinkle-free linen, and loose bed covering).
  e. Promote relaxation (e.g., provide warm milk or soup, offer back rub).
  f. Avoid/minimize stimulation before bedtime (e.g., no caffeinated drinks after dinner and reduce fluid intake prior to sleeping; individuals should also refrain from smoking).
  g. Avoid/minimize drugs that negatively influence sleep (see table)
  h. Create a restful environment (e.g., turn off lights as desired, reduce or eliminate noise, minimize disruptions for therapy or monitoring).

- Pharmacological treatment, prescription, and administration of a sedative/hypnotic, should be implemented to correspond with patient practices at home; e., low dosage. Pharmacologic treatment should be considered an intervention of last resort for individuals who have not been using sedatives or hypnotics at home.

<table>
<thead>
<tr>
<th>DRUG</th>
<th>INDICATION</th>
<th>SLEEP-RELATED EFFECT(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digoxin</td>
<td>Heart Failure</td>
<td>Apathy, psychosis</td>
</tr>
<tr>
<td>Rantidine</td>
<td>Ulcers, GI reflux</td>
<td>Malaise, somnolence, insomnia</td>
</tr>
<tr>
<td>Conjugated estrogens</td>
<td>Mod/severe motor symptoms of menopause</td>
<td>Headache, migraine, depression</td>
</tr>
<tr>
<td>Alprololam</td>
<td>Anxiety disorders</td>
<td>Drowsiness, depression, headache, confusion, insomnia, nervousness, tiredness/sleepiness</td>
</tr>
<tr>
<td>Diuretic combinations</td>
<td>HTN, edema</td>
<td>Nocturia</td>
</tr>
<tr>
<td>Diltiazem HCL</td>
<td>Angina</td>
<td>Depression, hallucination, insomnia, tremor nervousness, paresthesia, somnolence</td>
</tr>
<tr>
<td>Enalapril maleate</td>
<td>HTN, heart failure</td>
<td>None</td>
</tr>
<tr>
<td>Atenolol</td>
<td>HTN, angina, acute MI dreaming</td>
<td>Tiredness, drowsiness, depression, excessive nervousness, paresthesia, somnolence</td>
</tr>
<tr>
<td>Nifedipine</td>
<td>Angina, hypertension</td>
<td>Headache, fatigue, insomnia, nervousness, paresthesia, somnolence</td>
</tr>
<tr>
<td>Captopril</td>
<td>HTN, heart failure</td>
<td>Ataxia, confusion, depression, nervousness, somnolence</td>
</tr>
</tbody>
</table>
Older Adult Common Sleep Patterns – PowerPoint Notes

Patterns
Become sleepier earlier
Wake up more often
Get less deep sleep
Rise earlier
Older Adult Common
Sleep Patterns

Sleep Complaints
Insomnia
Hypersomnia
Parasomnias
Periodic Leg Movements
Restless Leg Syndrome

Sleep Complaints
** Insomnia
Short Term: Lasts a few weeks/Comes from temporary stressful experiences
Transient: Occasional episodes of restless nights - usually environmental (bed, pillows, noise, anxiety)
Chronic: Last > 3 weeks or throughout life

** Hypersomnia
Sleep Excessiveness
(>8-9 hrs/24)
Causes speculative: Inactivity, boring life style, depression. Often associated with sleep apnea, or in younger people: narcolepsy
S & S: Complaints of fatigue, weakness, memory and learning difficulties

** Parasomnias
Disorders of arousal, partial arousal, and sleep stage transition
Sleep walking, terrors, nightmares, partial seizures, acting out dreams

** Periodic Leg Movements (PLMS)
Myoclonic leg jerks during the night
Associated with dissatisfaction with sleep, sleeping alone, and reported kicking at night
One study found 45% of community dwelling elders have PLMS

** Restless Leg Syndrome

* 15% of population, often familial, increasing with age, etiology unknown
* Associated with sciatica, peripheral neuropathy d/t chronic renal failure or diabetes, B12 or iron deficiencies, rheumatoid arthritis
* Starts when resting, relieved by moving, worse pain in pm, may result in insomnia
(associated with PLMS)

S& S
Unpleasant limb sensations: creeping, crawling, jittery, tingling, burning, or aching in calves, thighs, feet, or even upper extremities

Treatment: Ibuprofen, warm baths and leg massages, music therapy, moderate exercise
(Mayo Clinic 1997 data)
Causes of Falls in the Elderly:
Summary of Eight Studies that Included Careful Workups

<table>
<thead>
<tr>
<th>Situation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Accident&quot;/environment</td>
<td>38</td>
</tr>
<tr>
<td>Gait problems or weakness</td>
<td>13</td>
</tr>
<tr>
<td>Drop Attack (sudden leg weakness)</td>
<td>11</td>
</tr>
<tr>
<td>Dizziness/vertigo</td>
<td>8</td>
</tr>
<tr>
<td>Postural hypotension</td>
<td>5</td>
</tr>
<tr>
<td>Syncope</td>
<td>1</td>
</tr>
<tr>
<td>Other specified causes (ie meds)</td>
<td>18</td>
</tr>
<tr>
<td>Unknown</td>
<td>8</td>
</tr>
</tbody>
</table>

Aging Changes Increasing “Accidental” Falls PPT Notes

**Gait Changes** -- proneness to trip and stumble
- Feet not picked up as high
- Men tend to develop a flexed posture, wide based and small-stepped gait
- Women tend to develop a narrow-based and waddling gait

**Postural Instability** -- tendency to lose balance
- Increase postural sway due to slowed central processing and proprioceptive signals
  (younger people are able to rapidly correct by moving their hips without taking a step; older people take steps to correct imbalance thus increasing possibility of falling)

**Impaired Muscular Control** -- inability to recover from trip or unexpected step
- Weaker muscle cushioning and slowed righting reflexes

**Deterioration of Vision and Hearing** -- impaired obstacle avoidance

**Loss of Short-term Memory** -- proneness to trip over forgotten objects

**Important Risk Factors for Falls**
(Summary of 17 Controlled Studies)

<table>
<thead>
<tr>
<th>Event</th>
<th>Significant Total **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weakness</td>
<td>11/11</td>
</tr>
<tr>
<td>Balance deficit</td>
<td>9/9</td>
</tr>
<tr>
<td>Gait Deficit</td>
<td>8/9</td>
</tr>
<tr>
<td>Visual Deficit</td>
<td>5/9</td>
</tr>
<tr>
<td>Mobility Limitation</td>
<td>9/9</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>4/8</td>
</tr>
<tr>
<td>Impaired ADL</td>
<td>5/6</td>
</tr>
<tr>
<td>Postural Hypotension</td>
<td>2/7</td>
</tr>
</tbody>
</table>

** Number of studies with significant association/total number of studies looking at each factor
Environmental Factors Associated With Falls

<table>
<thead>
<tr>
<th>Home</th>
<th>Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstable furniture and appliances</td>
<td>Recent admission or transfer</td>
</tr>
<tr>
<td>Creaky stairs with poor rails</td>
<td>Hazardous furniture</td>
</tr>
<tr>
<td>Throw rugs and frayed carpets</td>
<td>Slick hard floors</td>
</tr>
<tr>
<td>Poor lighting</td>
<td>Unsupervised activities</td>
</tr>
<tr>
<td>Low beds and toilets</td>
<td>Meal times</td>
</tr>
<tr>
<td>Pets</td>
<td>Absence of hand rails</td>
</tr>
<tr>
<td>Objects on floor</td>
<td>Inadequate lighting</td>
</tr>
<tr>
<td>Medications (psychiatric or hypotensive)</td>
<td></td>
</tr>
</tbody>
</table>

Preventing Falls

Treat the underlying illness (causes of muscle weakness, imbalance, pain)
Reduce any accompanying risk factors (ie visual problems, orthostasis)
Reduce environmental hazards
Teach adaptive behaviors (slow rising, gait training, cane, walker)
Increase leg ROM exercises
Develop individualized exercise plan
Support with adequate nutrition

Critical Thinking Analysis:

Find the Fall Assessment at your Agency, Compare it to the Heinrich Risk assessment on consultgeri.org

What are the similarities and differences?
Use of Mechanical Restraints with Elderly Patients
Source: Deborah Francis MSN, RN, GCS - UCDMC

RISK FACTORS: Falls risk. Tubes or IVs that need stability in an agitated and/or confused patient. Severe cognitive or physical impairments. Diagnosis or presence of a psychiatric condition. Surgery.

ASSOCIATED MORBIDITY AND MORTALITY: Nerve injury, new onset of pressure sores, pneumonia, incontinence, increased confusion, inappropriate drug use, strangulation, asphyxiation.

ALTERNATIVES TO RESTRAINTS:
- Physiologic Care: Provide comfort, pain relief, positioning; assess need for and camouflage necessary tubes, implement routine toilet schedules, review medications that cause delirium.
- Psychosocial Care: Reality orientation, therapeutic touch, active listening, attention to feelings and concerns, companionship and supervision, remotivation therapy, behavioral modification.
- Activities: Distraction, exercise, and planned recreation.
- Environmental Manipulation: Increased light, redesign of furniture, placement of patient near nurses’ station, beds close to floor with no side rails, and accessible call lights.
- Administrative Support: Reevaluation of current restraint policies, emotional support for staff who work with clients with behavioral disturbances, adequate or alternative staffing patterns and staff training.

INTERVENTIONS FOR SPECIFIC PROBLEMS

For unsafely mobile persons:
- Request PT/OT consult for assessment of gait and muscle strength and use of adaptive equipment.
- Keep bed in low position at all times, bottom side rails down.
- Check feet. Could you walk on those feet? Have patient wear appropriate shoes.
- Promote aggressive progressive mobilization (eg OOB for all meals, to commode the BR for toileting rather than bedpan).
- Discuss issue with patient and document conversation. Use repetition if needed and include family/surrogate decision maker as appropriate.
- Discuss and document risks of no restraints.

For Cognition/Poor Judgment/Disruptive/Aggressive Behaviors/Wandering:
- Implement Management of Confused Older Adult Protocol.
- Place patient in room close to nurses’ station to allow close observation.
- Enlist family members, friends, volunteer or sitter to be with patient, especially during pm/noc shifts.
- Discuss potential of confusion with family/pt. Call family to talk with pt in acute confusion. Talk with/listen to pt.
- Use medications/chemical restraints judiciously and only as a last resort.
- Request geriatric or psychiatric nurse specialist consultation.

Interference with Lines/Tubes/Life support:
- Evaluate need for therapy and how life threatening removal of device is. Consider hep lock if IV needed only for meds. PO food/fluid rather than IV or NG. Discontinue Foley ASAP and consider straight cath PRN. For pts.requiring NG tube, speech evaluation to evaluate patient swallow. If tube feed necessary, consider endoscopic GT that can be easily hidden.
- Offer thorough, simple explanation of all tubes. Let patient touch tubes. Use repetition.
- Keep lines out of view. Camouflage insertion site with arm warp, long sleeve gown or robe. Keep IV solution bags behind pt’s field of vision. Mittens for use over hands, Koosh Ball to occupy hands. Secure Foley cath with tape.
- Place familiar things in the environment. Minimize external stimuli such as TV. Consider familiar music.
- Liberal use of touch (if culturally appropriate) and reassurance.
- Encourage family and friends, volunteer to visit especially at night.

For all situations in which physical restraints may be considered, remember the following:
- Identify and address underlying cause of the problem.
- Document the specific behavior or reasons the patient is placed in restraints.
- Follow (Agency) Restraint Policy and modify care plan to compensate for restrictions imposed by restraint use (eg frequent position changes, providing skin care, providing adequate ROM, assisting with ADLs).
Depression Risk Factors - Notes

**Chronic Medical Conditions**
Somatic complaints, functional impairments & perceived health
Note: cyclical with exacerbations of illness: illness --> depression --> illness --> depression
also illness may be mistaken for depression and vice versa

**Sensory Deficits/Functional Impairments**
Vision, hearing other functional impairments sometimes --> Isolation --> depression --> Isolation

**Demographics**
Female, low SEL, divorce, widowed, separated, family history of depression,
early depression prevalence in cohort group.

**Medications**
Many medications have depressive side effects, some more so in older adults

**Serious Emotional Crises**
Multiple losses have cumulative effect, coping depends on earlier life skills and current support systems

**Guilt**
In younger people this is usually seen as decrease in self esteem

**Dependent Interpersonal Relationship**
Seligman’s learned helplessness theory: older adults view themselves as helpless at times of loss -->
ETOH use to decrease anxiety and restore a sense of control (goes along with disengagement theory)

**ETOH/Drug Abuse**
ETOH use --> depression --> ETOH use, causes for use need to be ascertained

---

A SYMPTOM CHECKLIST FOR DEPRESSION
National Institute of Mental Health Depression Awareness, Recognition and Treatment Program
4 or more for greater than 2 weeks

- A PERSISTENT SAD, ANXIOUS OR “EMPTY” MOOD
- LOSS OF INTEREST OR PLEASURE IN ORDINARY ACTIVITIES
- DECREASED ENERGY, FATIGUE OR FEELING “SLOWED DOWN”
- SLEEP PROBLEMS LIKE INSOMNIA, OVERSLEEPING OR EARLY MORNING AWAKENING
- EATING PROBLEMS LIKE LOSS OF APPETITE OR WEIGHT LOSS OR GAIN
- DIFFICULTY CONCENTRATION, REMEMBERING OR MAKING DECISIONS
  - IRRITABILITY
  - EXCESSIVE CRYING
- RECURRING ACHESS AND PAINS THAT DO NOT RESPOND TO TREATMENT
  - FEELINGS OF HOPELESSNESS OR PESSIMISM
  - FEELINGS OF GUILT, WORTHLESSNESS OR HELPLESSNESS
  - THOUGHTS OF DEATH OR SUICIDE OR MAKING A SUICIDE ATTEMPT
Geriatric Depression Scale (short form)

Ask First:
Over the past two weeks have you felt sad or blue? Or down, or depressed, or hopeless? During the past two weeks have you felt little interest or pleasure in doing things? Positive responses to any of these should be followed with the GDS.

Choose the best answer for how you have felt over the past two weeks:

1. Are you basically satisfied with your life? YES / NO
2. Have you dropped many of your activities and interests? YES / NO
3. Do you feel that your life is empty? YES / NO
4. Do you often get bored? YES / NO
5. Are you in good spirits most of the time? YES / NO
6. Are you afraid that something bad is going to happen to you? YES / NO
7. Do you feel happy most of the time? YES / NO
8. Do you often feel helpless? YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO
10. Do you feel you have more problems with memory than most? YES / NO
11. Do you think it is wonderful to be alive now? YES / NO
12. Do you feel pretty worthless the way you are now? YES / NO
13. Do you feel full of energy? YES / NO
14. Do you feel that your situation is hopeless? YES / NO
15. Do you think that most people are better off than you are? YES / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score < 5 is normal
A score > 5 points is suggestive of depression.
A score > 10 points is almost always indicative of depression.
A score > 5 points should warrant a follow-up comprehensive assessment.

Source: http://www.stanford.edu/~yesavage/GDS.html

This been proven to be a reliable measure to decide if you need go on with more assessments !! (92% sensitivity and 89% specificity fro detecting depression in elders!! Follow a positive GDS screen with assessments for suicide and substance abuse.
Holistic Changes: Geriatric Syndrome: Incontinence – PPT Notes

*Risks Influencing Urinary Control*
- Immobility
- Medications
- Psychosocial Influences
- Institutionalization
- Hx of childbirth
- Pathological Conditions

** Briefly describe why each of these can contribute to incontinence in elders.

*Types of Incontinence*
- Check out your class resources for descriptions of each of these & remember you need to know the cause as treatment varies!!
- Urge
- Stress
- Mixed
- Overflow
- Functional

*Incontinence: It's a Clue!!*
- UTI
- Impaction or chronic constipation
- Dementia
- Can’t walk or transfer self in time
- Dehydration

** Discuss why incontinence is often a clue to these other conditions.

*Application*
- Check out consultgerirn.org website
- Review Urinary Incontinence Topic

Describe the assessment parameters regarding transient urinary incontinence (UI) & persistent UI.

Describe at least two specific nursing care interventions for prevention of urinary incontinence concerns.

Describe at least one specific nursing intervention for management of each of the 5 types of urinary incontinence.

*Incontinence Assessment~ ways to remember .....*
- Stool impaction
- Pharmaceuticals
- Atrophy
- Infection
- Restricted mobility
- Excess Urine
- Delirium
  (Kelly Kendall CSUS - S08)

Delirium
- Infection
- Atrophy
- Pharmaceuticals
- Excess urine
- Restricted mobility
- Stool impaction
  (gero literature)
Constipation ~ causes
Evidence-based studies show it’s **Not** a consequence of aging!!
It’s related to:
- mobility/activity
- Dietary fiber
- Adverse Med Reactions
- Long term laxative use
- False definition of constipation:
  (Normal = 3x/day → 3x/week – depends on individual)

**Case Study: UTI/Dehydration**

Mrs. M is an 86 year old who lives at an assisted living facility (ALF) near her immediate family’s residence. She is here because of mild cognitive impairment (MCI) and medication management. Her family plans on bringing Mrs. M “home” to their House in May as soon as their next child graduates & leaves an Extra room available. In the mean time Mrs. M’s son & family visit her weekly. During their last visit they notice that Mrs. M is more confused than usual. Since they visit her regularly, the family is able to notice a slight change from Mrs. M’s “baseline” physical & mental health. When asked if she was in pain, Mrs. M said “it hurts to pee & burns a little”. Being extra observant, the family notices that she knows who she is but seems to have difficulty understanding what day and time it is.

**Case Questions**
Answer each of the following questions based on what you know as the “nurse consultant” for this ALF.

- What information would you, the nurse, need to collect?
- What procedures or tests, if any, need to be done to determine Mrs. M’s change in orientation?
- What interventions should the nurse overseeing Mrs. M’s care implement?
- What would you teach the staff that might help prevent this situation from happening in the future?

What myths were challenged?

What will you tell your patients?
Management of Change, Loss, & Grief, & Understanding Spirituality & Legacy
Personal Reflections ~ #5
When I think of being “home” I think of ….
What do you see yourself doing to ease a change-loss reaction – self/patient?
To Me, Spirituality means ….. How will this impact my nursing care?

Conclusions

BPNI

Outcome

Surprise!!
Myths Busted or …
I didn't know That!!
Loss & Changes in Life: Grief Wheel
Osborne, 1999 - Adapted from Healthwise Model
From Black and White to Color:
The Process & Feelings of Grieving – PPT Notes

Shock
S & S
• Numbness
• Denial
• Blunting
• Outbursts
• Weight Loss
• Decreased Energy to Deal with Life Events

Protest - S & S
• Searching
• Sleep Disturbances
• Anger
• Irritability
• Yearning
• Self-Criticism
• Crying
• Increased Affect/Energy
• Nausea/Loss of Appetite
• Preoccupation with the Loss

Disorganization - S & S
• Feelings of Unreality
• Sense of Presence
• Restlessness
• Aimlessness
• Loneliness
• Apathy/Loss of Interest in Usual Life Events
• Withdrawal
• Feeling Depressed/Great Sadness
• Decreasing Social Interactions

Organization - S & S
• Resuming Old Patterns and Social Connections
• Trying New Behavior Patterns
• Finding Meaning in the Loss
• Exploring New Interests/Skills

Goal: Understand four generational lenses and how they may cope with change & loss
Legacy

Reflect on the tangible and intangible aspects of the legacy you have received. Then think about the legacy you want to pass on. Fill in the space with words and phrases, don’t bother with complete sentences!! Enjoy your reflection and lessons!

Identify legacies from your past:

What are the positive and negative aspects of these legacies:

List the legacies you would like to leave for future generations:

List the steps you will take to ensure that your legacy will actually be carried out:

How might legacies be viewed differently/same through Generational Lenses?
Virtual Class #2
Living with Chronic Disorders:
System Failures, Meds, & Labs
Check SacCT for
PowerPoint & Case Study materials.
Complete as Instructed and
No Personal Reflections for this Class
Common Cardiac Changes in Older Adults

- Systolic ejection murmur (affects 50% of elders – benign; diastolic murmur – significant pathological finding, needs follow-up)
- Heart borders hard to percuss (insignificant without other findings)
- Diminished/distant heart sounds (increased AP diameter of chest)

**** Note: No change in mean resting heart rate !! Maximum rate that can be achieved with activity is decreased

Age Related Changes

- Decreased cardiac output (1%/yr after 60)
- Decreased stroke volume
- Thickening L ventricular wall
- Stiffening of vasculature
- Increased peripheral resistance (1%/yr after 60)
- Altered conduction tissue
- Altered response to adrenergic stimulation
- Decrease baroreceptor response
- Veins thicken, fibrose, & dilate
- Dyspnea
- Fatigue
- Postural Hypotension
- Increased BP
- Isolated systolic HTN (normal diastolic, systolic >160)
- Slowed heart rate on exertion
- Palpitations/arythmias
- Varicosities, postural hypotension
- Peripheral edema

Functional Consequences of Cardiovascular Disease in Older Adults

- Atherosclerosis (narrowing of arteries leading cause of death in >65 year olds; 25% in <65 year olds)
- Decreased cerebral blood flow (decreased baroreceptor response & atheroclerosis)
- Decreased exercise performance (decrease in maximal attainable heart rate during intense exercise)
- Diminished adaptive response to intense exercise
- Increased BP (life style choices; systolic women steady til 50s, men til 40s: after that increases 5-8 mmHg/decade)
- Increased susceptibility to:
  - Arrhythmias, (conduction tissue changes) falls, postural hypotension, venous stasis (decrease in baroreceptors) & varicosities – (increased tortuosity & dilation of veins, decreased efficiency of valves)

Primary Cardiovascular Disorders

Coronary Artery Disease (CAD)
Heart Failure (HF)
(advanced) Congestive Heart Failure (CHF)
(life-threatening) End Stage Heart Disease (ESHD)

Myocardial Infarction (MI) ~ Heart Attack
Transient Ischemic Attack (TIA)
Cerebral Vascular Accident (CVA) ~ Stroke/Brain Attack
Factors Influencing BP in Older Adults
Older bodies are more sensitive to changes, and responses are more variable

Internal Factors Influencing BP in Elders
Caffeine
Food
Meds
Size of Cuff
Nursing Interventions ……

External Factors Influencing BP in Elders
Postural changes
Nursing Interventions ……

Body temperature may be lower when hot or very warm indoors (d/t changes in hypothalamus response)
Nursing Interventions ……

•120/80 for all ages (140/90 for elders is no longer acceptable)
•HTN is defined as ≥140/80 → goal = ≤140/80 for elders
•≥ 140 & ≤ 90-95 or when taking any antihypertensive med is termed Isolated systolic hypertension (ISH)
  –In recent years, it has been recognized that elderly patients will often develop a form of isolated systolic hypertension. Their systolic pressure becomes elevated as they age (because blood vessels become "stiff" with age,) but their diastolic pressures remain within the normal range.
  –Measurements are based on the average of two or more blood pressure readings at each of two or more visits after the initial screening.
  –Measurements must be taken with equipment that meets certification criteria, and in a standardized fashion. (www.nhlbi.nih.gov/guidelines)
•It is not uncommon in elders but should be watched for increases

Heart Failure (HF)
Heart failure affects over 5 million people in the United States.
With heart failure, the heart attempts to meet the energy demands of the body and may begin to compensate for lost pumping power. The heart muscle becomes enlarged and changes shape.

Heart Failure ~ Facts
Prevalence increases with age ~ 85% occurs in persons ≥ 65 years
Leading primary dx for hospitalization among Medicare beneficiaries
Mortality rates are 75- 84% in hospitalized new-onset heart failure patients
Self-monitoring weight & other S & S ~ increases patient’s control of disease and lessens their anxiety
The parameter for monitoring “worsening of heart failure” = wt gain + increase of adverse symptoms (SOB, congestion, edema)

Heart Failure
These changes can result in an uncoordinated (or unsynchronized) and inefficient heartbeat called “ventricular dysynchrony”. In a normal heart the two lower chambers, right and left ventricles, beat at the same time. With ventricular dysynchrony the ventricles are not effectively "synchronized." Ventricular dysynchrony may force the heart to work harder which can cause more heart failure symptoms.

Heart Failure ~ S & S
Symptoms help classify the severity of heart failure and monitor the effects of drug and/or device therapy.
Heart failure symptoms are not always apparent. Some people in the very early stages of heart failure may have no symptoms at all. And others dismiss getting tired and being short of breath as simply signs of growing older. But some symptoms are more obvious. When the heart is not pumping properly or efficiently, daily activity can cause shortness of breath or difficulty in breathing when lying down. The legs and ankles may swell because too much water is retained in the body. Feeling weak and tired is common. Ordinary daily activities like going to the grocery store or even walking up a flight of stairs become exhausting.
Heart Failure ~ S & S
Diastolic dysfunction
* normal ejection fraction with heart failure - S &S on x-ray (pleural effusion, vascular congestion)
• No standard treatment
• Avoid digoxin, lower systolic pressure as much as possible without adverse symptoms Systolic dysfunction
• Ejection fraction ≤ 40%
• Treatment = ACE inhibitors
End Stage Cardiac Disease
* Ejection fraction ≤ 20%

Brain Attack Stroke & Cerebral Vascular Accident (CVA) (NIA, 2004) Brain Attack ~ CVA ~ Stroke

Facts
• Leading cause of long term disability among adults
• 3rd cause of death
• Morbidity and mortality increase with age

Cerebrovascular accidents:
— affect cerebral circulation — usually through occlusive thrombi and emboli;
— less often from hemorrhage (intracerebral or subarachnoid space) that evolve over hours and are usually associated with headache. These are more life threatening. Important to know (use CT scan) - because tx is different

Brain Attack ~ CVA ~ Stroke

Terms
• Thrombus – a clump of platelets, fibrins, &/or cell parts that get attached to the inner wall of artery → blocks blood flow
• Embolus – air, gas, or tissue that moves around and then gets stuck in a blood vessel → blocks blood.
• TIA - blood vessel spasms in various parts of brain → blocks blood flow. These temporary disturbances that can last up to 24 hours.

Brain Attack ~ CVA ~ Stroke Types
* Thrombotic (consequence of atrial fib → predisposes to systemic emboli)
• Hemorragic (local bleed)
• Vascular dementia (VaD) → > common with hx of HTN, TlAs & stroke

Brain Attack ~ CVA ~ Stroke Risks
Greater incidence in men & African Americans
• Prior TIA, or stroke
• MI, rheumatic heart disease, hypertension, CAD, CHF, atrial Fib, hyperlipidemia, peripheral artery disease
• Diabetes
• Smoking, lack of exercise & obesity

Brain Attack ~ CVA ~ Stroke Functional Consequences
• Higher rates of stroke-related impairments (can be related to type 1 diabetes and hypertension in minorities as well as possibly poor access to care & less preventative teaching and interventions) (Shen, et al, 2004)
• Impaired walking, seeing, feeling, thinking. remembering, speaking. Being tearful is common!
**Brain Attack ~ CVA ~ Stroke Warning Signs (Call 911 immediately)**
Sudden numbness or weakness in the face, arm, or leg – especially on one side of the body
Sudden confusion, trouble speaking or understanding
Sudden problems seeing in one or both eyes
Sudden dizziness, loss of balance or coordination, or trouble walking
Sudden severe headache with no known cause

**Brain Attack ~ TIA ~ Mini-Stroke ~ Transient Ischemic Attack**
Same Warning Signs but they may only last a few minutes and go away
Still a medical emergency
Can be followed in a couple of hours with a stroke

**Brain Attack ~ CVA ~ Stroke Treatment**
Recovery is most successful if treatment starts within the first 3 hours after symptoms appear …
Use clot busting drug t-PA (only used for ischemic strokes caused by a clot); CT scan shows if t-PA is the right treatment
Drugs, PT, Speech Tx, OT

**Brain Attack ~ CVA ~ Stroke Lower Your Risk!!**
Control BP
Stop Smoking (helps at any age).
Exercise Regularly (biking, walking, swimming, gardening).
Eat Healthy Foods (low in fats, cholesterol, & saturated fatty acids. Include variety of fruits & vegetables.
Control Diabetes (an damage blood vessels leading to build up of fatty deposits in arteries – atherosclerosis – that narrows arteries and blocks blood flow (blocked artery leads to stroke)

**Primary Respiratory Disorders in Older Adults**
Pneumonia
Bronchitis
Chronic Obstructive Pulmonary Disease (COPD)
Tuberculosis (TB)
Common Respiratory Structural Changes in Older Adults
• Chest wall thickens
• Shortened thorax
• Kyphosis (increased curvature of cervical spine – rt decreased bone and respiratory muscle mass, or rickets, or TB of spine)
• Increased AP diameter
  Decreased intensity of lung sounds
  Increased resonance
• Lungs decrease (20%) in size
• Increased tendency for adventitious sounds at the lung bases maybe superimposed over normal breath sounds
• Sleep apnea

**Common S & S of Pneumonia in Older Adults**
Common S & S <65 years
SOB
Productive cough
Fever (>102)
Bloody sputum
Increased WBC count
Common S & S in > 65 year olds May have common signs, but ….usually not!
Lethargy
***Tachypnea
***Changes in mental status
Anorexia
Dehydration
Decline in overall functioning

Common S & S of TB in Older Adults
Common S & S< 65 years
Hemoptysis
Night sweats
Chest pain
More Commonly Seen 65 year olds (May have common signs, but ….usually not!)
Cough
Dyspnea
Not feeling hungry
Weight loss

Diabetes in Older Adults ~ Facts
With increasing age:
Body is less able to absorb glucose from the blood stream into the cells
Most typical symptoms (dizziness & frequent urination are often absent)
Other S & S go unnoticed or are misdiagnosed (related to meds or aging)

S & S of Diabetes in Older Adults Early General S & S
Polydipsia
Recurrent skin infections, UTIs, or slow healing sores
Parathesias, dysesthesias, polyesthisias
Muscle weakness, diarrhea, orthostatic hypotension, impotence, overflow incontinence.

Most Common > 65:
Mental confusion, weight loss, incontinence
Depression and cognitive impairments
Older adults who use insulin seem to have more problems with low blood glucose
Diabetes in Older Adults ~ Risks
Anyone over 45 and is overweight
People of color

Diabetes in Older Adults ~ Ethnic Risks
3rd leading cause of death
Native American & Alaska Native men & women 65+
4th leading cause of death
Hispanic men & women 65+
Asian & Pacific Islander women 65+
Black women 65+
5th leading cause of death
Black men 65+
6th leading cause of death
White, Asian, and Pacific Islander men 65+
7th leading cause of death
White women 65+
Common Adverse Drug Reaction (ADRs) in Elders – PowerPoint Notes

Identifying Ways You Can Help

ADRs ~ Background

• Contributing Factors making elders more at risk:
  – Coexisting Illnesses (co-morbidity)
  – Patient Expectations
  – Age-related Considerations

Coexisting Illnesses (co-morbidity)

• 80% < 65 have one illness, 50% have < one
Multiple meds to manage illnesses
Multiple providers → multiple prescriptions & lack of coordination/communication (Larsen & Hoot Martin, 1999)

Susceptibility to ADRs

Physiological Δs resulting from aging vary among elders

Body fat composition (muscle to fat ratio) Δ as people age

Protein binding affects drug effectiveness (↓ protein stores d/t poor nutrition Δs protein binding capacity
OR Polypharmacy (meds may compete for protein binding sites)

Any Δs that affect absorption, metabolism, and clearance of drugs (ie ↓ CO, GI motility, GFR)

Any Δs in sensory/cognitive perception (sedation, confusion) from potential side effects from antidepressants and anticonvulsants.

Patient Expectations

• Patients expect to get a prescription when they visit the NP/MD
  – 75% of visits usually result in getting one! (all ages)

• “Successful” NP/MD visit is linked with receiving a prescription (Larsen & Hoot Martin, 1999)

Age-related Considerations

• Number of prescription meds increase because:
  – Diminished physical activity & IADLs (disuse syndromes and illnesses) (Hanlon, Schmadel, Ruby, & Weinberger, 2001).
  – Changing pharmacokinetics (absorption, distribution, metabolism & excretion) → Δ how meds are absorbed into bloodstream
  – Δ ing proportions of fat (↑), lean tissue, muscle mass, SQ tissue, & body H₂O (↓) affect relationship of med concentration and solubility (Larsen & Hoot Martin, 1999).

Pain Assessment & Management

Statistics
LTC
~ 80% of elders living in have chronic pain

Community-dwelling elders:
~ 25-50% report pain
~ 28% of elders of color report pain
~ pain r/t physical limitations accounted for 17%


Lessons Learned: Living with Chronic Disorders ~ Systems Failures & ADRs
Case Study #2 Answer Sheet Template

**Chronic Disorders Powerpoint:**
What were your answers to each of the following slides?

# 7

# 8

# 9a

# 9b

# 35

# 40

**Case Study (include information from ADR ppt also):**
Identify 3 key assessment points you would use for this patient; include your rationale.
1. 
2. 
3. 
Identify 2 interventions for each of the above assessment points; include your rationale.
1. 
2. 
3. 
4. 
5. 
6. 

List 3 key teaching points for this client/family.
1. 
2. 
3. 

List 2 Community Agencies/Services you would refer this patient/family to; include contact information.
1. 
2. 

Name at least 2 Assessment tools (from consultgerin.org) you would use to assist you in caring for this patient/family; discuss why these specific tools would be beneficial.
1. 
2. 
3.
## Non Pharmacological Interventions

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Possible Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Exercise, relaxation, biofeedback, increase fluid, and fiber intake,</td>
</tr>
<tr>
<td>Stress Incontinence</td>
<td>Pelvic muscle exercises, biofeedback</td>
</tr>
<tr>
<td>Anxiety, Depression</td>
<td>Counseling, exercise, meditation, relaxation techniques, touch, music &amp; pet therapy</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Acupuncture, heat therapy, therapeutic exercise program, postural or alignment aids, touch, music and pet therapy</td>
</tr>
<tr>
<td>Chronic neuromuscular problems</td>
<td>Massage, body work, touch &amp; music therapy</td>
</tr>
<tr>
<td>Sleep problems</td>
<td>Relaxation, mediation, warm milk, go to sleep at same time, imagery, touch, pet &amp; music therapy</td>
</tr>
</tbody>
</table>
Cognitive Impairments: Memory Loss & Dementias
Personal Reflections ~ #6
Knowing yourself, what challenges will you have being around or working with (permanently or temporarily) cognitively impaired individuals?
What challenges should you assess in family members whose loved one is cognitively impaired?

Conclusions

Surprise!!
Myths Busted or ...
I didn’t know That!!

BPNI

Outcome
Aging, Memory Loss & Dementia ~ PowerPoint Notes

What is Normal & What is Abnormal?
Brain Imaging (PET)

Healthy Aging & Memory: What’s Needed to Make a Memory
• We only remember what stands out – what’s unusual, personally significant, unpredicted or what we intentionally memorize (Cohen, 2005)

• Memory is a phenomenon of association, of chemical and electrical patterns of connections between existing brain cells (neurons) and if these are lost, even tho’ new neurons are created, the memory is gone. So it’s not age but disease/trauma that is the major factor in memory ability!!

What’s Needed to Make a Memory
• Perceives something
  – Information is received through our senses:
    • Hearing, smell, taste, skin, sight – Brain decides to keep the information or not
• Encodes message
  – Hippocampus packages info for storing
• Store’s message
  – Stored as miniscule amount of chemicals & electricity (has weight)
• Retrieves message
  – gets info when necessary

Forgetting - it’s a Necessary Thing!!
• Brain sorts/prioritizes what needs to be stored
  – lots of data, ideas, experiences, feelings in our brains over time
• Forgetting allows brain to get rid of unneeded chemical weight
  – useless memories - allowing more space for more storing important info

How Memory Works: Organization of “Faculties”
► Orientation, Attention, & Registration
  ▪ I am Mary Jones. It is Thursday afternoon. I am in a classroom room. I hear a man speaking.

► Language
  ▪ Comprehension of written or spoken language.
  ▪ Ability to produce speech & writing

► Memory
  ▪ Working Memory
    ► Limited to only seven or eight numbers or words at a time, like a phone #, names of people in class
  ▪ Short-term Memory
    ► A holding area for recently acquired information (ie studying for the test). Limited capacity. If organized and rehearsed, information will be filed away as one of the following:

  ■ Long term Memory (huge capacity)
    ▪ Declarative
    ▪ Semantic
  ■ Well stored facts, concepts, vocabulary
  ■ Knowledge of the world – a bicycle is a two wheeled vehicle with pedals and a handlebar
Episodic
• Autobiographical for “life’s” episodes. Memories made within a context of time.
• Your last time on a bicycle.

Long term Memory can also be
• Procedural
• can be activated without conscious thought) ie coordinated muscle movement – riding a bike or piano playing
• Visual-spatial skills
• Cooking. Typing. Mowing the lawn. Tennis.
• Calculation
• To make change, balance a checkbook, determine a waiter’s tip
• Executive Control (in frontal lobes)
• Reasoning, judgment, abstract thinking, focus, shifting attention, personality
• Self-Regulation (in frontal lobes)
• Socially appropriate behavior. Control over impulses. Sexual modesty.

Memory & Healthy Aging Changes

Memory & Healthy Aging:
Beginning of Common Changes after 40

Reaction time slows some, (less White matter)

Some forms of memory decline while others become more robust! – human brains have no memory storage limit (like computers) Working memory capacity (like phone numbers) declines only ~ 10%

Experience rearranges connections  working memory - used like on a desktop, for a while; long-term memories are stored throughout the brain (explains why we lose some memories and not others!)

Multitasking is more difficult Retrieval slows down on “tip of tongue” (name & numbers, arbitrary facts like appointments, addresses, locations)

Insignificant Small Declines/Changes
• Overall processing speed slows down (fractions of seconds)
• Semantic memory doesn’t decline – actually often increases because of experience
• Word recognition/cued recall – usually same or increased (experience)
• Ability to recall facts/meaningful info – ie recall the gist of conversations, stories, more than discrete facts
• Sense of humor may change depending on health of areas of brain

Transition Between Normal (Healthy) & Abnormal Memory Loss - Mild Cognitive Impairment
Memory loss that is more than expected with age but spares other “insignificant changes” seen with aging (recall, semantic memory, etc.)
– DOES NOT interfere with ADLS

** Transition Between Normal & Abnormal Memory Loss

Significant Abnormal Memory Loss

Each Time We Meet
Maureen Manuge

Each time we meet, tell me your name.
I may not remember the last time you came.
Don’t call me honey, sweety, or dear ~ I’ve my own name since my birth year.
Am I wearing my glasses? Is my hearing aid in place?
Don’t forget my dentures, they give me a cheerful face 😊
Tell me what care you are going to do.
I don’t like to be surprised and I don’t want to hurt you!
Help me find the word I may forget.
Patience and understanding are what I hope to get. When I can’t remember what you said or what to do, show me and tell me in a word or two. If I’m in a bad mood and not easy to calm, leave me alone, turn on my favorite music ~ to me a soothing balm. Do not scold me for things I may do. Keep your sense of humor, I beg of you. Guide me when I’m lost ~ show me to my room. For a while, sit with me. Help me rid the mirage that mayloom. Smile as you talk to me gently, look me in the face. Please don’t forget my personal space. Help me keep my memories alive. Remind me of who I was. Show me faces of those I have loved. Let me tell you the story of my day, listen while I talk to you and validate what I say. Don’t talk about me when I am near. Being thought of as “not all there” is something I fear. When your words, I no longer understand, talk to me with your face and the touch of your hand. Once in a while give me a hug ~ I don’t know about you, but it’ll give my heart a tug.

**Causes of Abnormal Memory Loss**

Depression
Delirium
Small Strokes (TIAs)
Alcohol
Metabolic Diseases (severe thyroid, Vit B12 deficiencies & recurrent low blood sugar)
Brain Tumors (malignant or benign)
Brain Injuries/Trauma
Hydrocephalus
Infections: syphilis, HIV, Lyme disease, Jakob-Creutzfeld (similar to mad cow)

**Neurodegenerative diseases causing Dementias**

Abnormal Memory Loss - Significant Changes

- **Depression**
  - Memory loss is a cardinal feature of depression in elders

- **Delirium**
  - Acute confusion state
  - Recent onset
  - Fluctuates during the day
  - Wandering
  - Usually a medical cause

- **Strokes** ~ Small (TIA) and large strokes, damage from arteriosclerosis, deep in the brain

- **Alcohol** ~ From excess intake over the years

**Neurodegenerative Diseases Causing Dementias**

- Pick’s Disease
- Huntington’s Disease
- Jakob-Creutzfeld (similar to mad cow)
- Parkinson’s Disease
- Lewy Body Disease
- Vascular Dementia
- Alzheimer’s Disease
- Multi-infarct Dementia (VA + AD)
Abnormal Memory Loss - Diseases causing the dementia syndrome

**Neurodegenerative diseases**

**Pick’s Disease** (build-up of protein)
Pick's Disease causes a slow shrinking of brain cells due to excess protein build-up.
Patients initially exhibit marked early personality & behavioral changes - impulsive, obsessive, abrupt mood changes & decline in the ability to speak coherently.

**Huntington’s Disease** (build up of protein)
Slight personality changes, forgetfulness, clumsiness, gradual development of random, brief, “fidgeting” movements of the fingers or toes. Emotional or behavioral disturbances tend to develop gradually over time and may become apparent before or concurrent with the motor manifestations of HD.

**Creutzfeld-Jakob** (variant = mad cow)
Rapid dementia, unsteady gait & sudden jerky movements
About 10% of reported cases

**Parkinson’s Disease** (dopamine “shortage”)
Tremor or shaking when body is at rest. Confusion is later in the disease.
About 40% develop dementia late in the disease often show reduced facial expressions and speak in a soft voice. Occasionally, the disease also causes depression, personality changes, dementia, sleep disturbances, speech impairments, or sexual difficulties. The severity of Parkinson's symptoms tends to worsen over time.

**Lewy Body Disease** (build up of protein)
Looks like Parkinson’s disease, but confusion comes early and fluctuates.
Often has vivid dreams & delirium-like episodes
Hallucinations are always present

**Vascular Dementia** (injured area of brain)
Occurs after TIAs or Brain Attack/Stroke. **S&S:** Sudden onset & Identifiable CV risk factors

**Multi-infarct Vascular Dementia** (cell death at point of injury)
Multi-infarct dementia is the most common form of vascular dementia, and accounts for 10-20% of all cases of progressive, or gradually worsening, dementia. It usually affects people between the ages of 60-75, and is more likely to occur in men. It is caused by a series of strokes that disrupt blood flow and damage or destroy brain tissue. A stroke occurs when blood cannot get to part of the brain. Strokes can be caused when a blood clot or fatty deposit (called plaque) blocks the vessels that supply blood to the brain. A stroke also can happen when a blood vessel in the brain bursts. Common S & S confusion and problems with recent memory, wandering or getting lost in familiar places, moving with rapid, shuffling steps, loss of bladder or bowel control, laughing or crying inappropriately, difficulty following instructions, & problems handling money.

**Alzheimer’s Disease (AD)**
(protein fragments plaques - outside & around neurons & protein fiber tangles –inside nerve cells)
Memory loss (hypocampus) - 1st key symptom
Causing ~ 75-80% of dementias

Abnormal Memory Loss - Significant Changes

Dementia – a Syndrome
Not Normal Aging – It’s a syndrome of intellectual decline
- Impairment of multiple intellectual faculties and interfering with ADL/IADLs (cooking, shopping, bill paying, hygiene
- Persists over time
Multiple causes/co-morbidities

Incidence of AD

Aggregate 65+ = 1/8 have AD
(Sporadic – not necessarily hereditary – 50% chance)

< 65 years - 4% (early onset)
2% 65-74 years
19% 75-84 years
42% after 85 years
Estimated 18 million world wide
(AD Association 2008 data)

Alzheimer's Disease - Neurodegenerative disease

• Early Onset AD
  – 30-60 years of age
  – Rapid onset, progressive, extensive brain damage Length, 3-5 years
  – Chromosome 21 → develop AD
  – Length ~ 3-5 years

• Late Onset AD
  – 65-74 = 2%; 75-84 = 19%; 85+ = 42%
  – Gradual onset, progressive
  – Length ~ about 7 years from dx ~ range = 2-20 years

S & S of AD

• First Stage
  – Decreased Spontaneity, Initiative & Energy
  – Depression

• Second Stage
  – Requires some ADL help
  – Slower to understand
  – Less decision making ability
  – More self absorbed
  – Less sensitive to others

• Third Stage
  – Greater intellectual deficits
  – More personality changes
  – Short term memory failing
  – Long term memory clear

• Fourth Stage
  – Needs help with all ADLs
  – Doesn’t recognize family/friends
  – Babbles, is incontinent
  – Needs to be reminded to swallow
  – Common AD Progression (see handout)

Summary Key Points
Alzheimer's disease is a progressive, degenerative disorder that attacks the brain's nerve cells, or neurons, resulting in loss of memory, thinking and language skills, and behavioral changes.
Neurons, which produce the brain chemical, or neurotransmitter, acetylcholine, break connections with other nerve cells and ultimately die.

—ie: short-term memory fails when Alzheimer's disease first destroys nerve cells in the hippocampus, and language skills and judgment decline when neurons die in the cerebral cortex.

Two types of abnormal lesions clog the brain

—Beta-amyloid plaques—sticky clumps of “sand-like” protein fragments & cellular material that form outside and around neurons

—Neurofibrillary tangles—insoluble twisted fibers composed largely of the protein tau that build up inside nerve cells.

Current AD Drugs
Cholinesterase Inhibitors
Does not allow breakdown of acetylcholine ~ mediates some of the symptoms but does not cure disease

► 1993 - Tacrine (Cognex)
  • 4x daily
  • High incidence of N & V
  • NOT USED NOW

► 1996 – Donepezil (Aricept)
  • QD
  • Less incidence of N & V

Current AD Drugs
Cholinesterase Inhibitors ~ con’t
► 2000 – Rivastigmine (Exelon)
  • Mild → moderate disease
  • BID
  • Generalized GI S & S; insomnia & dizziness

► 2001 – Galantamine (Reminyl)
  • Mild → moderate disease
  • BID
  • S & S similar to Excelon

Current AD Drugs
► 2004 – Memantine (Namenda)
Need glutamate to form memories too much glutamate = cell injury (has been used to tx Parkinson’s & other dementias)
  • Moderate → severe disease (MMSE = 10-20)
  • BID
  • Less N & V; > CNS S & S esp. agitation, depression, some psychosis

Future Drug Trends ~ 2008
Ginko Biloba - No empirical evidence but it maybe r/t antioxident effects
Vaccine - Worked in mice models but not humans – caused autoimmune response
Statins - Being studied but no empirical evidence yet – maybe r/t lowering of cholesterol effects decreasing comorbidity with vascular issues

Med Goal: Support independence and compress morbidity

Benefits:
Improvement in ADL abilities
Two (2) year benefit seen at this time

Limitations:
Side effects may outweigh benefits
Does not cure disease
Immediate return to baseline ADL behaviors with withdrawal of meds

Current Thinking:
Start early (low doses) at dx to stabilize ADLs
Start when MCI is suspected/diagnosed (before behaviors occur)
Switching drugs may enhance effects
Stop drugs when there is loss of independence
Our Mission: It should be the function of all health care professionals to help people die young, as late in life as possible!!

Additional:
Diseases Causing the Dementia Syndrome
Abnormal Memory Loss Diseases causing the dementia syndrome
Metabolic diseases & Cancer
●Metabolic disorders
●Severe thyroid deficiency
●Vitamin B12 deficiency
●Recurrent low blood sugar episodes
●Cancer
●Brain tumors malignant or benign ("meningioma" tumor of brain lining may be present for years)

Abnormal Memory Loss Diseases causing the dementia syndrome - Head Injury & Hydrocephalus
●Brain Injury
  * Contusions, “subdural hematoma” (blood between skull & brain)
  ●Hydrocephalus
   * Abnormal swelling of the fluid chambers (deep in brain)
   ** Common S&S: Small-stepped, awkward gait, loss of bladder control

Abnormal Memory Loss Diseases causing the dementia syndrome - Infections
●Varieties
●Syphilis
●HIV (AIDS)
●Lyme disease
●Jakob-Creutzfeld (similar to Mad cow)

Do's & Don'ts for Managing Patients with Dementia
● Do’s
  ●Stay calm, be consistent, look for patterns of behavior
  ●Watch for signs of frustration
  ●Give short, one sentence explanations
  ●Allow time for comprehension, then triple it!
  ●Repeat instructions exactly the same way
  ●Avoid insistence – try again later
  ●Agree or distract with different subject/activity
  ●Accept blame (even if fantasy)
  ●Leave room to avoid confrontation
  ●Respond to feelings rather than words he/she is saying
  ●Be patient, cheerful, & reassuring – go with the flow

Do's & Don'ts for Managing Patients with Dementia ~ con’t
●Don’ts
●Don’t try to reason
●Don’t argue
●Don’t confront
●Don’t remind them they forget
●Don’t question recent memory
●Don’t take it personally
6 R's of Behavior Management
- **Restrict**: Try to get them to stop what they are doing ~ calm voice, simple commands
- **Reassess**: Determine cause of behavior; what happened right before? Physical problem? Can it be removed/mitigated?
- **Reconsider**: Person’s point of view What are they thinking?
- **Re-channel**: Find ways to safely continue behavior or think of other ways to rechannel energy to another activity. Remember we don’t know why this is important to them but it is!
- **Reassure**: That things are ok and you’ll take care of them
- **Review**: What will you do when it happens again? Acknowledge behavior is symptom of the disease – not you! Realize the solution MAY be meds!

Types of Wanderers - *How Can You Work with Them?*
- Exit Seeker -> Specific goal – leave building/house
- Pacer -> Excess energy – needs room to move/roam
- Explorer -> Needs stimulation, likes to touch things because they are there
- Follower -> Looking for personal contact, does so because others do

**IMPAIRED COGNITIVE FUNCTIONING**

| DEMENTIA | • Progressive impairments in cognitive functioning  
|          | • Persistent decline in 2 or more acquired intellectual functions while still having a stable level of consciousness |
|          | **PERMANENT** |

| PSEUDO DEMENTIA | • Used in reference to depression or other physiologic conditions that look like dementia (ie med induced) |
|                 | **TOTALLY OR PARTIALLY REVERSIBLE** |

| DELIRIUM | • decreased level of alertness and attention along with thinking, psychomotor, memory and perception deficits  
|          | • often seen in hospitalized patients  
|          | • high risk factors = infection, prior cognitive impairment, fracture on admission, > 80 years of age, narcotic medications. - **ACUTE CONFUSIONAL STATE** |

**VASCULAR DEMENTIA VS ALZHEIMER’S DISEASE**

| VASCULAR DEMENTIA | ALZHEIMER’S DISEASE |
|                  | slow onset |
| sudden onset | stepwise progression of behaviors | vacillating progression of behaviors |
| stepwise progression of behaviors | can trace manifestations to specific parts of the brain | only verified on autopsy |
| can trace manifestations to specific parts of the brain | associated with identifiable risk factors (ie smoking, HTN, hyperlipidemia, previous CVAs, C.V. pathology, sedentary lifestyle) |

**FUNCTIONAL CONSEQUENCES OF ALZHEIMER’S DISEASE**

- Cognitive declines are progressive
- Emotional responses & behavioral changes occur as cognitive deficits increase
- The longer the person has AD ---> the more the person is influenced by the environment
Theories of Causes of Alzheimer's Disease (AD)

Amyloid hypothesis (excessive amts of B-amyloid in neuritic plaques & blood vessel walls)
Neurotransmitters (Cholinergic) hypothesis [loss of serotonin receptors and < serotonin into platelets, < acetylcholine production & reduction in production of acetylcholinesterase and choline acetyltransferase (possibly = impaired memory and < cognitive functioning)]
Genetic: Chromosome 19 (late onset), & 14 & 21 (early onset)
Multiple neurotransmitter deficits
Aluminum and other toxic exposure
Infectious and inflammatory
Post traumatic
Vascular abnormalities
Oxidative mitochondrial deficits
Accelerated aging/decreased plasticity

Alzheimer’s (AD) Cognitive Clinical Features versus Common Aging Cognitive Changes

<table>
<thead>
<tr>
<th></th>
<th>Common</th>
<th>AD</th>
</tr>
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<tbody>
<tr>
<td>Attention Span</td>
<td>Ability to pay attention to two things at once</td>
<td>decrease</td>
</tr>
<tr>
<td>Memory</td>
<td>Learning function</td>
<td>takes longer to learn/remember</td>
</tr>
<tr>
<td></td>
<td></td>
<td>but retention same as for younger person</td>
</tr>
<tr>
<td>Language</td>
<td>Production, comprehension, flexibility</td>
<td>vocab. improves naming may decline</td>
</tr>
<tr>
<td>Visuospatial Skills</td>
<td>Copying/reproducing what is seen</td>
<td>slower but able to replicate correctly</td>
</tr>
<tr>
<td>Reasoning &amp; Problem Solving</td>
<td>Critical thinking/problem solution</td>
<td>increases d/t experience; decrease in abstraction ability; decrease in proverb understanding</td>
</tr>
</tbody>
</table>

Note: Very early stages of AD look like common characteristics of aging
COGNITIVE IMPAIRMENTS (Welfare and Institutions Code section 14522.4)

“Cognitive impairment” is “the loss or deterioration of intellectual capacity characterized by impairments in short- or long-term memory, language, concentration and attention, orientation to people, place, or time, visual-spatial abilities or executive functions, or both, including, but not limited to, judgment, reasoning, or the ability to inhibit behaviors that interfere with social, occupational, or everyday functioning due to conditions, including, but not limited to, mild cognitive impairment, Alzheimer’s Disease or other form of dementia, or brain injury.”

Stage 1: No cognitive impairment
Unimpaired individuals experience no memory problems and none are evident to a health care professional during a medical interview.

Stage 2: Very mild decline
Individuals at this stage feel as if they have memory lapses, forgetting familiar words or names or the location of keys, eyeglasses or other everyday objects. But these problems are not evident during a medical examination or apparent to friends, family or do-workers.

Stage 3: Mild cognitive decline
Early-stage Alzheimer’s can be diagnosed in some, but not all, individuals with these symptoms. Friends, family or do-workers begin to notice deficiencies. Problems with memory or concentration may be measurable in clinical testing or discernible during a detailed medical interview. Common difficulties include:

- Word- or name-finding problems noticeable to family or close associate
- Decreased ability to remember names when introduced to new people
- Performance issues in social and work settings noticeable to others
- Reading a passage and retaining little material
- Losing or misplacing a valuable object
- Decline in ability to plan or organize

For purposes of CBAS eligibility, participants classified as having mild to moderate Alzheimer’s disease or other dementia must have the symptoms seen below or be characterized by the descriptors of, or equivalent to, Stage 4 as seen below.

Stage 4: Moderate cognitive decline
(Mild or early-stage Alzheimer’s disease) At this stage, a careful medical interview detects clear-cut deficiencies in the following areas:

- Decreased knowledge of recent events
• Impaired ability to perform challenging mental arithmetic. For example, to count backward from 100 by 7s.
• Decreased capacity to perform complex tasks, such as marketing, planning for dinner guests, or paying bills and managing finances
• Reduced memory of personal history
• The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations.

For purposes of CBAS eligibility, participants classified as having moderate to severe Alzheimer’s disease or other dementia must have the symptoms seen below or be characterized by the descriptors of, or equivalent to, Stages 5, 6, and 7 as seen below.

Stage 5: Moderately severe cognitive decline
(Moderate or mid-stage Alzheimer’s disease) Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential. At this stage, individuals may:

• Be unable during a medical interview to recall such important details as their current address, their telephone number, or the name of the college or high school from which they graduated
• Become confused about where they are or about the date, day of the week or season
• Have trouble with less challenging mental arithmetic; for example, counting backward from 40 by 4s or from 20 by 2s
• Need help choosing proper clothing for the season or the occasion
• Usually retain substantial knowledge about themselves and know their own name and the names of their spouse or children
• Usually require no assistance with eating or using the toilet

Stage 6: Severe cognitive decline
(Moderately severe or mid-stage Alzheimer’s disease) Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with daily activities. At this stage, individuals may:

• Lose most awareness of recent experiences and events as well as of their surroundings
• Recollect their personal history imperfectly, although they generally recall their own name
• Occasionally forget the name of their spouse or primary caregiver but generally can distinguish familiar from unfamiliar faces
• Need help getting dressed properly; without supervision, may make such errors as putting pajamas over daytime clothes or shoes on wrong feet
• Experience disruption of their normal sleep/waking cycle
• Need help with handling details of toileting (flushing toilet, wiping and disposing of tissue properly)
• Have increasing episodes of urinary or fecal incontinence
• Experience significant personality changes and behavioral symptoms, including suspiciousness and delusions (for example, believing that their caregiver is an impostor): hallucinations (seeing or hearing things that are not really there); or compulsive, repetitive behaviors such as hand-wringing or tissue shredding
• Tend to wander and become lost

Stage 7: Very severe cognitive decline
(Severe or late-stage Alzheimer’s disease) This is the final stage of the disease when individuals lose the ability to respond to their environment the ability to speak, and, ultimately, the ability to control movement.
• Frequently individuals lose their capacity for recognizable speech, although words or phrases may occasionally be uttered. Individuals need help with eating and toileting and there is general incontinence
• Individuals lose the ability to walk without assistance, then the ability to sit without support, the ability to smile, and the ability to hold their head up. Reflexes become abnormal and muscles grow rigid. Swallowing is impaired.

COMMON CAUSES OF DELIRIUM
Adapted from: American Family Physician (1994), 50(6).

Drugs
- Alcohol & sedative-hypnotics (intoxication and withdrawal)
- Anti convulsants
- Antidepressants
- Antihypertensive drugs
- Antiparkinsonian drugs including amantadine (Symmetrel)
- Corticosteroids
- Digitalis
- Histamine H2 receptor antagonists
- Narcotics
- Phenothiazines

Infections
- Meningitis
- Pneumonia
- Sepsis
- Pyelonephritis

Cardiac illness
- Arrhythmias
- CHF
- MI

Metabolic disturbances
- Fluid & electrolyte disturbances
- Hypercalcemia
- Hyperglycemia & hypoglycemia
- Hypoxia
- Liver failure
- Renal failure

Central nervous system disorders
- Epilepsy
- Vascular injury

Neoplasms
- Metastases to brain
- Primary brain tumors

Urinary retention/fecal impaction

Trauma
- Anesthesia
- Burns
- Fractures (especially hips)
- Surgery
- Location change
- Hospitalization (especially intensive care)
Caregiving Relationships: Self & Professional Aspects
Personal Reflections ~ #7
What are some differences between family/friend & professional caregivers?
What will you do to help yourself to ward off caregiver burnout?

Conclusions

Surprise!!
Myths Busted or ... I didn't know That!!

BPNI

Outcome
An Example of How a Person’s Life Can Change with the Responsibility of a Dependent Loved One

Draw your 24-hour Day as it would be today

Draw Your 24-hour Day as it would be today with Caregiving

Draw your 24-hour Day During a Vacation-time

Draw your 24-hour Day During a Vacation-time with Caregiving
A CAREGIVER’S BILL OF RIGHTS

I HAVE THE RIGHT

•• to take care of myself. This is not an act of selfishness. It will give me the capability of taking care of my disabled relative.

•• to seek help from others even though my relative may object. I recognize the limits of my own endurance and strength.

•• to maintain facets of my own life that do not include the person I care for, just as I would if he or she were healthy. I know that I do everything that I reasonably can do for this person, and I have the right to do some things just for myself.

•• to get angry, be depressed, and express other difficult feelings occasionally.

•• to reject any attempt of my relative (either conscious or unconscious) to manipulate me through guilt, anger or depression.

•• to receive consideration, affection, forgiveness, and acceptance for what I do for my loved one for as long as I offer these qualities in return.

•• to take pride in what I am accomplishing and to applaud the courage it has sometimes taken to meet the needs of my relative.

•• to protect my individuality and my right to make a life for myself that will sustain me in the time when my relative no longer needs my full time help.

•• to expect and demand that as new strides are made in finding resources to aid physically and mentally impaired older persons in our country, similar strides will be made toward ailing and supporting caregivers.

•• to ______________________________________________________
  __________________________________________________________
  __________________________________________________________
  __________________________________________________________.

Adapted from Elaine M. Brody’s, Women in the middle.
FOUR STAGES OF CAREGIVING (Hipskind & Brown, 1999)

Stage 1 - The Anticipatory Caregiver

**Characteristics**
- No immediate crisis
- Looking forward to a time caregiving will be needed
- Some small ADLs/IADLs have shifted (need some help with finances, shopping, keeping clothes clean/making beds)

**Actions**
- Get legal documents in place
- Look at finances
- Investigate home/community-based services
- Identify/know health care professionals/
- Know meds taken
- Be realistic (expectations) & talk about it

**Common Blocks**
- Don’t know what questions to ask/how to ask
- Can’t tell fact from myth
- Can’t envision contingencies

**Keys for Success**
- Learn what Normal aging FOR THIS PERSON is
- Learn about services/diseases

Stage 2 - The Freshman Caregiver

**Characteristics**
- Level of involvement increasing
  - Six to eighteen months
  - From household help to hands on care

**Actions**
- This is a mutual process
- Learn more about care recipient’s condition
- Learn new skills
- Join a support group
- Remember the caregiver
- Use community resources (oversee care given by others)
- Know what loved one’s wishes are

**Common Blocks**
- Unrealistic expectation
- Acting FOR loved one and not WITH them
- Feeling only they can do it

**Keys for Success**
- Learn, learn, learn
- Let care recipient participate in decisions
- Involve other family members (all levels of care)
- Know what person values in life and in dying process (be sure other family members know)
Stage 3

**CHARACTERISTICS**
Precarious position at the point
The Entrenched Caregiver
- Two to seven (+) years
- Daily or constant involvement
- Mixed emotions
- Fatigue
- Melancholy
- Day is structured to life with them/visit

**ACTIONS**
Focus on the caregiver - entrenched in present
The Entrenched Caregiver
- Determine limits
- Take regular breaks, accept respite
- Develop/call on support network
- Record changes in loved one’s health/condition

**COMMON BLOCKS**
Come from exhaustion & unresolved issues
The Entrenched Caregiver
- To tired to give good care
- Can’t count on friends and family
- Losing sight of own needs
- Unresolved anger
- Feeling lack of appreciation

**KEYS FOR SUCCESS**
Direct away from exhaustion/issues - refer to pastor, counselor etc to regain sense of balance
The Entrenched Caregiver
- Find/access respite care
- Talk with counselor/clergy
- Reduce anxiety with exercise
- Watch unhealthy habits
- Keep a sense of balance & humor
- Learn forgiveness

Stage 4

**CHARACTERISTICS**
Change in role as caregiver
The Caregiver in Loss
- Two to seven (+) years
- Significant change in caregiving role

**ACTIONS**
OK to grieve
The Caregiver in Loss
- Allow time for grief & mourning
- Keep memories of loved ones at hand & cherish them
- Think back on caregiving with pride
- Share experiences with other caregivers
- Acknowledge that you made the best decisions at that time

**COMMON BLOCKS**
Come from exhaustion & unresolved issues
The Caregiver in Loss
- Denying feelings
- Discounting/cutting short feeling the feelings
- Not allowing enough time for grief: “put on a happy face for family/society

**KEYS FOR SUCCESS**
Direct away from exhaustion/issues - refer to pastor, counselor etc to regain sense of balance
The Caregiver in Loss
- See a professional bereavement counselor
- Let memories bring peace and comfort
- Make time for self reflection
- Use support groups/talk individually
- Journal about your experiences
Family Caregiver Survey Advice for Professionals
(Hipskind & Brown, 1999)

Recognize we’re caregivers, even in beginning stages
Be empathetic and have a caring attitude
Forgive me when I’m crabby
Listen to the patient
Reinforce and praise
Be patient with us - often it’s very new!
Remember, our loved ones we not always this way
Take time to explain
Be sympathetic - It’s a hard job!
Mind caregivers’ well being and budget
Don’t dismiss caregiving situation with offhand advice
Remember caregivers are learning on the job - help them succeed
Help caregivers to find meaning in daily changes and guide them
Help them to see the past as well as today

CAREGIVER BURDEN
“Physical, psychological or emotional, social and financial problems that can be experienced by family members caring for impaired older adults.” (George & Gwyther, 1986; Zarit, 1980)

Incidence:
80-90% of the care given to dependent adults in the community is given by family and friends, especially middle aged women.

Functional Consequences (negative)
privacy infringement
decreases in social contact
loss of income and assets
increases in levels of family conflict and distress
little or no time for personal or recreational activities
increases use of alcohol and psychotropic drugs
changes in living arrangements (usually sharing households)
increases in likelihood of decreasing or giving up job responsibilities’
increases in risk of clinical depression
increases in feelings of anger, guilt, anxiety, grief, depression, helplessness, chronic fatigue & emotional exhaustion
poorer physical health with greater frequency of stress-related illness & injuries

Functional Consequences (positive)
drawing families closer together
making a difference in appropriate and high quality care
companionship
financial assistance
gaining a broader perspective on stressor
increasing understanding of the care recipient
increasing feelings of usefulness and self worth
improving relationship between care giver and care recipient
Caregivers’ Advice – PowerPoint Notes  
King, R.B & Semik, P.E (2006)

**Preparation for Caregiving**
- Get lots of professional advice. Find out everything you can
- Go to workshops, get family counseling
- Figure out what works for you
- Be a patient advocate
- Be sure what you do is right so you won’t feel guilty
- Talk to people in the same situation
- Join support groups to get information from those going through what you are.

**Enhancing Survivor’s Function**
- Put yourself in their place (< anger)
- Get checkups 1X/yr
- Be supportive and show love
- Let them get on with their life – don’t be judgmental
- Stand by your spouse – give encouragement & hope but let them know it will be difficult
- Keep them going – be persistent even if they get angry at you
- Have people in – they’ll overcome fear of going out
- Don’t hold them back – treat with respect … leave them to be independent
- Don’t talk for them; don’t yell at them
- Trust them they can help you!
- Don’t give up on what you believe; videotape progress so they can see too.

**Sustaining the Self & Family**
Leave room when frustrated; take time out; accept their fickleness
- Get used to the mood swings; don’t go to bed mad
- Have patience & love
- Be flexible, it may work another day
- Enjoy each day; keep mind active
- Relax & do what you can; the best you can ~ it gets better after awhile. Don’t give up!
- Be positive, don’t dwell on negatives
- Use others to help you
- Trust in God
- Have people around you that you can count on who don’t make you feel guilty
- Accept help. Don’t be ashamed to ask for it either!
- Get help – have them do the legwork
- Talk with friends or support group especially those in similar situations
- Take advantage of your support network. They will keep you strong!

**Barriers and Solutions to Accessing Senior Services ~~~ Literature**

<table>
<thead>
<tr>
<th>Common Barriers</th>
<th>Common Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of transportation</td>
<td>Community transportation services</td>
</tr>
<tr>
<td></td>
<td>Public transportation</td>
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<td></td>
<td>Family and friends</td>
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<table>
<thead>
<tr>
<th>Chronic Illness</th>
<th>Management of illness</th>
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<tr>
<td></td>
<td>In home services</td>
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<table>
<thead>
<tr>
<th>Financial Limitations</th>
<th>Government programs</th>
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<tr>
<td></td>
<td>Non profit organizations</td>
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### Knowledge of Services Available

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<thead>
<tr>
<th>Category</th>
<th>Community outreach programs</th>
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<tr>
<td></td>
<td>Advertising</td>
</tr>
<tr>
<td></td>
<td>Referrals</td>
</tr>
<tr>
<td>Vision Impairments</td>
<td>In home services</td>
</tr>
<tr>
<td></td>
<td>Public assistance</td>
</tr>
<tr>
<td></td>
<td>Family assistance</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>Senior outreach organizations</td>
</tr>
<tr>
<td></td>
<td>Family support</td>
</tr>
<tr>
<td>Depression</td>
<td>Counseling centers/hotlines</td>
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<td>Family assistance</td>
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<tr>
<td>Fear of Leaving the Home</td>
<td>In home services</td>
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<td></td>
<td>Visiting Nurses Association</td>
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<tr>
<td>Hearing Impairments</td>
<td>In home services</td>
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<tr>
<td></td>
<td>Public assistance</td>
</tr>
<tr>
<td></td>
<td>Family assistance</td>
</tr>
<tr>
<td>Lack of Social Support</td>
<td>Community support groups</td>
</tr>
<tr>
<td></td>
<td>Senior outreach organizations</td>
</tr>
</tbody>
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(Area 4 Agency on Aging, 1996; Clark, et al., 1997; Friedrichs-Fitzwater & Bisset-Grady, 1998; LaVeist, et al., 1997; Neeld, 1998; Osborne, 1998; Spaid, 1998)

### Caregiver Needs

**Caregiver Needs Literature**

(Osborne, 1998, 2007)

- Education about the ailment
- Time to themselves
- Vacation
- Someone to confide in
- Companionship
- Friendship
- Guidance
- Assistance
- Adequate Transportation
- Patience

### Caregiver Needs CONCLUSIONS

1. Need to develop sensitivity for older adults and their family caregivers - it’s where the care is being given.
2. Caregivers’ solutions for meeting their needs center around socialization/support.
3. Caregivers frequently sacrifice themselves for their loved ones - health is often affected - need frequent assessment and intervention for caregivers along with care recipients.
4. Education is desirable if the individuals can get the information - transportation needs, respite needs, classes with care provided, web access, written materials provided.
5. Finding reliable alternate caregivers is very difficult - need to develop centralized, monitored referral to expedite getting help.
6. Respite care for all is badly needed to address loss of independence, fatigue, depression, isolation, lack of support. Find/develop more programs such as Faith in Action Project that would help older adults accept care, as they have ties to a particular community.
Caregiver Strain Questionnaire
Say: I am going to read a list of things which other people have found to be difficult in helping out after somebody comes home from the hospital. Would you tell me whether any of these apply to you? (Yes/No)
(Examples are in ( ) to cue the caregiver, if needed. Be prepared to share community agency resources with the caregiver).

Yes = 1
No = 0

1. Sleep disturbed
   (because ___ is in and out of bed, wanders, needs assistance with medications, voiding).
   1  0

2. It is inconvenient
   (because helping takes so much time or because you have to drive over to help).
   1  0

3. It is a physical strain
   (because of lifting in and out of a chair; a lot of effort or concentration is required).
   1  0

4. It is confining
   (because helping restricts your free time or you cannot do what you desire doing).
   1  0

5. There have been family adjustments
   (because helping has disrupted routines; there has been no privacy).
   1  0

6. There have been changes in personal plans
   (had to turn down a job; could not go on vacation).
   1  0

7. There have been other demands on your time.
   (from other family members).
   1  0

8. There have been emotional adjustments
   (because of severe arguments).
   1  0

9. Some behavior is upsetting ...
   (because of incontinence, trouble remembering things, or accuses people of taking things).
   1  0

10. It is upsetting to find that ____ has changed so much from his/her former self
    (he/she is a different person than he/she used to be).
    1  0

11. There have been work adjustments
    (because of having to take time off).
    1  0

12. It is a financial strain.
    1  0

    (because of worry about ____; concerns about how you will manage).
    1  0

Total Score (Count the "Yes" responses)

> 4 indicates strain

GLENN’S PERSPECTIVES ON GRACE
Observation Sheet

What does Glenn do to cope on a daily basis?

What are some of the concerns of caregivers?

What support systems help Glenn to “keep going”?

How does Glenn’s outlook affect his care of Grace?

What can you, as nurse or friend, do to help family members to manage their lives?

How does this video make you feel?

What thoughts will you take with you from this video?
    Negative?

    Positive?

How will you use it in your nursing practice and/or life?
Notes from a Family Caregiver
By Glenn Kirkland

Tips for Caregivers

Developing Empathy
• Ask yourself how you would feel if you did not know where you were, what time it was, or who was talking with you. How would you feel if you could not completely understand what was being said?

Utilizing a Positive, Problem-Solving Approach
• As a caregiver, try not to see difficulties as problems but as challenges. Look for innovative ways to deal with these challenging situations.

Making the Patient Feel Good
• We often forget the dementia patient has feelings. Like anyone else, the patient likes to be thanked and commended for a good job.
• Encourage self-esteem by setting up situations so that the patient can be successful.
• Find ways to make the patient smile and laugh.

Activities of Daily Living
• Keep the patient involved in activities of daily living, and helping around the house.
• Break down tasks in single steps. Try to arrange things in simple steps so that the patient can feel good about continued involvement. Everyone enjoys helping and participating.

Avoiding Stress
• Avoid overstimulation.
• Avoid asking the patient to do something that he or she cannot do.
• Eliminate surprises. Let the patient know what you are doing. For example, if a bath is stressful, gently explain what you are doing during the bath.

Reality Orientation
• Keep clocks and large calendars visible.
• Write the date on a chalkboard.

Environmental Safety
• Remove knobs from gas stove.
• Remove loose throw rugs.
• Remove all poisonous materials from the home or place them where they're inaccessible.
• Install safety features such as nightlights, a railing in the bathtub, and railings on all stairs.

Simplification
• To insure that the patient does as much as possible, simplify the daily routine and activities of daily living.
• Choose clothes that can be easily fastened.

Maintain a Daily Routine
• Observe the patient. Some will do better in the morning; others will be better in the evening.
• Develop a schedule so that the most challenging needs of the day can be accomplished when the patient functions best.
• As soon as incontinence becomes a problem, schedule regular visits to the bathroom.
• Keeping to a routine provides a reassuring structure to the patient and reduces anxiety.

Caregiver Guilt
• If you have not responded well to a situation, don’t dwell on it. You will have repeated chances to try again.

Caregiver Health
• As a caregiver, you must also remember to take care of yourself.
• It is important to relax, get exercise, eat well, and do things for yourself.
• Arrange for regular respite care.

Caregiver Support
• There are times when every caregiver needs a shoulder to cry on. Do not be ashamed to do so.
• Join a support group. Share your problems with others in the same situation. Learn from their experiences. It is very important to talk about your problems.
• Contact community agencies. Try to find housekeeping services, respite care services, adult day care and other services which will enable you to have some free time.

Financial and Legal Counsel
• As soon as possible after diagnosis, get legal and financial counsel.
Nursing Home/Foster Home Placement
• Placement of the patient in a nursing home or foster home is not an easy matter for any family
caregiver. It is a difficult decision that each caregiver must face individually. As the disease progresses
the time may come when it is no longer possible to care for the family member at home. Before this time
comes, know what resources are available in your community.

Challenging Situations and Potential Solutions
Repeated Questioning
• Ask the patient to write down the answer you give, then just point to it, each time the question is asked.
• Ask the patient to keep repeating the answer.
• Use your imagination and make up a poem, rhyme or verse to a song, which gives the answer to the
question. Recite or sing the response each time the question is asked. Amuse yourself with your creativity
rather than getting annoyed.

Incessant Wandering
• Exercise is beneficial; try to see wandering from this perspective.
• Restrict the area of movement for safety. Doors may need to be shut or locked so that the patient does
not wander into situations that may have some potential hazard. Flexible gates, normally used for infants,
can be installed well above floor level. Patient should be able to see gate to prevent falls.
• When necessary, restrict wandering by using a bean bag chair or other type of chair from which it is
difficult to get up.
• Have the patient wear an ID bracelet with name and phone number as well as information about the
disability at all times, in case precautions for wandering outside of safety areas fails.

Communication Breakdown
• Use simple language.
• Although you do not want to talk down to the patient, you may be able to facilitate communication by
simplifying your language.
• Use short one-thought sentences.
• Speak slowly.
• When trying to find out something from the patient, it is often useful to ask questions with yes-no
answers if the patient is having difficulty speaking.
• Even though the patient may have only minimal apparent problems in speaking and understanding,
using the telephone may be difficult. Recording devices can be placed on the phone to record both sides
of a conversation; an answering machine can be used to receive messages.
Sleeplessness

It appears that as the disease progresses, the biological clock does not function appropriately, resulting in sleeplessness at night.

• Use soft music or "white or pink noise" produced by electronic devices to induce sleep.
• Provide extensive exercise during the day.
• Do not allow cat naps during the day.

Fear of Being Left

Patients often get extremely restless when their family caregiver is out of sight.

• Try placing a large chalkboard in a prominent place. Leave a note indicating when you will be back.

Lack of Response or Inappropriate Response

As the disease progresses, it is often necessary to give the patient directions to facilitate personal hygiene, dressing, eating, or other ADLs. Frequently the patient will respond or will appear to refuse to cooperate.

• Do not argue; but do not accept "no" for an answer. Continue as if the patient will comply. Use "gentle" repetition and give physical assistance as needed.
• At an impasse, do not argue; Stop. Try again in several minutes.
• Do not raise your voice; do not shout. This will only make the patient more anxious or alarmed.
• If the patient shouts, lower your voice to a very gentle, reassuring tone.

Crying, Emotional Labiality and Fear

You may not know the cause of crying outbursts, but the reasons are important.

• It is important to reassure the patient.
• Respond with verbal kindness and gentleness as well as a pat or a hug to clearly show your concern and empathy.
• Do not attempt to reason with the patient.

Loud Talking or Shouting

Anxiety or fear often lead to loud talking or shouting.

• Lower your voice in response to this elevated level of talking.
• Never shout back.

Notes for Health Professionals

Establishing Rapport with the Patient

• Take time to let the patient get to know you.
• Frequently remind the patient who you are and what you’re doing.
• Have a person who is familiar to the patient present during assessment or treatment. This person’s support and reassurance may enhance patient compliance.
• Speak gently and calmly if the patient becomes anxious or fearful.

Assessment/Evaluation
• Patient assessment or evaluation may be very difficult. The patient may not be able to understand or respond to instruction. Allow an extended amount of time for the assessment. Multiple visits may be necessary before all essential information is gathered.
• Instructions should be very simple and should allow for one patient response at a time. Repeat instructions as necessary.
• Initial clinical findings may be incomplete or inaccurate because of the patient’s inability or unwillingness to follow instructions. Reassessments may be required in order to complete exams or to insure the reliability of earlier findings.
• Subjective complaints, or more specifically, their exact nature may be difficult to elicit.

Treatment Goals
• Realistic or practical treatment goals must be established that accommodate the needs and constraints of the family or caregiver.
• Treatment goals must ensure the safety or the patient and of the caregiver.
• Keep the patient functional in ADLs for as long as possible.

Treatment
• Whenever possible, the same person(s) should be responsible for providing treatment in order to establish familiarity and a routine for the patient.
• Some patients may be on psychotropic medications. These medications, while controlling emotional behavior, may also affect functional performance by impairing balance and stamina.
• Combative patients may require medication to permit treatment and enhance general compliance.
• Treatment including ADL instruction or instruction in functional activities should be carried out in simple, one-stage steps.
• Repetition and reassurance will be necessary throughout the treatment process. Instruct and reassure in a calm, supportive manner.
Quality of Life
Issues & Solutions

Part I ~ Elder Abuse
Personal Reflections ~ #8
Explain how the Elder Abuse content has impacted you ... How will you use it in your Nursing Practice? Describe what Quality of Life means for You.

Surprise!!
Myths Busted or ...
I didn't know That!!

Conclusions

BPNI

Outcome
368 CALIFORNIA PENAL CODE

ELDER OR DEPENDENT ADULT; INFLICTION OF PAIN OR MENTAL SUFFERING OR ENDANGERING HEALTH; THEFT OR EMBEZZLEMENT OF PROPERTY.

a) Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult, with knowledge that he or she is an elder or a dependent adult, to suffer or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation such that his or her person or health is endangered, is punishable by imprisonment in the county jail not exceeding one year, or in the state prison for two, three, or four years.

b) Any person who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult, with knowledge that he or she is an elder or dependent adult, to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation such that his or her person or health may be endangered, is guilty of a misdemeanor.

c) Any caretaker of an elder or a dependent adult who violates any provision of law proscribing theft or embezzlement, with respect to the property of that elder or dependent adult, is punishable by imprisonment in the county jail not exceeding one year, or in the state prison for two, three or four years when the money, labor, or real or personal property is of value exceeding four hundred dollars ($400), and by fine not exceeding one thousand dollars ($1000) or by imprisonment in the county jail not exceeding one year, or both, when the money, labor, or real or personal property taken is of a value not exceeding four hundred dollars ($4000).

d) As used in this section, “elder” means any person who is 65 years of age or older.

e) As used in this section, “dependent adult” means any person who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. “Dependent adult” includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

f) As used in this section, “caretaker” means any person who has the care, custody, or control of, or who stands in a position of trust with, an elder or dependent adult.
**Enacts enhanced Adult Protective Services provisions that would be implemented only to the extent funds for this enhancement are provided in the annual Budget Act, including a.) 24 hour response, b.) providing victims of elder or dependent adult abuse with case management services, including investigations, assessment and a service plan; c.) the coordination of community resources to provided victims with comprehensive treatment; and d.) providing emergency services such as shelter, food, and aid.**

**Expands the mandatory reporting of abuse of an elder or dependent adult to include abandonment, isolation, financial abuse, and neglect in addition to the current requirement of reporting physical abuse.**

**Redefines “abuse” of an elder or dependent adult to mean a.) physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering, and b.) the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.**

**Redefines “neglect” to include when the elder or dependent adult negligently fails to exercise that degree of care that a reasonable person in a like position would exercise.**

**Expands the definition of mandated reporter to include adult day cares, agencies providing nutrition services or other home and community-based services, designated agencies on aging, and any other sectarian, mental health r advocacy agency or person providing health services or social services to elders or dependent adults.**

**Provides for the Bureau of Medi-Cal Fraud to provide training regarding when to report a suspected instances of abuse for potential criminal action.**

**Adds that a mandated reporter shall not be required to report, as a suspected incident of abuse, an incident where all of the following conditions exist:**

- the mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, or neglect.
- the reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
- the elder or dependent adult has been diagnosed with a mental illness, deficit, dementia, or incapacity, or is the subject of a court-order conservatorship because of a mental illness, defect, dementia, or incapacity.
- the mandated reporter reasonably believes that the abuse did not occur.

**Adds that in a long term care facility (use Ombudsman), a mandated reporter shall not be required to report, as a suspected incident of abuse, an incident where all of the following conditions exist:**

- the mandated reporter is aware that there is a proper plan of care.
- the mandated reporter is aware that the plan of care was properly provided or executed.
- a physical, mental, or medical injury occurred as a result of care provided pursuant to the above two conditions.
- the mandated reporter reasonably believes that the injury was not the result of abuse.
** Adds “public guardian” to the list of those included in a multidisciplinary personnel team who provides services related to dependent and elder abuse.

** Provides that the Director of the Department of Social Services (DSS) must adopt regulations to implement the Act no later than January 31, 2000 and allows DSS to implement the provision of the bill in the meantime through an all-county letter or similar instruction.

** Provides that this bill will be implemented only to the extent funds are provided in the annual Budget Act (Chapters to become operative effective May 1, 2999).

** Amends sections within Welfare and Institutions Code Sections 15610-15760.

** Mandatory Reporting Requirements

All health care providers must file a report if, in the scope of their employment (use Ombudsman, if not on duty, APS):
•• they observe physical injury, whose circumstance, location or injury repetition indicates possible abuse.
•• the patient tells about experiencing behavior constituting abuse.
•• they observe an incident that appears to be abuse.
•• any suspicion of abandonment, isolation, financial abuse and neglect.

** Profile of the Abused

• Female, frail, 75 year or older, socially isolated
• Physically and/or cognitively impaired
• Dependent on caregiver. Loyal: may defend abuser or deny abuse.
• Fear of caregiver, change of lifestyle or health care provider.

** Profile of Abuser

More than two-third of abusers are family member of the victim. Causes of elder abuse include:
Caregiver Stress: About 90% of the estimated 6 million dependent older adults are card for at home. Care giving can become overwhelming without adequate social support, respite, and financial resources.
Impairment of Physical and Cognitive Functioning: Cognitive and/or physical impairment can increase caregiver frustration which can lead to abuse.
Personal Problems: There is a dramatic correlation between children that were abused by their parents and adults who subsequently abuse their patients. An abusive caregiver may suffer from mental and/or emotional disorders, alcoholism, drug addiction and financial difficulty. Conscious or unconscious retribution may occur.
## Types & Examples of Elder Abuse
(National Center on Elder Abuse (NCEA), 1998)

<table>
<thead>
<tr>
<th>Types</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Abuse</td>
<td>• Hitting, illegal or unnecessary use of restraints, over-medication</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>• Sexual contact without consent</td>
</tr>
<tr>
<td>Neglect</td>
<td>• Failure to provide basic needs (e.g. adequate food, fluids)</td>
</tr>
<tr>
<td>Physical Neglect</td>
<td>• Pertains to clothing, mobility, cleanliness, safety which is delayed or denied</td>
</tr>
<tr>
<td>Medical Neglect</td>
<td>• Pertains to medical treatment (e.g. provision of mammograms for 85 year old women, active treatment of depression) because of age, expense, or limited reimbursement; attribution of symptoms to age without specific diagnosis</td>
</tr>
<tr>
<td>Emotional Neglect</td>
<td>• Failure to communicate effectively (e.g. calling individuals by terms like “sugar,” “sweetie,” and “honey;” shouting without assessing hearing ability) and failure to provide psychological stimulation, being exposed to unpleasant odors and sounds.</td>
</tr>
<tr>
<td>Self Neglect</td>
<td>• Refusal to request or receive help, forgetting to take medications or eat or drink, wearing inappropriate clothing, having conscious or subconscious thoughts of potential suicide</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>• Verbal abuse, social isolation, lack of respect</td>
</tr>
<tr>
<td>Financial or Material Exploitation</td>
<td>• Theft or criminal scam, failure to provide adequate resources for care (e.g. eye glasses, hearing devices, orthopedic shoes), medical fraud (e.g. selling hearing aids door to door), improper financial advice or management by a person who has obtained power of attorney but is not considering the older person’s best interests</td>
</tr>
<tr>
<td>Violation of Personal Rights</td>
<td>• Loss of physical or psychological privacy, lack of autonomy in decision-making, receiving inadequate treatment options and insurance plans</td>
</tr>
<tr>
<td>Abandonment</td>
<td>• Desertion by individual who is responsible for providing care</td>
</tr>
</tbody>
</table>
S & S OF ELDER ABUSE

Physical Abuse
- Frequent visits to the ER with traumatic injuries
- Delays in medical treatment
- Missed appointments or noncompliance with treatments
- Unexplained prior injuries
- Bruising, bite marks, scratches (e.g. fractures, black eyes or broken teeth, burns, loss of hair or teeth)
- Does not want a bath because of injuries

Physical Neglect
- Malnourishment (e.g. weight loss, lack of energy, sleepy)
- Dehydration (e.g. skin turgor, sunken eyes)
- Poor hygiene (e.g. dirty clothes, decayed teeth, dirty nails)
- Pressure ulcers at any site
- Unsafe living conditions (e.g. inadequate heat or air, high crime)
- Lack of clean bedding or clothing, incontinence without protection
- Fecal impaction or diarrhea
- Broken or missing glasses, dentures, or heating aids
- Signs of over or under medication
- Contractures caused by lack of movement of joints

Psychological Abuse
- Paranoia or depression
- Fear of strangers or fear in own environment
- Ambivalence toward caregiver or quiet around caregiver
- Confusion or disorientation

Psychological Neglect
- Hunger for attention & socialization
- Depression
- Withdrawal
- Anger or indifference
- Low self-esteem
- Abuser speaks for abused
- Not included in decision making
- Anger, rage
- Social or physical isolation
- No clear explanation for injuries

Financial Abuse
- Utilities turned off because of lack of payment when other person is supposed to pay bills
- Checks signed by another person without legal authority
- Purchase of expensive goods, supplies, or services not needed or wanted
- Pressured into endorsing checks received in the mail
- Poor work or no work on year or house when previously paid for

Financial Neglect
- Very little food in house
- Prescribed medications not available
- Stacks of mail, bills, & un-cashed Social Security checks
- Does not remember writing large checks for repairs
Quality of Life
Issues & Solutions

Part II – QoL Strategy & Discussion;
&
Lessons Learned Summary
## Defining Quality Of Life

List the top 5 “must haves” (priority order) in your definition of Quality of Life

<table>
<thead>
<tr>
<th>Today</th>
<th>Holistic Parameter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical, psychological, social, cultural, spiritual, environmental, gender, generational</td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

### When you are 65

| 1.                            |                                                                                   |
| 2.                            |                                                                                   |
| 3.                            |                                                                                   |
| 4.                            |                                                                                   |
| 5.                            |                                                                                   |

### When you are 75

| 1.                            |                                                                                   |
| 2.                            |                                                                                   |
| 3.                            |                                                                                   |
| 4.                            |                                                                                   |
| 5.                            |                                                                                   |

### When you are 85

| 1.                            |                                                                                   |
| 2.                            |                                                                                   |
| 3.                            |                                                                                   |
| 4.                            |                                                                                   |
| 5.                            |                                                                                   |
**SURVEY ON HEALTH DECISIONS** *

**Part I:**
Medical knowledge and technology has increased dramatically over the past thirty years. The availability of new procedures and machines are forcing us to now make decisions we have never had to make in the past. Most of the following questions relate to issues presented by our increased medical knowledge and technology.

Please circle the appropriate response which best reflects your opinion on the corresponding statements:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

1. If I had an illness and there was little hope of cure, I would want to know the truth.  
   Disagree

2. I should have the right to refuse treatment even if I am going to die and no one should be able to overrule me.

3. If I have an incurable disease and cannot speak for myself, my family should be able to tell the doctor what I want and have the doctor abide by their wishes.

4. If I am in an irreversible coma and will never regain consciousness, my family should have the right to stop any machines or tube feeding which keep me alive.

5. If I become permanently unconscious and couldn’t eat normally, I would want to be kept alive by artificial (tube) feedings.

6. I would vote to change the law to allow a competent dying adult to ask and receive a doctor’s help to die in a quick and painless way.

7. People should be kept alive in all cases in spite of their medical condition or the wishes of the patient or his/her family.

8. Experimental drugs and procedures should be available to dying patients even if the drugs and procedures have not been fully tested by our government agencies.

9. Doctors should encourage patients to write down what they would want in the event that they become seriously ill ad could not speak for themselves.

10. The patient’s quality of life should be considered when deciding whether he/she should be kept alive with a respirator or by artificial (tube) feedings.

11. I would want to be kept alive even if I would be severely handicapped as a result of my illness.
12. As a parent, I would want the right to refuse treatment for my newborn infant if he/she is likely to survive with severe handicaps.  

13. The government, not the parents, should have the last word on whether babies with severe handicaps should be treated.  

14. If I had a seriously ill newborn infant, I would want the doctors to do everything they could to treat it, even if the child might survive with severe handicaps.  

15. There is a critical shortage of donor organs. I would support a law that allows for everyone’s organs to be used for transplants after their death unless the family objects.  

16. The government should guarantee that a drug is safe before your doctor is allowed to give it to you.  

17. It should be illegal for men and women to have children with the help of medical technology such as sperm donors and egg donors.  

18. It should be illegal for a woman to give birth to another couple’s baby (surrogate mothers).  

19. Men and women should be able to use medical technology (e.g. sperm and egg donors and surrogate mothers), but government should regulate such procedures.  

Part II:  
Costs for health care are expected to continue to increase so much that decision makers must consider additional ways to reduce expenses, find other ways to pay for it, or ration health care. Please mark how you feel about some of the possible choices.  

20. In the U.S. people should receive basic health care even if they cannot pay for it themselves.  

21. I would vote for a greater share of taxes to be given to health care for everyone if it would mean less money would be available for other government programs (e.g. military defense or education).  

22. In deciding whether or not to provide needed medical treatment, the cost of the treatment should never be one of the concerns.  

23. Even if I have to pay more taxes, I think the government should pay for health care for everyone who cannot afford it.  

24. A hospital should be allowed to refuse treatment to a patient on the basis of inability to pay.
25. If a hospital becomes overwhelmed with patients who cannot pay, public funds from taxes should be made available to cover the cost of care. 1 2 3 4 5

26. I would see the doctor less often if I had to spend more of my own money every time I went to the doctor. 1 2 3 4 5

27. The government and/or insurance carriers should determine how long a patient should stay in the hospital based on his/her illness. 1 2 3 4 5

28. People over 65 and covered by MediCare should be expected to pay a greater share of their medical costs according to their ability to pay. 1 2 3 4 5

29. People who smoke and drink should pay higher insurance rates. 1 2 3 4 5

30. I would be willing to pay higher insurance premiums so that more people could have long term health care coverage (nursing home care). 1 2 3 4 5

31. Insurance should pay for the care of patients at home not just in hospitals and nursing homes. 1 2 3 4 5

32. I would be willing to pay more taxes so that more people could receive long term health care (in home care). 1 2 3 4 5

33. As a taxpayer, I would vote for public programs to provide prenatal care for women even if they cannot pay for it. 1 2 3 4 5

34. My tax dollars should be used to prevent disease rather than to keep patients alive for a longer time. 1 2 3 4 5

35. Public funds from taxes should be spent to provide basic health care for everyone rather than for the development of expensive medical equipment which would benefit fewer people. 1 2 3 4 5

36. Public funds from taxes should continue to be spent on artificial organ research such as the artificial heart. 1 2 3 4 5

37. Taxes should continue to be used to pay for the 24 hour care needed to keep patients who are permanently unconscious on life-support machines. 1 2 3 4 5

38. If I had to make a choice on how health care dollars are spent, I would choose that those who could get well should be treated before those who have incurable diseases. 1 2 3 4 5

39. If I had to make a choice on how health care dollars are spent, I would choose that the young be treated before the elderly. 1 2 3 4 5
40. My tax dollars should be used to pay for health care for AIDS patients who cannot pay for it themselves.

1 2 3 4 5

41. As a taxpayer, I would vote to spend more money on preventive education and research to cure AIDS even if it means there is less money for other health programs.

1 2 3 4 5
Rose & Zelda
Video Observation Sheet

What are Rose's messages to Us about Quality of Life?

What are Zelda's messages to Us about Quality of Life?

What changes & losses did each of them contend with?
Rose:
Zelda:

What strengths helped them to cope?

What changes/losses did the MD experience? How did she cope?

What losses have/will you experience as a patient's Quality of Life changes? How will you cope?

What losses are incurred when someone goes into Hospice?

How will you use what you have learned in your life?
Personal:

Professional

CAO/12
Retirement or Re-invention?!?
How will you spend the second half of your life??

List:
Positive Aspects of Work  Negative Aspects of Work

Old = Education → Work → Leisure (Bolles, 1987)

New =

% of Americans in Very Good or Excellent Health

<table>
<thead>
<tr>
<th>Years</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>51-59 years</td>
<td>50 %</td>
</tr>
<tr>
<td>60-69</td>
<td>42</td>
</tr>
<tr>
<td>70-79</td>
<td>33</td>
</tr>
<tr>
<td>80-89</td>
<td>25</td>
</tr>
<tr>
<td>90 +</td>
<td>26</td>
</tr>
</tbody>
</table>

Do you plan to?
_____ Semi retire  _____ Retire  _____ Not retire

When do you plan to retire or reinvent? Why at that time?

What do you plan to do during retirement or reinvention?
What are you doing now to prepare for this?

How will you pay for retirement/reinvention?

What will you do to create your new identity?

**Get a Life Tree** (Zelinski, 2004)

Activities that turn you on
Activities that turned you on in the past (but you stopped doing)
New activities you have thought of doing (but haven't done yet)
Activities that will get me fit

Think about each of the following and write them around the descriptor

Discussion:
Critical Thinking, Study Group Discussion Questions & Case Studies
N117 Critical Thinking Study Questions

Experiencing the Elder Individual/Multidimensional Assessment, Myths & Resiliency
1. Define Aging from each of the following perspectives:
   - Chronological aging
   - Subjective aging
   - Functional aging
2. Analyze your own definition of aging (done in class) using the above parameters.
3. You’re doing an admission assessment on Mr. Smith, an 85 year old man who is being admitted to your unit for CHF for the second time in the past two years. He lives alone in his own apartment and is not cognitively impaired. When you ask why he is in the hospital he answers, “I’m 85 years old! Don’t you expect you’ll be in a hospital when you’re my age?!” What is your response to Mr. Smith?
4. What Resiliency characteristics do you have? How will you “work” on them?
5. Observe elders in your family and community. What resiliency characteristics do you see?

Common Holistic Changes & Rest/Sleep
1. You’ve been asked to help develop and conduct a health education program at your local senior center. What would you emphasize for these older adults (include cultural and gender aspects) about for each of the following:
   - Common aging changes – normal vs abnormal
   - Rest/sleep patterns in older adults
2. Describe the experiences you expect an older adult to have with rest and sleep.
3. What “Tips for Good Sleep” will you tell your grandma when she says that she frequently has a hard time sleeping at night? Remember to include tips that address possible changes in each of the following categories: physiologic reasons, psychological reasons, and environmental influences).
4. Answer the questions in the Psychosocial & Cultural Self Assessment.

Common Holistic Changes: Skin/Feet & Sensory
1. What environmental factors are likely to interfere with the visual function of older adults?
2. List at least ten (10) adaptations that might be implemented to improve the visual functioning of older adults.
3. Identify at least two (2) community resources that provide help and information to a visually impaired person.
4. Name at least ten (10) behavioral cues that would alert you to hearing impairments.
5. Describe at least five (5) ways you can adapt your communication for a hearing impaired person.
6. Find at least two resources in your community that you can recommend to an older adult who needs a hearing evaluation (not a hearing aid dealer).
7. What would a healthy 85 year old person notice about their skin, hair and nails?
8. What information would you be sure to include during discharge teaching for your older patient following uncomplicated skin cancer removal? Be sure to address: personal care practices, injury prevention, maintenance of healthy skin, and tips for avoiding sun damage.

Common Holistic Changes: Nutrition, Fluid & Continence
1. Describe how you would expect each of the following conditions to influence older adults’ eating patterns: sensory impairments, medications, economic factors, social circumstances, oral health factors, depression cognitive impairments, transportation restrictions, energy level.
2. Describe how your assessment of nutrition, digestion and medications would vary among your clients/patients in the following places: home, acute care hospital, assisted living home, skilled nursing center, a retirement community, and a senior center.
3. Describe at least three (3) characteristics of eating patterns for each of the following cultural groups:
   - African American, Asian Americans, Hispanic Americans, Native Americans, & Russian/Ukranian.
4. Contrast these with your cultural heritage and eating patterns.
5. Think of questions to ask your older adult patients to determine the underlying cause of their incontinence problem.

6. Write steps you would include when teaching pelvic floor exercises (Kegels) to your older adult patients.

7. Describe how each of the following age related changes or risk factors might influence urinary function in older adults: medications, functional abilities, changes in urinary or nervous systems, renal function, altered thirst perception, environmental conditions, and myths and misunderstandings on the part of the older adults, their caregivers, health care professionals.

8. What are the psychosocial consequences of urinary incontinence for older adults and caregivers?

9. Describe how you would address the following statement made by a 74 year old woman: “Of course I have to wear pads all the time, just like I was a teenager. I haven’t talked to the doctor because I figured this was pretty normal at my age.”

10. Write three (3) open ended questions that you would be comfortable using to assess your older adult’s sexual function.

**Mobility Challenges: Bone/Joint Considerations, Falls & Restraints**

1. Describe how each of the following age-related changes or risk factors might increase an older adult’s risk for falls & fractures:
   - Nocturia
   - Medications
   - Altered gait
   - Pathologic conditions
   - Sensory impairments
   - Osteoporosis
   - Functional impairments
   - Slowed reaction time

2. Look in journals (professional and lay) and see what you learn about older adult mobility from their ads. Summarize what you learned in two to three sentences.

3. Contact an agency or organization and request information about fall prevention products that you can then use in your practice or for your family.

4. Explore the restraint policies in your agency (if you work in one).

5. Think about what you think about restraints – When is it justified?

**Living with Chronic Illness: Medications, Pain/Comfort, & Sexuality**

1. You are preparing to present a ½ hour talk on “Medications and Aging” to a local senior citizens group. Describe the following:
   - What age related changes would you cover?
   - How would you address the risk factors that affect medication action and medication-taking behaviors (remember, most of these individuals have minimal A&P background!)
   - What tips would you include about taking medications?
   - What educational materials would you include?
   - How would you involve the group participants in the discussion?

2. Decide how you would phrase questions, in your own words, for the following situation:
   - You are working in a Senior Wellness program in a city with a large number of elders who were born in Mexico. You are preparing for 15-minute interviews with older adults who have agreed to participate in an educational session where they will bring all their pills in a bag and ask the nurse about them. How might you approach this same situation with people who were born in China, Italy, or the Philippines?

3. Describe some of the facts that dispute myths about pain in the older adult.

4. Identify and describe some of the pain cues you may see in older adults.

5. When your elder patient asks you about pain treatment, what do you say?
Living with Chronic Illness: System Failures ~ Cardiovascular, Respiratory & Pancreatic

1. Decide how you would phrase questions, in your own words, for the following situation:
   You are doing an admission interview for a 78 year old Caucasian man who lives alone and has been admitted to the hospital for the third time in 18 months for congestive heart failure. Would this change if the man were Asian, Hispanic, or African American? Why? How would you modify your questions?

2. Describe how you would teach a home health aid to assess blood pressure and postural hypotension correctly on older adults. Remember, he/she has probably been taking these measurements for a long time, without knowing the differences in older bodies!

3. You’ve been asked to conduct a health education program at your local senior center. What would you emphasize for these older adults (include cultural and gender aspects) about each of the following:
   Risk factors for heart attacks and strokes
   S & S symptoms of a heart attack and stroke
   Ways they protect themselves against heart attack and stroke
   Common treatments for heart attack and stroke

4. You’ve been asked to conduct a health education program at your local senior center on respiratory illnesses. What would you emphasize for these older adults (include cultural and gender aspects) about each of the following:
   Risk factors for pneumonia, TB & flu
   S & S of pneumonia, TB & flu
   Ways they protect themselves against pneumonia, TB & flu
   Common treatments for pneumonia, TB, & flu.

5. You’ve been asked to conduct a health education program at your local senior center on diabetes. What would you emphasize for these older adults (include cultural and gender aspects) about each of the following:
   Risk factors for diabetes
   S & S of diabetes
   Ways they protect themselves against diabetes
   Common treatments for diabetes

Cognitive Impairments: Memory Loss & Dementia

1. Your grandma complains that her memory is failing because she is old. What do you tell her?

2. Identify situations in your life that interfere with your cognitive functioning.

3. What memory aids do you use in your life? Are they effective?

4. Describe how you would explain Alzheimer’s disease to the following families and what approach you would take to interventions for the person with AD in each of the following situations:
   A Caucasian person and his family
   An Hispanic person and her family
   An African American person and his family
   A Chinese person and her family
   A Russian/Ukranian person and his family
   A Native American and his family

5. You are working in a nursing clinic at a senior center. How would you respond to the following questions, posed by a 74 year old woman:
   “I’ve been having memory problems lately, but I know it’s not Alzheimer’s because I haven’t done anything really stupid. What do you think I should do? My friend says ginkgo helps her a lot, and I was thinking of trying that. Do you know how much I should take?”
Emotional Challenges & Responses: Loss, Grief, Depression, & Spirituality

1. Think of a recent life event in your own life and answer the following questions:
   * How close in time was the life event to other stressful events in your life?
   * What impact did the life event have, and what were the manifestations of stress in your life (e.g., in your work, your health, your personal life, your relationships with other people).
2. List the positive and negative functional consequences of each of the following: widowhood, retirement, decisions about driving, relocation, death of family and friends, confronting ageist stereotypes, and chronic illness.
3. Identify coping resources for each of the situations in question #2.
4. Describe three (3) nursing interventions for older adults experiencing loss.
5. List at least four (4) cultural variations in the way depression might be expressed.
6. List assessment observations you would expect to see and the questions you would ask to differentiate between dementia and depression in older adults.
7. Devise at least three (3) ways you can ask your patients/older adults about their spiritual/religious needs and practices.
8. Identify five (5) ways to promote a sense of control in older adults (think of a family member or patient you’ve cared for recently).

Caregiving Relationships: Self/professional & Financial Aspects

1. What do you believe about family caregiving responsibilities?
2. How will you deal with families whose values about caregiving differ significantly from yours?
3. Identify at least two (2) organizations in your community that you would refer caregivers to.
4. Discuss the financial impact of growing older in the US today. Include both positive and negative factors for both the elder and their family.

Caregiving Issues: Abuse, Life Space Options & Retirement

1. In each of the following categories, identify factors that are currently contributing to elder abuse and neglect in the United States:
   * Demographic imperative/statistics
   * Changes in families
   * Health care systems
   * Health status and other characteristics of older adults
   * Social awareness
2. What are your beliefs about the degree of risk, a frail elder should be allowed to take? Under what circumstances should an elder be denied the right to remain in his or her own home?
3. Your neighbor calls you to find out about local agencies to help her with the challenges of caring for an aging parent. Her mother also needs more help with her ADLs. Explain to your neighbor about each of the following community agencies:
   National Elder Care Locator
   Senior Infolines
   Area Agencies on Aging
   Senior Centers
   Home-Delivered Meals
   Companions and Friendly Visitors
   Telephone Reassurance
   Personal Emergency Response Systems
   Energy Assistance Programs
   Home Weatherization and Home Repair Service
   Telephone Services for the Hearing Impaired
   Low Vision Services
4. Your elderly aunt is considering moving to your city from her home in a rural community. She asks you to explain the housing options in your community to her. Explain the differences among the following options (be sure to include positives and negatives):
   - Family residence or apartment
   - Assisted living facility
   - Life-care or continuing care retirement community
   - Retirement community
   - Homecare suite
   - Foster care or board and care
   - Shared housing
   - Congregate housing

5. You are working at a senior center and several of the people there ask you whether they should sign up for the new managed care program that is being advertised in various brochures. What approach would you use in providing information to assist them with decision making?

6. A Mexican American woman, aged 78, is being admitted to the hospital with hemiplegia following a stroke. There are no advance directives on her chart. What information would you want to know before you approached her about a living will and durable power of attorney for health care? Think of how you would phrase your questions. How would you explain the documents to her?

7. What cultural aspects must be considered with older adults when discussing decision making, advance directives, prognosis, information dissemination to family members, informed consent and end of life issues?

8. Discuss with a colleague or your parents/grandparents what you learned about how to plan for retirement (holistically).
Study Group Discussion Exercises

STUDY GROUP DISCUSSION TOPIC: Assisting Elders with Medication Compliance and Safety

Purpose:
To identify and explore nursing interventions to assist elderly individuals with medication compliance and safe use of medications.

Directions:
Individually or in small groups (3-4 members) discuss and decide on answers to the following concepts. If done in class, choose a spokesperson to report your group’s findings to the total class at the end of your (15 minute) discussion period.

• Three (3) reasons for noncompliance:
  1.
  2.
  3.

• Three (3) nursing interventions to correct noncompliance:
  1.
  2.
  3.

• Three (3) nursing interventions to assist seniors to use meds safely.
  1.
  2.
  3.

• “Many heads create many ideas” (thoughts of my classmates on this topic):
STUDY GROUP DISCUSSION TOPIC: Sexual Dysfunction in Elders

Purpose:
To explore common nursing diagnoses and nursing interventions related to sexual dysfunction in the elderly.

Directions:
Form small groups (3-4 members). From the following sexual dysfunction nursing diagnoses, choose three to discuss:
- Sexual Dysfunction R/T institutionalization as manifested by rules restricting cohabitation.
- Sexual Dysfunction R/T menopause as evidenced by frequent hot flashes, breast tenderness and vaginal dryness.
- Sexual Dysfunction R/T decrease in mobility as evidenced by pain and medications.
- Sexual Dysfunction R/T fear of recurrent illness as manifested by statements like “my husband might have another heart attack.”
- Sexual Dysfunction R/T benign prostatic hypertrophy as manifested by increased length of arousal and ejaculation time.

Include in your discussion, the necessary assessment techniques, and data required. From this, identify three nursing interventions for each of the nursing diagnoses chosen. Include outcome statements and methods of evaluation. Choose a spokesperson to report your group’s findings to the total class at the end of your (15 minute) discussion period.

Nursing Diagnosis:

Outcome Statement:

Assessment technique(s):

Assessment Data Needed:

Interventions:

Evaluation Method(s):
Nursing Diagnosis:

Outcome Statement:

Assessment technique(s):

Assessment Data Needed:

Interventions:

Evaluation Method(s):

Nursing Diagnosis:

Outcome Statement:

Assessment technique(s):

Assessment Data Needed:

Interventions:

Evaluation Method(s):
STUDY GROUP DISCUSSION TOPIC: QUALITY OF LIFE *

Please respond to the following as briefly but completely, as possible. Do not read the next question until you have responded to the prior one!

Right now I would define quality of life as:

If I should live to be 90 I would define quality of life as:

I would define death as:

Factors which would affect my decision to be allowed to die would be:

If a client said to me "Nurse, please let me die" I would:

If a physician told me to "pull the plug" on a client I would:

STUDY GROUP DISCUSSION TOPIC: Activity - Exercise

Purpose:
To apply functional pattern and nursing diagnosis knowledge to a clinical situation.

Directions:
1. Read the Case Study. Develop three (3) or four (4) nursing diagnoses, within the Activity-Exercise Pattern, that holistically reflect care you would give to Mrs. L.
2. Develop your nursing interventions including patient outcomes and methods for evaluation.
3. Divide into small groups of 3-4 participants. Discuss your diagnoses and interventions.

Mrs. L. is a 75 year old black woman, a housewife, with a 9-year history of PVD and arteriosclerotic heart disease. She has had several lower-limb bypass grafts, both aortoiliac and femoral-popliteal. She is strong-willed and takes pride that she was able to walk unassisted in the ICU after her aortoiliac bypass surgery. She is not concerned about falling. Mrs. L’s cardiac output status as well as her respiratory and tissue perfusion status is consistent with expectations for a women of her age. She is not sleeping well. She is used to getting 6-7 hours/night.

Even during exacerbations of her illness, Mrs. L. continued to exhibit a strong self-care focus and internal locus of control. Some of the following statements show further indications of Mrs. L’s outlook:

“I’m the strong one in my family.”
“You’ve got to help yourself get better around here. No one can do it for you.”
“God can give me strength and courage to do anything, even to quit smoking.”
“What I do to take care of myself will make the difference; it is not up to the doctors and nurses.”

Mrs. L coped by striving for autonomy and used self-care practices consistent with Orem’s nursing theory. She walked the halls daily and sat in the lounges, instead of her bed in her room, so she could visit with family, friends and so she could meet new friends. She gave as well as gained encouragement from these interactions. Mrs. L. felt that she was the main support in her family. Prayer and religion were very important to Mrs. L. She gained much strength from them.

Nursing Diagnosis:
Outcome:
Interventions:
Evaluation:

Nursing Diagnosis:
Outcome:
Interventions:
Evaluation:

Nursing Diagnosis:
Outcome:
Interventions:
Evaluation:
STUDY GROUP DISCUSSION TOPIC: Taking a Stand on Elderly Issues
Deontology vs Teleology

Purpose:
To explore philosophical focuses as they relate to ethical decision making regarding issues facing the elderly.

Directions:
1.) Read the following situation:
Your Aunt Mary (85) is typical of the elderly who live alone. She is a widow and rents her apartment in San Francisco. She has no income other than Social Security and is increasingly anxious about her health, her mobility, making ends meet and her safety. "I've been self-sufficient and independent all my life," she tell you. "Now with my failing health and rising expenses, I don't know what will happen to me. Please help me decide what to do."
As Mary's closest relative (though you live in Sacramento) you feel an obligation to help Aunt Mary. After great consideration you see the options as one of the following:
   1.) Have Aunt Mary come live with you and your family.
   2.) Find a board and care facility for Mary in San Francisco.
   3.) Find a board and care facility for Aunt Mary in Sacramento.

2.) Decide/State what you will do in this situation.

3.) State how you used the following ethical principles in reaching your decision:
   BENEFICENCE:

   NONMALEFICENCE:

   JUSTICE:

   AUTONOMY:

4.) Decide /Circle whether your decision is based on the philosophical focus of Deontology (Rightness or wrongness is the same regardless of the situation - "Do unto others") or Teleology - Utilitarianism (Rightness or wrongness is decided by the greatest good and the least harm done for the greatest number of individuals).

5.) Identify an instance/issue in which you would use the other philosophical focus:
STUDY GROUP DISCUSSION TOPIC: Consent, Conflict and Euthanasia *

A seventeen year old boy was riding in the back of a pickup truck when it went off the road and turned over in an embankment. He was thrown from the truck into a wooded area and a small branch was forced through his skull. He was rushed to a local hospital ER, comatose and near death. His parents and a well-known neurosurgeon were called: I don't know in which order.

A tracheotomy was performed in the ER and the patient was placed on a respirator. Subsequently he underwent emergency surgery. To maintain his nutrition, hyperalimentation was started post-surgically in the ICU. Surprisingly, except for contusions and abrasions, there was no damage other than that caused by the head wound. Although an EEG revealed some brain activity, all vital signs were absent. His pupils were dilated and unresponsive to light, he had no deep reflexes and he did not respond to stimuli of any kind. The heat-control mechanism in his brain was affected and his temperature varied from severe hypothermia to severe hyperthermia.

Three weeks after surgery, the boy still was in a deep coma and still was in the ICU. The parents maintained a constant vigil and were consulted about all major decisions, including procedures that required written consent and those that did not. Decisions about continuing the respirator, continuing hyperalimentation and about whether or not to resuscitate the boy if he experienced cardiac arrest were among these decisions.

The parents experienced increasing anxiety and depression during this period. The mother suffered from recurrent nightmares and the father was in a car accident that destroyed the family's only auto. They had four other younger children who also had problems and needs. To make matters worse (if possible), a major storm hit the area and a large tree in their front yard fell, crushing their garage and damaging the roof of their house; fortunately no one was hurt. However, their child's apparent suffering and the seeming hopelessness of his case increased their suffering and the hospital staff felt a conflict over their duty to the boy as patient and to the parents as patients. It sometimes seemed that the boy's continued existence was harmful to the parents' and siblings' well-being, and the parents began requesting that all the machines be disconnected in the hope that the boy would die.

The nursing and medical staff members were divided over the resolution of this situation. A significant number believed that all treatment should be stopped and that the boy should be allowed to die. On the other hand, a large number thought that the boy still had a chance to live and that to deny the boy this chance would be unjust - it would be an act of euthanasia.


Questions:
What do you think should be done to settle this dilemma?

If you were the boy, what would you tell your family and the staff?
If the boy was your son, what would you do?

What ethical theories can you identify that you used in deciding your actions?

Which ethical principles did you use in deciding your actions?
STUDY GROUP DISCUSSION TOPIC: Cardiopulmonary Resuscitation and the Nurse *

As I walked into Christy's room with a tray full of pills, I heard her ask her mother, "Mommy, what's it like to die?" I stopped - halfway through the door. Her mother answered, "Honey, it's sort of like this. Do you remember when you were at home and you'd fall asleep downstairs? Daddy would pick you up in his arms and carry you upstairs and everything would be all right. Well, dying is something like that, only this time God will pick you up in His arms and then everything will be fine." I entered the room then and Christy's mom and I gave her the medications.

Christy was a three-year-old child, made mature beyond her years by suffering. She was dying of lymphosarcoma. For three months, she had been in and out of the hospital - and this trip was the last one. Everyone knew that she was dying: her physician, her parents and her nurses. Christy's mom stayed with her all day every day and her dad usually spent the nights with her.

One night about 12:30 a.m., I went into her room. She was resting quietly, but her mother had had about all she could take. Tears of exhaustion, pain and grief were sliding silently down her cheeks. I sat down next to her and we stayed together for a few minutes until her husband arrived. The floor was fairly quiet that night so I suggested that both of them go down to the automat for a cup of coffee and a little time together. I promised that I would not leave Christy's room until they returned.

Perhaps ten minutes after they left, Christy awoke. She was much worse and appeared to be very frightened. I called the practical nurse and told her to call the doctor, the supervisor and the chaplain and to send an aide down to the automat stat to get her parents. Christy was struggling to breathe and there was fear in her eyes. Suddenly, I remembered what her mother had told her. Gently I leaned over and picked her up and held her in my arms. She seemed to relax as she laid her head against my shoulder. She died like that - quietly in my arms. I do not know how long I stood there holding Christy. It seemed like an eternity but it could not have been more than a few minutes.

Her parents rushed into the room, I looked at them - and they knew Christy was dead. As we were tucking her into bed a young resident physician entered the room. He took one look at Christy and said "My God, why didn't you call a code?" He started to pound on Christy's chest, but her father stopped him. I turned to Christy's mom and said "I'm sorry". She started to cry and so did I. I held her in my arms and she held me. In a few minutes I was able to tell her how Christy died, how I held her in my arms and how she wasn't afraid anymore. The chaplain arrived about that time and we all went to the lounge. As he talked to them, I left to get coffee from the nurse's locker room.

The priest was talking with the parents and other children on the floor needed my attention, so I did not stay long. I made rounds and then helped to prepare Christy's body for the morgue. I thought the incident was ended - although I knew I would never forget Christy or her parents. However, the incident was far from over. The next morning I was called to the nursing office. Why hadn't I called a code on Christy? Hospital policy required that a code be called on all patients unless there was a written no code order. Her pediatrician had not written a no code order; who was I to make such a decision?

In all honesty, I could only respond by saying, "It never occurred to me to call a code. Everyone knew Christy was dying; now one disagreed. Even if I had called a code, it probably wouldn't have been successful. If it had been, the only result would have been that Christy would have suffered longer before she died." Fortunately for me, the chaplain had heard (through the super efficient hospital grapevine?) that I was in trouble. He made an impassioned plea in my behalf and I was "let off" with a severe reprimand. I feel no guilt about my care of Christy - only sorrow for her suffering and her death at so young an age. I also feel privileged to have known Christy's parents: gentle people of courage and strength. However, there are other children like Christy; doctors still won't write no code orders (no matter what they may say) and the hospital policy remains the same. If I fail to resuscitate some other dying child, I don't know what will happen. What will (or Should) I do when faced with similar situations in the future?

Questions:
Do you agree with the outcome of this situation? Why/why not?

If you were the nurse in this situation, what would you have done?

If you were Christy’s parent, what would you do in this situation?

What ethical theories can you identify that you used in deciding your actions?

Which ethical principles did you use in deciding your actions?
Theory to Practice CASE STUDIES

Clinical Situations faced by Written by CSUS Nursing Students

Communication
Mrs. Lopez, a 74-year old Hispanic woman, was brought into the ER by her neighbor Maria, who lives next door in the next apartment, after Mrs. Lopez C/O heart pain, SOB, dizziness, and palpitations. Labs were done and came back with elevated CKMB, myoglobin, and troponin T levels. Her history includes: father died at 69 of heart problems; husband passed away a year ago; her only son lives on the other coast of the country; living in USA for three-and-a-half years, and has not learned the English language; is Catholic and prefers to use folk-medicine. She was transferred to a med-surg floor to monitor her for her post-MI condition. The son was called and said that he will be there sometime in the evening or the next morning. The nurse you are working with told you that she will not be calling in a translator now because “it’s a hassle” and she can “get by” with the Spanish she learned in high school.

Questions:
Analyze Mrs. Lopez’s support system. Do you think she has a good support system? Why or why not?
What can you, as a nursing student, do to help improve Mrs. Lopez’s patient teaching?
If an interpreter would be called in, or when her son arrives, what kind of skills can you use to make the experience more comfortable for the patient and the patient teaching more informative when working with a translator?
(Kudelin Y., 2007)

Culture
You are a home health nurse that has received a call from a physician to visit an 80-year-old woman (C.Martinez) in her home. She has a right below the knee amputation five weeks ago and was scheduled for routine follow-ups with her primary doctor, but she had missed most of her appointments. Due to not going to the appointments, her wound had not healed and she was scheduled for a re-hospitalization, which she has refused, only agreeing for a home health nurse to visit her and assist in wound care. One of the things that she tells you that she liked the least about hospital is the hospital food because it was too bland. She said that the doctors told her that she has hypertension and to not eat salt. C.M. also told you that she wanted to wait a little more to come in with the wound, after she had tried to see if the herbal paste would treat the wound. You reviewed the dressing changes with C.M. and learn that she did not wash her hands before beginning the dressing change and changed the dressing every two to three days (not every day as was ordered). The patient states that the nurses in the hospital usually changed her dressing for her because “I am too slow”. Also, you want to review the patient’s ability to use crutches, but the patient says that she uses a neighbor’s wheelchair to get around (which is very old and the wheels squeak) and that she has walked with a physical therapist only once down the stairs. C.M. lives in a two-story house which she shares with her granddaughter, who moved in two days ago, and the house has many hazards, such as small rugs, no hall light over the stairs, and drawn curtains. You teach C.M. to do a correct dressing change, and tell her that you will be coming around tomorrow and that she will then demonstrate the dressing change to you.

Questions:
Stereotyping can lead to unsafe nursing practice. Determine what kind of biases about aging and culture may have been present in this case.
How did those biases affect the care of C.M.?
What kind of interventions could you develop about C.M’s ethnicity, folk practices, food, and social support?
What can you do as a nurse, to help yourself become more culturally sensitive and competent?
(Kudelin Y., 2007)
**Life History/Legacy**
You are the nurse that is coming in to Mrs. C.M. to assist her in her dressing change. While doing her dressing change C.M. tells you a little about her background. She and her husband came to America 50 years ago after WW2 with their three young kids from Mexico. Her husband started working in an apple orchard and she started taking ESL classes in a community college and working in the college cafeteria part-time. Her husband died ten years ago of “old age” and now she has three grown up children and 18 grandchildren, all living in the same city. The family visits her and her oldest granddaughter is now living with her, but C.M. says that she often feels that they are just doing that to be nice to her. Now, with an amputated leg, she feels that she will become a bigger burden to them. As soon as her granddaughter came into the room, she stops talking about being “a burden” and tried to cover up her leg.

**Questions:**
What can you do as a nurse to let C.M. know that you are paying attention to her story?
What kind of questions can you ask C.M. to keep her talking about her past?
How would you encourage C.M. to record her life history?
How can you involve the granddaughter in helping her grandmother reminisce? In leaving a legacy?

(Kudelin Y, 2007)

**Grieving**
Mr. Edward Fox, an 85-year old white male, who arrived an extended care facility, from a two-week hospital stay. He is oriented X3 to person, place, and time but seems confused about what he is doing in this location, stating that he wants to go home. He is generally in good health, although he suffered fractures of the left wrist and several bones a year ago after being hit by a car. E.F. was married for 45 years, but has been widowed for one-and-a-half years. His wife, 11 years his junior, died of colon cancer. Since the death of his wife, E.F. has cared for himself, assisted by a housekeeper who comes in one to two times a week. He stated that he usually has a good appetite, but for the past five months, he has been very tired; it’s sometimes tiring for him to even heat up the food the housekeeper has prepared. He says he likes to walk a lot, and often walks to a little restaurant, which takes him an hour to get there. He was a professor of philosophy in a university, until he retired at 65. He stated that he smoked a pack of cigarettes a day for about 20 years, but quit 15 years ago. E.F. states he has no hobbies since he didn’t have much time to cultivate one. He and his wife didn’t have any children, and his only known relative is his sister-in-law and her two children, who have failed to maintain any contact. He doesn’t have many friends, except those that he socialized with in church, which he stopped attending about six months ago. E.F. responds readily when approached and enjoys brief contacts. For him, conversation with people is the only means of intellectual stimulation and reality orientation.

**Questions:**
Which stage of widowhood is E.F. in?
What are the interventions for a patient who is in that stage?
What are some of the nurses’ roles concerning widowers?
Discuss how you would assess loneliness in a patient. Which interventions would you incorporate?
What type of grief is E.F. experiencing?
What are some interventions that nurses can do when they see a grieving patient?

(Kudelin Y, 2007)

**Sensory Changes**
You are caring for Alice Norman, 75-year-old who had a seizure while in the ICU while being treated for her abdominal pain due to constipation. On her past medical history it states that she has some hearing loss and has one hearing aid in place. After her seizure, she lost her ability to speak, but you still continue to talk to her and she responds by shaking her head, pointing to things, or pointing to words on a piece of paper that you wrote in order to be able to communicate with her. However, sometimes she doesn’t seem to understand what you are saying and just shrugs her shoulders. Luckily, her husband is also at the bedside and answers questions about his wife. He says that her hearing loss has been getting worse with age, that she doesn’t have any impaction in her ears, she didn’t mention any hissing/ringing sound in her ears, and that she just recently got her first hearing aid (about a month ago). He states, that
they are only able to afford one hearing aid for right now, and that A.N. was able to start hearing better with that hearing aid in place. While doing your Q1H VS on A.N, you notice that he often starts to talk louder when he talks to A.N., after which she becomes even more confused.

Questions:
Which type of hearing loss is A.N. most likely experiencing?
How can you assess for hearing loss?
What other questions should you ask A.N.’s husband to get a better assessment of his wife’s hearing loss?
What should you teach A.N’s husband about his wife’s hearing aid?
What interventions can you implement in your care for a pt that has hearing loss?
What can you teach A.N’s husband about hearing loss and how to communicate with his wife?

Constipation
Mrs. Alice Norman is a 75-year-old woman (5’2”, 162 lbs) that comes into the hospital complaining of constipation. She says her constipation has been getting worse with age. Sometimes she won’t have a bowel movement for 3-4 days. The doctor prescribes Colace and asks that she keeps a food diary for a week and bring it in next time. Next week she comes in again and brings the food diary, saying that Colace helps, but not too much as she still experienced constipation this week. This is an example of what she ate for Tuesday:
Breakfast: 1 c coffee; bagel with cream cheese
Noon: drank 1 c water; apple; chicken-noodle soup
Snack: apple; 1 c water
Dinner: 1 c orange juice; pasta; meatballs; ½ of a cucumber
Drank 1 more c of water before going to bed.
You ask her about her activity level and she states that she tries not to do a lot because her osteoarthritis makes everything hurt. She says she takes acetaminophen and Aleve (NSAID) to reduce her joint-pain. Other medications she takes are insulin for her DM and Maalox for heartburn.

Questions:
Assess A.N.’s nutrition. What is she lacking in her diet?
What will you teach A.N. about nutrition in seniors?
List some precipitating factors that may lead A.N. to experience constipation.
What is Mrs. A.N. lacking a lot of in her diet that may lead to constipation?
What will you teach your patient regarding constipation and interventions she may take to reduce her symptoms?

UTI/Dehydration
Mrs. M is an 86 year old who lives at an assisted living facility (ALF) near her immediate family’s residence. Her family plans on bringing Mrs. M “home” to their house as soon as their next child graduates and leaves an extra room available. In the mean time Mrs. M’s son and family visits her weekly. During their last visit they notice that Mrs. M is more confused than usual. Since they visit her regularly, the family is able to notice a slight change from Mrs. M’s “baseline” physical and mental health. When asked if Mrs. M was in pain she states that it “hurts to pee and burns a little”. Being extra observant, the family notices that she is not orientated (X3) to person, place, and time. She knows who she is but seems to have difficulty understanding what day and time it is.

Questions:
Since this ALF is sometimes short of staff, which concerns/complaints should the family direct to the caregiver/nurse?
What information would you, the nurse, need to collect?
What procedures or tests need to be done if any to determine Mrs. M’s change in orientation?
What would you teach the staff that might help prevent this situation from happening in the future?
Nutrition
Tom has been residing in an independent living facility since the age of seventy-two. He decided to move there after the passing of his wife. Tom is a fairly health man who has been wearing a hearing aid and some dentures for the last two years. He exercises daily and participates in a program that helps to teach young children how to read. Tom’s natural upbeat attitude began to feel forced and he decided he would visit his physician regarding his constant fatigue. The doctor reviewed his symptoms and decided to refer Tom to a nutritionist. The nutritionist suggested that Tom keep a nutrition log for a week and then return to the office for a review of his intake. At his follow up appointment, the nutritionist discovered that Tom had been eating an extremely well-balanced diet. As a runner, Tom was conscious of healthy eating. His diet consisted of green leafy vegetables, broiled chicken or fish, fresh fruit, whole grains, and water. After reviewing his diet the nutritionist and the physician were at a loss but suggested that Tom take an additional iron supplement to help with his fatigue.

Questions:
A few months went by and Tom continued to feel fatigued and even began to notice a few physical changes. Tom noticed that he began to lose weight, most of which being his muscle mass. What other factors could contribute to these findings?
Knowing that Tom is still suffering symptoms, which referrals would you make?
(Forbes, N., 2007)

Nutrition and Aging
Martha is a 90 year old Caucasian female, who is legally blind and living independently in her own apartment. Martha can see enough to get around in her home and walk her little dog “Lacey”. Martha uses a cane to help her get around and has a history of falls. Martha occasionally cooks with some boxed dinners she buys at Grocery Outlet. She has a friend write the cooking directions in very large letters with a sharpie and tapes it to the box so she is able to cook the meal. Most of the time Martha eats a big lunch and eats ice cream for dinner. Martha has 2 sons, one of which lives in the area and visits her once a week.

Questions:
What are some of your concerns regarding Martha and her nutrition?
Why might Martha be having ice cream for dinner as opposed to other foods? (think about changes in taste sensations that occur in older adults)
What are some nursing interventions you could implement for Martha to improve her nutrition? (think about how socialization and transportation could be affecting Martha’s eating)
(Forbes, N., 2007)

Rest/Sleep
Mr. Magoo is an eighty-two year old male who lives with his son. Over the last three months Mr. Magoo’s son, Fred, has noticed some major changes in his father’s behavior. Fred reports that his father is a kind and gentle man that is functional during the day hours but once the late afternoon arrives his father begins to mumble incoherent words and make statements that do not make sense. Fred also reports that his father has even forgotten who he was and where he lived on a couple of occasions. Fred realized there was a serious problem when he received a phone call from his neighbor at ten o’clock in the evening informing him that his father was wondering around outside. Fred has become very irritable and overwhelmed by his father’s recent behavioral changes and is considering the idea of moving his father into a long-term care facility.

Questions:
What do you think could be the source of Mr. Magoo’s recent behavioral changes? What were his signs and symptoms?
Do you think that if Fred was aware of his father’s syndrome it would change his decision to move him?
As a nurse, what interventions could you teach Fred that could possibly improve his father’s nightly behavior?
(Forbes, N., 2007)
Pressure Ulcers
Mr. Martin West is a 78-year-old widowed male who lives alone in his apartment. He has a son that lives in the same apartment complex, who visits him daily. M.W. is 5’10” and weights 120 lbs. He is in good health, but a week ago he fell and fractured a left hip. The son took him into the hospital and M.W. had a surgery to repair the hip. After the surgery, he complained of 5/10-8/10 pain and was prescribed PRN pain medications. Post-op day #1, he stated that he did not want to do physical therapy and rather decided to stay in bed and not move a lot. He ate about 25% of his soft food diet. Four days post-op, M.W. has become confused and does not want to get out of bed. He needs assistance for transferring. Two weeks post-op, M.W. was admitted to a long-term care facility for rehabilitation. He is no longer confused, eats 50-75% of his meals, and ambulates with a walker. Plans are being made to discharge the patient back home, after complete recovery.

Questions:
What are M.W.’s risk factors for developing pressure ulcers post-op day 1?
Post-op day 4?
What pressure ulcer prevention elements would you recommend for M.W. post-op day 1?
What changes would you make in your pressure ulcer prevention plan on post-op day 4?
What patient education would you include to give M.W. and his son after discharge from a long-term care facility?
(Kudelin Y., 2007)

Skin
Kate is a fifty-nine Caucasian female. Kate has been an avid gardener. She spends hours on end tending to her roses. In her forties she began to notice changes on the skin of her hands and chalked them up to just being “sun spots”. It wasn’t until her granddaughter, a nursing student at the local university, explained to her that her “spots” may actually be cancerous that Kate decided to make an appointment with her doctor. Upon assessment the MD recommended a cell biopsy. The results showed that Kate has actinic keratosis, precancerous lesions. Shortly after hearing the news, Kate had the lesions removed. With the help of her doctors, nurse and granddaughter Kate was fortunate enough to prevent further problems. Her granddaughter helped to provide Kate information on how to decrease her risk factors of developing cancer and proper skin care.

Questions:
If you were Kate’s granddaughter, what types of information would you have given her?
What were some of the risk factors that increased Kate’s chances of developing pre-cancerous/cancerous skin lesions?
How often should Kate be seen by her doctor now that she has had issues with her skin?
(Forbes, N., 2007)

Medication Compliance
Mr. S is an 82 year old with a current medical hx of coronary artery disease, atherosclerosis, hyperlipidemia, and HTN. He has had two relatively minor heart attacks within the last 5 years. Mr. S is an easy-going individual who doesn’t like to stress about life’s worries. His family, however, is concerned that Mr. S is a bit too lackadaisical and doesn’t take his medications regularly. He is prescribed a variety of meds related to his heart condition that require certain precautions. Anti-hypertension meds, for example, should be held if the patient’s BP is below 100/40. Mr. S states that he takes his medications "whenever he feels like it”. If he is feeling alright he doesn’t bother to put “poison” into his body. Sometimes if he misses a dose he’ll just take an extra amount the next morning to “catch up”. Mr. S’s family has a right to be concerned!

Questions:
If you were Mr. S’s adult child (and a nurse) what would you do next?
What can his family members do or say to correct Mr. S’s misconceptions about his disease process and medication compliance?
Suggest some ways that Mr. S can organize/manage his meds to help prevent errors.
(Broadley, T., 2007)
Medications
Mr. John Smith is a 77-year old male, who lives with his son and daughter-in-law after his wife passed away one-and-a-half years ago after a sudden heart attack. After the death of his wife, he has become forgetful and depressed, for which he was prescribed an SSRI-antidepressant. Three months later, he began hearing his wife’s voice. The son took him to a specialist, who prescribed him a neuroleptic medication. You are a nurse working in a day clinic, and J.S. comes in with his son for an annual exam. After completing a thorough H/P, you find out that J.M. has six other medications, besides the neuroleptic and the antidepressant, four of which he takes everyday. He states, however, that often he forgets to take his medication, especially if he is not reminded of that by his son or daughter-in-law. He also told you that he doesn’t like to take thecapsulated medication because he has a hard time swallowing them.

Questions:
What kind of methods do you think a nurse can use to assist older adults with their adherence to medication regimen?
How can you involve the J.S’s family to help J.S. adhere to his medication regimen?
What are some of the side effects of SSRI’s?
What are some of the side effects of neuroleptics?
What can you advise J.S. and his family to assist him in swallowing his capsulated medications?
List and describe positive measures that could be taken by a nurse to promote positive patient teaching in regard to medications.
(Kudelin Y., 2007)

Pain & Comfort
A. S. is an 85-year-old woman that came in for abdominal pain. She came in with her husband. A.S. says that she did not have a bowel movement for eight days. After doing an assessment on her, you find out that she rates her pain 5/10 to 7/10 and it’s colicky. Her past medical history include some hearing loss (she has one hearing aid in place), diabetes, osteoarthritis, and an MI three years ago. The patient was taken to a med-surg floor. After being on the floor for about four hours, the patient had a seizure, after which she lost sensation of her left side and ability to talk. She was transferred to an ICU, where they will continue to assess her and give her medications to relieve her constipation.

Questions:
What are some of the pain cues of older adults?
List data needed for an accurate pain assessment.
What interventions can you do to relieve pain in patients?
How can you assess pain in patients who can’t talk?
What are some of the interventions for osteoarthritis?
What pharmacological and non-pharmacological therapy is available?
(Kudelin, Y., 2007)

Diabetes
D. H. is a 67-year old Native-American male. He was recently diagnosed with diabetes, which is new-onset. He was brought in by his wife. She says that he has been sick for four days with the flu and doesn’t eat much, except for some broth about once a day. Today, he became sweaty, shaky, confused, weak, and anxious, so they decided to go to the hospital. His past medical history includes: mother and sister had diabetes; drinks alcohol; 5’ 10” 250 lbs; smokes ½ pack/day for 40 years. D.H’s current labs have come back with increased white blood cells. His VS are 150/92, 98%, 135 HR, 20 RR.

Questions:
What risk factors does D.H. had/have for developing diabetes?
What type of diabetes does D.H. have? How do you know?
D.H. developed symptoms of what complication of diabetes?
What other complications of diabetes does this patient have?
What goals do you have for this patient in regard to patient teaching and interventions?
(Kudelin, Y., 2007)
Diabetes Mellitus
T.J. is a 67 y.o male who lives in Mississippi. He was diagnosed with D.M II about 7 years ago and has had poor compliance with his therapeutic regimen. T.J is 5’4” and 237 lbs. His BP is 142/86, and T.J has high cholesterol. T.J. enjoys nothing more then meeting his friends in the morning for breakfast for some sausage, eggs and biscuit. His family is constantly on him to eat better and exercise. T.J.’s wife doesn’t want to fight with T.J. about his diabetes so she doesn’t get on him about it. T.J. has candy hidden in his house and sneaks ice cream when he is out shopping by himself. T.J. gives himself insulin injections before meals. He has 4 units of Novolog scheduled at 0730 and 1200 before meals and then sliding scale insulin for blood sugars above 150 dL/mg. T.J.’s Hemoglobin A1C comes back as 8.5%. T.J. still refuses to change his diet. T.J. tells you that his feet have started to become very swollen and they are starting to become numb. You palpate his pedal pulses and note they are barely palpable. Meds T.J is on are Metoprolol 62.5 mg Q12 hr, Amlodipine 10 mg QD, Atorvastatin 80 mg QHS, and Spironalactone 25 mg BID.

Questions:
What is the significance of a Hemoglobin A1C of 8.5%?
What are signs of hypoglycemia and hyperglycemia?
Using the Health belief Model, How would you teach T.J. about the seriousness of diabetes?
What are some barriers that may be keeping T.J. from not complying with his therapeutic regimen?
What teaching learning principles would you keep in mind when teaching T.J.?
Why is it so important for diabetic patients to inspect their feet daily and take meticulous care of their feet?
(Kopral, A., 2007)

Diabetes
George, 53 years old, has type 2 diabetes. For the past seven years, he and his doctor have worked to control his blood sugar levels with diet, exercise and diabetes pills. Recently, George has noticed some changes with his body. He went to see his physician and reported having headaches coupled with blurred vision, fatigue, and cold feet. George swears he had been consistent with his diet and exercise. He also reports that he has been diligent with checking his daily blood glucose levels. George’s labs were drawn. Accucheck BS 213, HgbA1C 9, BUN 32, Serum Creatinine 2.1, and trace urine proteins. Assessment of George’s feet shows no signs of infection or necrotic tissue. After reviewing George’s labs and assessing his physical complaints the physician determined that George had not been controlling his DM and now needs to be started on insulin.

Questions:
What complications do George’s lab values suggest is occurring?
As George’s nurse, what types of referrals would you make?
What areas of patient teaching do you need to review?
Are there any changes you would suggest to George make in his home in spite of his recent visual changes?
What types of factors that normally affect the elderly would add to George’s diabetes diagnosis?
(Forbes, N., 2007)

Bone & Joints
Mary Oaks, 66 yrs old, presents asking for an evaluation of a possible osteoporosis. She is a full-time homemaker, married, with one grown child. She became concerned that she has osteoporosis after attending a health fair at which the disorder was discussed. Past medical history: mother, alive, recovering from fractured hip; father died at 45 in MVA; smoked ½-1 pack/day for five years about 36 years ago. She states that she has increasing frequency of backaches and noticeable rounding of shoulders. Her clothes fit tighter across abdomen, despite no change in weight and that she is hemming clothes that have fit her for years. “My daughter teases me about shrinking”. She drinks three cups of coffee and 4-5 cups of tea daily. M.O. has lactose intolerance but eats occasional cheese and yogurt. She eats fruits, vegetables, and rice daily; rarely eats red meat. Upon doing a 24-hour dietary recall, her calcium intake was less than 800 mgs. She is rather active - walks at least a mile a day and rides stationary bike daily; swims 2-3 times a week. She also likes to work in the garden a few times a
Questions:
What risk factors does M.O. have for developing osteoporosis?
What can you teach M.O. that will help to reduce her risk factors?
What kinds of foods can M.O. eat daily to increase her daily calcium intake?
What else can increase her calcium intake?
List some of the pharmacological interventions for preventing and treating osteoporosis.
(Kudelin, Y., 2007)

Mobility Challenges: Bone/Joint, Falls and Restraints
Mrs. D. is a 65 y.o. female who suffers from bone pain and has gait problems that require her to use a walker. Mrs. D. reports having balance problems since childhood. Mrs. D. wears glasses. Her past medical history includes GERD, hypertension, breast cancer, hiatal hernia and she is currently taking over 18 different meds. She is also diagnosed with Major Depressive Disorder-recurrent. Mrs. D. lives in a HUD housing facility in Davis. She receives a modest amount of money from SSI and a widower’s pension. She states that her biggest support person is her case manager whom she only sees once a week for about an hour.

Questions:
What fall factors does Mrs. D. present?
What are some interventions you would implement for Mrs. D. to reduce the risk of a fall?
What concerns you about Mrs. D.’s social network?
What are some other questions you would ask Mrs. D. in your assessment?
(Kopral, A., 2007)

Bone/Joint Challenges
At the age of seventy-six, Joan suffered her first major fall. The ambulance was called to her home and transported her to the hospital where she was hospitalized due to a fractured hip. An x-ray was taken and shown that Joan had at least 30% bone tissue loss. As a result Joan was diagnosed with osteoporosis. On admission her H&P is as follows: Caucasian female, 130 lbs, 5’5”, fifty years of smoking and alcohol consumption, sedentary lifestyle, post-menopausal with a history of estrogen replacement therapy. Joan has four children and resides by herself in a dual level condo in a city near her eldest daughter. Joan has no prior surgical history to date and declines any psycho-social issues. Joan underwent surgery to repair the fracture. Since her recent fall and surgery Joan has been in severe pain and has decrease her contact with friends and family.

Questions:
What factors did Joan have that could have contributed to her diagnosis?
As Joan’s nurse you know that physical therapy would benefit Joan. How would you reassure her that this something she should seriously participate in?
Which other types of issues are beginning to present themselves?
Would you make any referrals? Are there any other resources that may be available to Joan?
(Forbes, N., 2007)

Cardiac
You are a nurse in a hospital and admitting a new patient to your floor that got transferred from ER. The patient is Billy Hanan, an 81-year old male. He came in to ER with heart pain. VS are 160/98, 94, 18, 93%. Past history includes: hypertension, smoking ½ pack for 32 years, increased cholesterol, and mild arthritis. His mother died of cancer, his father of a heart problem (myocardial infarction). He is married and has three children that live visit him often. He states that over the past half-year he has gained about 10-12 pounds. Also, he says that he has a hard time walking around, especially to church, which is a few blocks away from his house. He states that he gets short of breath, tired, and has heart pain. He says that the pain stops when he rests. He said that he did not think that this was very serious and that having those symptoms when he walks was part of getting old. His wife is very anxious and is always in the room with him. She says that she never told her that his heart hurt so much and confesses to you that she
is very afraid of what will happen to him.

Questions:
The symptoms that B.H. exhibits are typical for which cardiac disorder?
What risk factors does B.H. have to experience the cardiac disorder that you choose for the above question?
List at least four more things that you can do to assess the patient for a cardiac disorder, besides that ones that you have already completed (VS, history, etc).
Which atypical symptoms of the cardiac disorder should you be alert for?
What interventions can you institute?
What family teaching can you give to B.M.'s wife about the cardiac disorder?
(Kudelin Y, 2007)

Respiratory Compromise
K.M is a developmentally delayed 74 y.o. female who was transferred from a SNF after one day of fever. She was found to have PNA (pneumonia). K.M was being treated for a UTI prior to the transfer. She was very agitated and uncooperative during admission. Chest X ray showed a R lung empyema. The pt.'s empyema was drained and she underwent decortication(fibrin and inflammatory cells are removed) which resulted in closed chest drainage with suction to re-expand the lung. VS upon admission were temp 99.1'F, pulse 105, RR 24, BP 132/64 and O2 sat 93% on RA. Pt has Stage I pressure ulcers on back of heels and sacral area. Pt.s CBC came back with WBC 13.3, Hgb 11.3, Hct 33.8, RBC 3.82, and Platelets 922. The pt. continually tries to pull her chest tube out and asks why she has it.

Questions:
What are some priority nursing diagnosis related to the diagnosis of this patient?
When assessing the respiratory system what do you look for?
Why was K.M.'s platelet count so high?
What are some interventions you could use to keep K.M. from pulling at her chest tube with using restraints?
What are signs and symptoms of pneumonia in older adults?
(Kopral, A., 2007)

Cognitive Impairment
Mr. B is a friendly 68 year old who lives alone in his tidy, 3-bedroom house. He is visited several times a week by friends as well as family who live nearby. Over the past few weeks Mr. B has been acting a bit different. Family and friends notice that he has been getting angry easily and raising his voice defensively. He seems confused when his neighbor visited him in the morning and demands that he only has visitors in the afternoon. The neighbor tells Mr. B’s daughter about his odd behavior and she checks out the situation for herself. Since she has a key to her dad’s house she entered on her own when her knock was not received. In the kitchen she finds the stove on with nothing cooking. She yells her dad’s name. Mr. B was in the bathroom and seemed quite startled at his daughter’s presence. Mr. B’s daughter was shocked to find her dad’s face unshaven, his hair uncombed, bags under his eyes, and his clothes a wrinkled mess!

Questions:
What may be wrong with Mr. B?
List all (holistic) the parameters you would assess if you were there with Mr. B’s daughter?
What are his daughter’s first priorities?
What possible challenges could Mr. B’s daughter face emotionally, physically, and/or financially?
(Broadley, T., 2007)

Cognitive Impairments: Memory Loss and Dementia
Mr. W is an 86 y.o male who presents to the E.R with delirium. His Board and care facility explains that Mr. W has been intermittently delusional and has been having hallucinations and has been becoming argumentative and agitated with staff. Mr. W has also not had an appetite the past week. Upon getting
Mr. W has a UTI. Mr. W’s PMH (past medical History) is significant for osteoarthritis, rectal cancer, atrial fibrillation, osteoporosis, depression, urinary retention and has had multiple UTI’s in the past. He also has a Stage II Decubitis ulcer. When caring for Mr. W you enter his room and ask for his name, the date and where he is. Mr. W. states his name correctly but states the date is November, 30 1997 and then when you probe him further to answer where he is he gets very frustrated saying “I’m sick of you nurses constantly asking me these stupid questions” and finally correctly states he is at UC Davis med center. Throughout your shift you continually have to remind Mr. W to use his call light when he needs you because he yells loudly into the hall for you.

Questions:
What are some of the high risk factors Mr. W displays for delirium?
What are some of the tests you could perform on Mr. W to assess the severity of his delirum
What are some prevention techniques you as a nurse can use to prevent delirium?
What are some important communication techniques to use when talking with Mr. W?
What are the differences between delirium and dementia in regards to course of onset, speech, affect, psychomotor activity etc.?

(Copral, A., 2007)

Cognitive Impairment and Older Adults- Stroke
C.T is a 65 y.o Hmong female with PMH of DM II, and HTN. She was found lying on the floor with saliva bubbling from the right corner of her mouth and her R. foot was shaking. She was unresponsive to her family. EMS arrived and brought her to UCD med center where CT showed her to have a L hemorrhagic CVA in the left MCA territory (middle cerebral artery). Her physical assessment was significant for R sided hemiparesis (weakness) and aphasia. C.T. does not speak any English but her family was there to help with neuro assessment and she wouldn’t respond to them or follow commands. Her GCS was a 5-6. C.T. was intubated and had to have left wrist restraint to keep her from pulling out her IV’s and NG tube.

Questions:
Why did C.T. only need a wrist restraint on her L wrist?
What risk factors did C.T. have for stroke?
Why is aphasia common with a L sided stroke?
Why does C.T have Right sided hemiparesis if she had a L hemorrhagic CVA?
You take a BP and it is 131/93. Why would it be beneficial in this situation for the BP to be high?

(Copral, A. 2007)

Parkinson’s Disease
Henry retired from his career of carpentry over ten years ago due to the onset of arthritis. He has been self treating his aches and pains with over-the-counter Ibuprofen for years. His arthritis was the only health issue that had plagued Henry that is until he was diagnosed with Parkinson’s disease two years ago. Henry’s was unaware of any of his symptoms being that of Parkinson’s disease. He assumed that the rigidity and stiffness were a progression of his arthritis. He knew there was something suspicious happening when he experienced uncontrollable hand tremors. After being seen by his physician, he was referred to a neurologist and diagnosed with PD. Henry was prescribed Sinemet, Mirapex, Selegiline, Comtan, and a daily multi-vitamin. Lately, Henry has begun to experience additional symptoms including grimacing, bradykinesia, depression, slight CI, and hallucinations. Henry returned to see his neurologist and also mentioned that he tires easily.

Questions:
What signs and symptoms is Henry exhibiting that are a result of his disease process and/or his medication regimen? Consider his symptoms; are any of them suspicious of possible toxicity?
As a nurse you know that people with Parkinson’s disease are at high risk for developing dementia. What concerns you about his polypharmacy treatment?
What types of interventions could you make that would decrease Henry’s chances of developing adverse drug reactions and help with management of Henry’s Parkinson’s symptoms?

(Forbes, N., 2007)
Falls
Mrs. K is a 76 year old who lives alone with her toy poodle Toby. She has a hx of falls and had a total hip replacement 3 years ago. Her sister died of complications due to osteoporosis. Mrs. K is generally able to care for herself; her ADL’s include bathing three times per week, cooking homemade vegetable soups, watching TV, and trimming the bushes. She cannot drive because she did not pass her license test renewal after three attempts. Her daughter lives 20 minutes away and takes her grocery shopping once a week. Mrs. K’s son who also lives about the same distance away handles her banking. Mrs. K’s granddaughter comes to visit from Sacramento! She is a nursing student. (this is you!) As you stay at her home for the weekend you notice that her hot water is really hot and that you keep tripping on the rugs throughout her house and her hyper dog! You notice that she has prescription for a new Calcium medication lying on the counter with a mixture of other unorganized papers. You open the fridge hoping to drink some milk with a hearty chicken dinner but find neither.

Questions:
Knowing grandma’s history and current living conditions, what can you teach her?
What can you suggest to her son and daughter?
Suggest some improvements that would support Mrs. K’s independence and optimize her health and wellness.
(Broadley, T., 2007)

Falls
Mrs. Rubinstein is a frail 92-year-old woman that arrives at the hospital following a fall in her house. An operation was performed on her, where she had a hip replacement done for her fractured hip. After the surgery, she was transferred to the floor, where you were assigned to her. Her VS on arrival were 89/46, 100, 22, 37.2°C, O₂ 99%. While doing her assessment you learn that Mrs.R. lives alone with her two “kids” (cats Bingo and Aba). She was married for 45-years, has five children and eleven grandchildren, most of who live in the area and visit her often. She lives in an apartment on the first floor, about three blocks away from her son’s family. Her medical history includes: diabetes 2, osteoarthritis, one heart attack about four years ago, back pain, a foot problem, and depression after the death of her husband. She says that when the weather gets hot, she gets headaches and feels dizzy. She states that she almost fell two times that year, but was able to catch herself by grabbing onto the couch, but that “this time I was just not lucky, I guess. You ask her questions about her home environment and learn that T.R. has one rocking chair that she likes to sit in, which she says is a little hard to sit down on since it’s a little low. Also, she says that she has a few throw rugs, one electrical cord on the floor, and that her living room has one lamp for lighting. She likes to knit, read books, and be with her “kids”. She tells you that she feels somewhat nervous about going back to her apartment because she is afraid that she will fall again. Her family visits her and seems anxious about letting her live alone now.

Questions:
Assess the risk factors that Mrs. R. has for a fall.
What other information do you need to get a good fall assessment of Mrs. R.?
What interventions can you take or teach Mrs. Rubinstein about related to: dizziness; foot problems; low light.
What can you teach Mrs. R. and her family to implement in the apartment to make it safer for her to live in?
(Kudelin, Y., 2007)

Falls
Janet is a public health nurse who was recently assigned to Jack. Jack was referred to the county public health nurse by his neighbor who was worried about him because she hadn’t seen him out and about since the passing of his wife six months ago. Jack is a seventy-one year old Caucasian male who now lives alone in his one bedroom apartment. Janet phones Jack and schedules a day and time for her to come visit. Upon arriving at Jack’s apartment Janet instantly can see many environmental safety issues that may pose a risk to Jack’s health. The apartment is dimly lit, has furniture pieces surround all entry ways, and clutter lives on each surface. Jack takes Janet on a tour and she notices loose rugs in the hallways and an electrical cord in the middle of Jack’s bedroom that connects to a space heater on the
floor which is used to heat his room at night. While assessing the physical environment Janet also assessed Jack’s gait and footwear. She noticed he was shuffling and was wearing slippers. During the hour that Janet spent in Jack’s home, she noticed other significant issues that needed to be addressed, such as his emotional pain and his social isolation. Before leaving Janet and Jack scheduled their next appointment together.

Questions:
As a public health nurse on a first home visit, what should Janet’s main priority be?
What types of risk factors would have increased Jack’s probability of falling? How should Janet address these issues with Jack?
Would you make any referrals for Jack? Why?

(Forbes, N., 2007)

Restraints
It has now been two weeks since C.T.’s admission for a L hemorrhagic CVA. She is still in a L wrist restraint. The family is becoming frustrated and asks if it is still necessary. C.T. still tries to pull at her NG tube and trach whenever her restraint is loosened during bathing or during turning.

Questions:
What are some of the benefits of restraint free care on residents/patients?
What are some alternatives to restraints that can be used in the hospital setting?
C.T.’s family comes to visit for a couple of hours a day. What could the family help with so they could help care for their loved one?
What is one of the most important nursing assessments for a person in restraints?

(Kopral, A. 2007)

Abuse
Mary is a seventy-eight year old woman who was diagnosed with Alzheimer’s disease one year ago. Mary has been living with her daughter Alice for the last five years. A recent fall sent Mary to see her physician. Upon assessment, her physician noticed some bruising across her arms and a change in her demeanor. Mary was usually very outgoing and often brought the office cookies when she came in for visits and was now very quiet and shied away from providing any details to questions. The problem was confirmed when Mary’s physician prescribed her some Ibuprofen for her pain and Mary responded that she could not afford any medication ever since her daughter started managing her money. Mary suddenly began to cry and explained that Alice often becomes very frustrated with her. Mary also told her physician that Alice locks her in the house so she can’t get lost and refuses to allow Mary’s friends over. Mary then began to defend Alice’s behavior stating that she was the only one able to take care of her since her husband’s passing.

Questions:
What signs indicate elder abuse?
How is Alice being affected by her mother’s diagnosis?
As a health care professional, what are the appropriate actions to take and agencies to notify in this case?
If you were Mary’s nurse, what would you do or say to comfort and provide support to Mary? What types of resources and support groups would you recommend?

(Forbes, N., 2007)

Sexuality
Mr. G. Miller is a 65-year-old male that comes in to the ER with his wife and oldest son, due to lower abdominal pain. He said that he has been dribbling urine for the past two months and had not voided for 15 hours. After getting his labs and other exams back, the physician decided to hospitalize the patient due to a suspected enlarged prostate. They told him he would have to have a surgery to remove his entire prostate in order for him to regain his ability to urinate normally. After the surgery, G.M. stayed in the hospital for five days. On one of the days you decide to talk to M.G and his wife to teach them about the side effects of the prostate removal and what he can expect. You tell them that he may have a
decrease in his sexuality. Also, you teach him how to do exercises to strengthen his perineal muscles. The wife confesses that she’s glad that somebody has talked to her about the effects of the surgery, because she didn’t know how to bring the subject up for discussion with the physicians.

Questions:
What attitudes toward elders and sexuality are held by the American society? By you?
What are some popular myths concerning sexuality and the elders?
What kind of adjustments to his decreased sexuality do you think G.M may develop?
Do you think the nurse in the scenario was comfortable with her own sexuality & the attitudes toward elders & their sexuality? Why or why not?
How can you help yourself become more competent in dealing with sexuality in the elderly?
(Kudelin Y., 2007)

Paranoia
R.W is a 76 y.o male who is in the hospital for a UTI. He is also very suspicious and paranoid. R.W. must have his glasses on all the time in the hospital or else he will become very anxious. R.W. also has trouble hearing and so you must speak in a loud, clear voice. While in the hospital he insists that the nurses ignore him even though you continually remind him that they have other patients that they have to help. You are aware of R.W.’s suspicions so when it is time for morning meds you make sure you keep all the meds in their packages and show R.W. while you open each one and explain it’s purpose. R.W. appreciates this and seems to feel more comfortable. R.W.’s lunch comes and is not soft diet like he is prescribed. R.W. says the staff is trying to get him to choke by giving him roast beef. He is also very upset because he says he is going to be charged for two meal trays. You assure him it was an accident and you will go get him the correct meal tray and that he will not be charged for the meal tray. After his meal you ask R.W. if he would like his bed bath and oral care. R.W. says that will be fine but would like to watch you fill the bath water. During R. W.’s bath he starts to talk to you and you start to understand that it is the loss of control that has R.W. so paranoid.

Questions:
When might you expect to see these symptoms?
What are some reversible causes of this?
What can paranoia be an early symptom of?
What are important nursing interventions for a suspicious patient?
What is the difference between hallucinations and delusions?
(Kopral, A., 2007)

Caregiving Relationships
I volunteered for Eskaton’s Christmas program called “The Giving Tree”. It is a program in which volunteers deliver Christmas presents to isolated seniors. A year ago I delivered a Christmas present to Mrs. C. Her caregiver and daughter Val was so appreciative of someone coming to deliver her mother a gift. I stayed and visited a while and had a really nice time. I could tell Val was an excellent caregiver to her mom. Her mother was in a hospital bed that was in the family room right next to a big window. The window let in so much light and there was a hummingbird feeder outside next to the window. Her mother enjoyed being in the room where all the action was and watching the hummingbirds outside. Val and her mother seemed to have a wonderful and loving relationship. As Val walked me outside, she asked me for help in finding someone to help her. She said she needed to be able to give her self a break a few hours a week and was really stressed out (although she had not shown any sign of it when we were inside). I had sent messages and posts within the nursing program for someone to help Val as she had asked. She found someone and I did not know what happened after that. About 11 months later, I received a voicemail from a lady who explained to me that I had delivered presents to her house and if I could please call her back. When I called her back I learned it was Val and that her mother had passed away a few weeks earlier. She let me know that she thought I was very friendly and cheerful and then let me know she was very distressed by her mother’s passing and wanted someone cheerful around. Val had been taking care of her 86 y.o. for the past 4 years. Her mother had been in hospice the last year of her life and Val had become very close to the staff that came in daily. When her mother passed away she was devastated. Val was devastated after losing her best friend and losing the visitors and staff that came into
see her mother everyday. Val explained that she was very lonely and that she didn’t have any family or friends in the area. “All the people that came to visit during the day were there to see my mom and now that she is gone, no one comes to visit me”. Val was very upset that she was not allowed to contact the hospice staff after her mother’s passing. Val began smoking a pack and a half a day and had severe anxiety. Val was not able to make her dentist appointment three times because she was in such anxiety. Val said she gets tightness in her chest and hyperventilates when thinking about her mom.

Questions:
What are some nursing diagnosis you see with Val?
What are some resources you would suggest for Val?
What are some barriers that might prevent Val from accessing those resources?
What are some interventions you think would be important in helping Val deal with her grief?
What are the four stages of Caregiving?
(Kopral, A., 2007)

Loss, Dying & Spirituality
Margie was a smoker since the age of sixteen and was diagnosed with lung cancer at the age of sixty-four. She had her right lower lobe removed and underwent radiation therapy, however, her cancer had already metastasized and her prognosis is terminal. After months of treatment and receiving her prognosis from her physician, Margie decided to leave the hospital setting and go home to be with her family. Before being discharged, hospice care was established. Margie’s husband arranged for their daughter to fly in from out of town to spend the last few moments together as a family. Margie’s chief complaints at this stage are pain control and nausea. A hospice nurse has been visiting the home daily and recognizes that Margie is in the final moments. The family gathers at her bedside and the hospice nurse stays in the home. Margie’s husband and daughter each hold a hand and say their last goodbyes. Margie gives one last squeeze of her hands and passes on surrounded by her loving family.

Questions:
As Margie’s hospice nurse, what are your goals in providing care to Margie and her family?
What actions could you take to make their last moments together as peaceful as possible?
If Margie’s family asks you to participate in a family prayer, how would you respond? What if you were of a different religion?
(Forbes, N., 2007)

Late Life Planning
Mr. Jones lived fifty years of his life with his beloved Betty. She passed away just six months ago and the seventy-three year old is slowly resuming his life. He noticed that with her unexpected illness and passing that there was a lack of planning incase of situations such as these. He decided to take the necessary measures to insure that their children wouldn’t have to go through agony again. Mr. Jones had bought the plot next to his wife and established a will. He also appointed his eldest son his durable power of attorney. Mr. Jones specified in his advanced directive that he doesn’t want to be placed on life support especially with the aid of feeding tubes. He also stated his wishes for organ and tissue donation. Once Mr. Jones had completed these tasks he felt very assured that he had done the right thing to help out his family. A few months later, he decided to move in with his son to be closer to family.

Questions:
What is the main goal of the advanced directive?
What are some of the barriers to completion of an advance directive for the elderly?
Where can nurses tell patients to go to get one?
If Mr. Jones were to wait until hospitalization to appoint his son, could his nurses or doctors be witnesses to the advance directive? Why or Why not?
(Forbes, N., 2007)

Relocation - Translocation
Mrs. K was an 82 y.o widow who had lived in Germany all of her life. She came to America once a year to visit her two children and granddaughter. Her husband had been an American soldier in WWII and so
Mrs. K spoke very good English. Mrs. K was the last of her family in Germany and she didn't have much social support. One day her cousin stopped by to see her and found Mrs. K on the floor. She had fallen and couldn’t get up and had been on the floor for 3 days. Her son, A.K., found out about this and was very concerned. About a month later Mrs. K developed a very bad case of Shingles and became very ill. Her son and his wife took turns flying out to care for Mrs. K. A.K decided it was time for his mom to move closer to him and started making arrangements for her to sell her home, car etc in order to come back with him to Sonoma County. A.K found Mrs. K a very nice assisted living place about 2 miles away from where he lived. A.K and his wife had Mrs. K over for dinner weekly and tried to introduce her to people. Mrs. K’s granddaughter would come visit often as well but she could tell her grandmother was not happy. Mrs. K was very isolated and did not feel she related to the people she lived around. She felt Americans were very different and liked to gossip which she did not like to do. She was very independent and did not like socializing. Mrs. K enjoyed long walks by herself. Mrs. K would often complain about how different America was compared to Germany. Mrs. K became more and more depressed and would tell her granddaughter that she thought she was old and that she wished God would take her. Shortly after her move, Mrs. K ended up needing to have triple bypass surgery. While in the hospital recovering from her surgery she had a stroke. She recovered remarkably in a matter of months from her stroke and was finally getting her life back in order. About two months after that Mrs. K died while hiking. She had been taking Coumadin and fell during her hike which caused intracranial hemorrhage.

Questions:
What symptoms did Mrs. K display of translocation syndrome?
What are some interventions that could have been tried in getting Mrs. K to become more involved in her community?
What are some things that could have been done to ease Mrs. K’s transition to America?
Coumadin is an anticoagulant many patients receive in the hospital. What is some important patient teaching with Coumadin?
(Kopral, A., 2007)
Appendix
CSUS
Advisory Standards for Writing in the Undergraduate Major

EXCELLENT - a paper in this category:
• Addresses the assignment thoughtfully and analytically, setting a challenging task.
• Displays awareness of and a sense of purpose in communication to an audience.
• Establishes a clearly focused controlling idea.
• Demonstrates coherent and rhetorically sophisticated organization; makes effective connection between ideas.
• Provides clear generalizations with specific detail, compelling support and cogent analysis.
• Cites relevant sources and evaluates their validity, effectively integrating them into text when appropriate.
• Displays superior, consistent control of syntax, sentence variety, word choice, and conventions of Standard English.

STRONG - a paper in this category:
• Addresses the assignment clearly and analytically, setting a meaningful task.
• Addresses audience needs and expectations.
• Establishes a clearly focused controlling idea.
• Demonstrates clear and coherent organization.
• Provides clear generalizations and effective support and analysis.
• Cites relevant sources, effectively integrating them into text when appropriate.
• Displays consistent control of syntax, sentence variety, word choice, and conventions of Standard English.

ADEQUATE - a paper in this category:
• Addresses the assignment with some analysis.
• Addresses most audience needs and expectations.
• Establishes a controlling idea.
• Demonstrates adequate organization.
• Provides support for and some analysis of generalizations.
• Cites appropriate sources, adequately integrating them into text.
• Displays adequate control of syntax, sentence variety, word choice, and conventions of Standard English.

SERIOUSLY FLAWED - a paper in this category:
• Addresses the assignment inadequately.
• Shows insufficient audience awareness.
• Strays from the controlling idea or the idea is unclear.
• Displays formulaic, random, or confusing organization.
• Lacks generalizations, or provides generalizations with inadequate support or analysis.
• Fails to cite sources or cites and/or integrates them inappropriately.
• Shows deficient control of syntax, word choice, and conventions of Standard English.

FUNDAMENTALLY DEFICIENT - a paper in this category:
• Fails to address assignment
• Demonstrates a lack of audience awareness.
• Lacks a controlling idea.
• Lacks organization or organizes illogically.
• Fails to use outside sources or misuses the texts of others.
• Shows inadequate control of syntax, word choice, and conventions of Standard English.
California State University, Sacramento
Composition Grading Standards

“A” - Excellent Essay

Thesis: The “A” essay has a clearly stated thesis that controls the direction and development of the essay. The thesis is worthy of development, and it has been narrowed sufficiently to be manageable. The thesis and the essay it introduces clearly address the assignment and the instructor’s specific assignment requirements.

Communication: The essay communicates clearly to the reader. The writer has met the audience’s needs and expectations, has chosen a tone that interests and persuades the audience, and has chosen language and examples that clarify the essay’s message.

Development: The main point of each paragraph is clear, and it supports the thesis. These points are in turn developed within the paragraph through analysis and example. The writer uses developmental techniques such as comparison/contrast, cause/effect, or definition to clarify and develop the thesis and adequately support his or her contentions.

Organization: The essay is logically organized, with each paragraph leading clearly to the next and building support for the thesis. Transitions are effective and clear. The essay’s introduction engages the reader’s interest, and the conclusion is appropriate, effective, and not mechanical or redundant.

Style: The essay is clear and concise with little awkwardness or ambiguity. Sentences show variety and effective use of subordination, and there are few, if any, examples of choppy sentences, awkwardness or wordiness. Diction is not only correct but shows careful and sensitive choice. The essay reflects the writer’s awareness of the relationship between voice, audience, purpose and the essay’s content and style. The writer has created a fresh personal and provocative essay.

Mechanics: There are few, if any, mechanical or grammatical errors. Editing is thorough, and the manuscript is neat.

Revision: The essay reveals that the writer has thought carefully about the assignment and the topic, has explored and analyzed his or her thoughts, and has revised for clarity, audience awareness, development, persuasiveness, and correctness.

“B” - Good Essay

The “B” essay will contain some, but not all, of the strengths of the “A” essay, falling away from the “A” essay in some of the following ways:

The “B” essay responds appropriately to the assignment with a thesis that is challenging, clear and worth developing. As in the “A” essay, the thesis controls the direction of the paper. The writer addresses the audience persuasively, though the essay might occasionally fall short of anticipating the audience’s needs and expectations.

The thesis is persuasively argued and adequately supported, though the essay’s examples might be less specific, vivid, or appropriate than those of the “A” essay. Organization is clear and logical, though occasionally relocating a paragraph or an example or searching for a smoother transition would have strengthened the essay.

Generally, sentence structure is varied and correct and diction reflects careful revision and thoughtful choices. Though the essay might contain a few mechanical errors and some ineffective sentences, others might occasionally show rhetorical flair. As with the “A” essay, the “B” essay reflects the writer’s thoughtfulness and care with revision. Editing is thorough, and the manuscript is neat.
“C” - Satisfactory Essay

Like the “A” and “B” essays, the “C” essay will be organized around a central idea and will address the assignment. However, the thesis might be less clearly defined, it might not be sufficiently narrowed to tightly guide the essay’s direction, or it might be less engaging than the thesis of the “A” or “B” essay.

While the essay does focus on the assignment and the writer does develop the thesis with examples and details, the examples might sometimes be sparse or the details might occasionally be too general. The essay’s organization is generally clear but might be stiff or formulaic, transition might be weak, and some lapses in paragraph unity or occasional repetition of ideas might lessen the essay’s effectiveness and weaken its clarity. While the essay does reflect some awareness of audience and tone, this awareness will generally be less strong than in the “A” or “B” essays, and the essay will thus be less persuasive and less clear.

Most sentences are correct, but some might be monotonous (choppy, repetitive, or lacking in variety or subordination) or might contain some errors in grammar, punctuation, or sentence structure. While the errors are not so severe as to impede understanding, it might be apparent that ideas calling for complex construction and fine distinctions over-extend the writer’s stylistic and rhetorical resources.

The essay communicates, but the writer does not exhibit complete control over clear, effective expression of his or her ideas nor over the process of revising for clarity, persuasiveness, and correctness. Editing has occurred, and the manuscript is neat.

“D” - Poor Essay

The “D” essay has no central idea or one that is too general to give shape to the paper or too obvious to be developed. The essay might not focus adequately on the assignment and it might not adequately address the audience’s needs and expectations. The essay’s arguments lack support, development is inadequate, and the writer might exhibit a poor balance between general ideas and specific development of those ideas. The essay might contain organizational problems such as faulty or nonexistent transitions or paragraphs that do not logically connect to one another or to the thesis.

As a result of incorrect or ineffective work choice, lack of audience awareness, or a weak sense of voice, the essay is not persuasive. Sentences are often ungrammatical or poorly constructed, or they contain inadequate variety and subordination. Problems with spelling, punctuation, diction, proofreading and editing further impede understanding, force the reader to pause or backtrack in order to follow the discussion, and hinder effective communication. The writer needs to increase and improve his or her revision for clarity, focus, persuasiveness and correctness. Editing has not occurred, and the manuscript is not neat.

“F” - Failing Essay

The “F” essay often has no central idea. Its organization might be random, or the essay might lack focus. The writer does not exhibit a sense of audience awareness. As a result, the essay might have little development of support, it might be missing clarifying details and examples, or it might contain details that are irrelevant or distracting. The essay might be off the topic or be unduly brief.

The essay’s sentences might be choppy, with the writer depending on may simple sentences lacking variety or subordination. The essay will usually contain major and repeated errors in diction, syntax, grammar, punctuation, spelling. and/or proofreading. The essay, because of its multiple problems, fails to communicate, and needs extensive revision for clarity and effectiveness. Editing has not occurred, and the manuscript is not neat.
Citation Decision Chart

Ask yourself the following questions to help determine the need for citations in your papers.

Did **You**
Come up with
the idea?

*Think about where the idea came from ...*

No

---

Do most people know this information?

*Think about where you learned it ...*

No

---

Cite it!!

Yes

---

Don’t Cite!!
Loneliness and How it Affects Older Adults

(Your Name)

California State University Sacramento

Paper (abstract) starts on next page, page 2. Include heading (same as on first page but no Running head label, left side, in caps) with page # in upper right margin (as done in syllabus).
Elder Panel Discussion Questions

Thank you for agreeing to participate in the CSUS Senior Panel!! You will be presenting along with several other elder members of our community. The age varies from semester to semester but ranges from 65 years onward (the oldest so far has been 102)!!

We plan for the panel and discussion time to take approximately 1 1/2 hours (it varies with the number of panel participants). The class begins at 1:30. This should allow you to leave around 3:10 pm.

The following topics/questions have been designed to allow you to think about some of the questions our students are interested in hearing you talk about. These topics were developed to help you organize your thoughts - they are topics we have been studying throughout the semester. Please feel free to talk about any or all topics. We plan for each of you to have about 5 - 10 minutes to share your outlook on growing older and then we will open up the discussion for questions and answers.

Topics to think about........

How "old" do you feel? How does that compare with your "real" age?

What does "growing older" mean to you?

Do you think others should treat you with more respect just because you are older? Do they?

What do you see as the positive and negative aspects of growing older?

Who taught you about aging as you grew older?

Have your values/beliefs, habits or ideas changed over the years? If so, how?

What do you do to stay healthy and fit?

What was the hardest transition for you in your life?

What world event/situation affected you/your generation the most?

How do you stay involved with and connected to society and the world?

Do you think technology has simplified our lives or do you think life is more complex with these conveniences?
What was “good pay” when you started to work?

What preparation/preplanning did you do for retirement?

How do you feel about the way older Americans are portrayed in the media?

If you could, what if anything, would you do differently in your life?

Describe a typical day in your life.

What are some of the best moments in your life?

What is your greatest worry about growing older?

How have your relationships changed since you were young?

What helps you get through hard times?

What do you see as the biggest issue facing seniors today?

What differences do you see in the government from when you were young?

Describe the happiest time in your life.

What wisdom can you leave with us?
COMMUNITY AGENCY/SERVICE ASSESSMENT GUIDE
Use to get helpful information for your elders related to your Fact Sheet for Elders & Families

GENERAL INFORMATION:
Name of Agency/Service:

Name of Program:

Address:

Phone Number:

Fax Number:

Website:

Funding Sources(s):

Hours/Days of Service:
  Appointments needed?
  How far in advance?
  Length of waiting period?

Accessibility to Transportation?
  Public?
  Other?

SERVICES PROVIDED:

ELIGIBILITY CRITERIA:
Residency:

Age:

Financial:

Other:

FEES:
Insurance?

Medicare?

Sliding Scale?

Free to indigent?

Other:
REFERRALS:
By whom (who can make them to this agency?):

Telephone/Written?

Client information needed:

OTHER PERTINENT AGENCY INFORMATION:

QUESTIONS ASKED BASED ON YOUR FACT SHEET LITERATURE REVIEW (cite authors):

ANSWERS TO QUESTIONS BASED ON YOUR FACT SHEET LITERATURE REVIEW (cite authors)
Complete the following information for your each of your group member’s Community agencies/services on this one Grid. Remember to include citations tying it to your Fact Sheet research! Email this grid to Dr. O (osborne@csus.edu) on the date designated in your N117 Week At a Glance so it can be included in the Gero Department Web Resource Guide.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address /Phone</th>
<th>Website/Contact</th>
<th>Eligibility</th>
<th>Service Summary (Benefits/limitations)</th>
<th>Fees, Payment, Transportation</th>
<th>Student Impressions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Network</td>
<td>425 University Ave. Suite 222</td>
<td>myercmcmedicalgroup.org/For_Patients/Counseling_And_Psychiatry/STGS S046591 (Home Page for all services)</td>
<td>- 60 years of age or older&lt;br&gt;- A resident of Sacramento county&lt;br&gt;- In a present or potential crisis due to mental health problems such as confusion, disorientation, failing memory, depression, fearfulness, social isolation, adjustment or other emotional problems (Lee, 2008)&lt;br&gt;- Or have significant stressors, which may include: post psychiatric crisis unit contact or hospitalization, or frequent emergency response calls or emergency department contacts, have physical limitations, transportation issues or difficulty accessing psychiatric services (Vourakis, 2009)</td>
<td>- Crisis prevention &amp; intervention, including assessment &amp; treatment planning (Osborne, 2009)&lt;br&gt;- Preliminary conservatorship evaluation and referral&lt;br&gt;- Case management to provide an in-home psychosocial assessment and coordination of care to maintain appropriate level of independence&lt;br&gt;- Medication evaluation, education and monitoring (Osborne, 2009)&lt;br&gt;- Referral and linkage with other community resources&lt;br&gt;- Consultation with family agencies, residential facilities or other providers of care (Eskaton, 2009)&lt;br&gt;- Community education about senior services &amp; the mental health needs of the elderly&lt;br&gt;- Trained &amp; supervised senior companions &amp; senior peer counselors provide supportive services such as companionship, emotional support, assistance with errands, paperwork, transportation or other duties PRN.</td>
<td>Payment for deductibles, co-payments and non-covered services is required at the time of your visit. To request special payment arrangements, or to see if you are eligible for the charity care policy, contact the Patient Financial Services Department (800) 576-5050.</td>
<td>(Student Name) This in-home mental health program for Sacramento Residents is a partnership between CHW Medical Foundation and the County of Sacramento Health and Human Services Department. It is easy to access on-line or in phone book &amp; community pamphlets; Office staff are friendly and willing to answer all questions for family. This service is in-home focused so transportation is not an issue.</td>
</tr>
</tbody>
</table>
## Generation By Generation

<table>
<thead>
<tr>
<th>GENERATIONAL COHORT</th>
<th>BIRTH YEARS</th>
<th>DEFINING EVENTS</th>
<th>INFLUENCES</th>
<th>CHARACTERISTICS &amp; ATTITUDES</th>
<th>CLASHPOINTS</th>
</tr>
</thead>
</table>
| **Traditionalists**  | 1900-1945 (ages 64+) | Flue epidemic of 1918, Roaring 20s, Great Depression, WWII, Korean War, GI Bill | FDR, Bob Hope, Betty Crocker, Joe DiMaggio, Joe McCarthy, Duke Ellington, Frank Sinatra | Loyal, patriotic, hardworking, faith in institutions | Career Goals = Build a legacy  
Work Environment = Chain of command  
Feedback = No news is good news  
Training = I learned the hard way - you can too!  
Balance Concept = Support me in shifting the balance  
Rewards = The satisfaction of a job well done  
Job Changing = Carries a stigma  
Retirement = Reward (well-earned for service to company, country & family) |
| **Baby Boomers**     | 1946-1964 (ages 45-63) | TV, Motown, civil rights, Vietnam War, assassinations of JFK, MLK, Bobby Kennedy, Woodstock, Kent State, Cold War, Haight-Ashbury, Watergate, women’s rights, disco, sputnik | James Dean, Elvis Presley, Beaver Cleaver, Bob Dylan, The Beatles, Eldridge Cleaver, Gloria Steinem | Idealistic, optimistic, career-driven, question authority, challenge status quo | Career Goals = Build a Stellar career  
Work Environment = Change of command  
Feedback = Once/year & lots of documentation  
Training = Train 'em too much and they’ll leave!  
Balance Concept = Help me balance everyone else & find meaning myself  
Rewards = Money, title, recognition, the corner office  
Job Changing = Puts you behind others  
Retirement = Retool |
Work Environment = Self command  
Feedback = Sorry to interrupt, but how am I doing?  
Training = The more they learn, the more they stay  
Balance Concept = Give me balance now, not when I’m 65  
Rewards = Freedom is the ultimate reward  
Job Changing = Is necessary  
Retirement = Renew during career |
| Generation Y (Millennials) | 1981-1999 (ages 10-28) | Columbine, hip-hop, 9/11, Iraq War, cell phones, text messaging, IM, My Space, global warming | Sammy Sosa, Mark McGwire, Prince William, Chelsea Clinton, Eminem, Serena Williams, Britney Spears, Justin Timberlake | Realistic, confident, techo-savvy, take the best from earlier generations | Career Goals = Build a Parallel career  
Work Environment = Don’t command  
Feedback = Whenever I want it at the push of a button  
Training = Continuous learning is a way of life!  
Balance Concept = Work isn’t everything; I need flexibility so I can balance all my activities  
Rewards = Work that has meaning for me  
Job Changing = Is part of my daily routine  
Retirement = Recycle |
|--------------------------|------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Cuspers | 1940-1945  
1960-1965  
1975-1980 | | | Identify with one or other generation, or have characteristics of both | |

Assessment and Management of Falls

- **Ask patient about any falls in the past**
  - No Falls
    - **No Intervention**
    - **Recurrent Falls**
    - **Gait/Balance Problem**
      - Check for Gait/Balance Problem
        - No Problem
          - **Single**
          - **Fall Evaluation**

Patient presents to Medical facility after Fall

**ASSESSMENT**
- History
- Meds
- Vision
- Gait/Balance
- Lower Limb joints
- Neurological
- Cardiovascular

**MULTIFACTORIAL INTERVENTIONS**
- Gait/Balance Exercise ~ Programs
- Medications ~ Modification
- Postural Hypotension ~ Treatment
- Environmental Hazards ~ Modification
- Cardiovascular Disorders ~ Treatment