Chapter 3: Common Health Problems of Older Adults
Test Bank

MULTIPLE CHOICE

1. An older client is agitated and develops new-onset confusion on admission to the long-term care unit. What is the best action for the nurse to take to minimize relocation stress syndrome for this client?
   a. Provide reorientation during hourly rounding.
   b. Obtain a certified sitter to remain with the client.
   c. Speak to the client as little as possible to avoid overstimulation.
   d. Provide adequate sedation to lessen fear-provoking situations.

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

   DIF: Cognitive Level: Application/Applying or higher REF: N/A
   TOP: Client Needs Category: Psychosocial Integrity (Stress Management)
   MSC: Integrated Process: Nursing Process (Implementation)

2. Which intervention would best support a client who relates a feeling of "loss of control" after having a mild stroke?
   a. Explain that such feelings are normal, but that expectations for rehabilitation must be realistic.
   b. Encourage the client to perform as many tasks as possible and to participate in decision making.
   c. Further assess the client's mental status for other signs of denial or psychopathology.
   d. Obtain an order for physical and occupational therapy evaluations.

   ANS: B
   Older adults can experience various losses that affect their sense of control over their lives, including a decrease in physical mobility. The nurse should support the client's self-esteem and increase feelings of competency by encouraging activities that assist in maintaining some degree of control, such as participation in decision making and performing tasks that he or she can manage. Obtaining an order for therapy evaluations is a normal part of the rehabilitation process. The other choices imply that the client's sense of loss is abnormal after a stroke.

   DIF: Cognitive Level: Application/Applying or higher REF: N/A
   TOP: Client Needs Category: Psychosocial Integrity (Coping Mechanisms; Grief and Loss)
   MSC: Integrated Process: Nursing Process (Implementation)

3. What will the nurse teach the older client with hypertension who complains that "food does not taste good without salt"?
   a. Salt can be used as long as blood pressure remains controlled.
   b. All salt should be removed from the diet to preserve kidney function.

c. Table salt can be used in small amounts in conjunction with diuretics.
d. Herbs and spices can be substituted to season food.

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

DIF: Cognitive Level: Application/Applying or higher REF: N/A
TOP: Client Needs Category: Health Promotion and Maintenance (Self-Care)
MSC: Integrated Process: Teaching/Learning

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

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

DIF: Cognitive Level: Application/Applying or higher REF: N/A
TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control—Accident/Injury Prevention)
MSC: Integrated Process: Nursing Process (Implementation)

5. An older adult client is in physical restraints. Which intervention by the nurse is the priority?
a. Assess the client hourly while keeping the restraints in place.
b. Assess the client every 30 to 60 minutes, releasing restraints every 2 hours.
c. Assess the client once each shift, releasing the restraints for feeding.
d. Assess the client twice each shift while keeping the restraints in place.

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

DIF: Cognitive Level: Application/Applying or higher REF: N/A
TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control—Use of Restraints/Safety Devices)
MSC: Integrated Process: Nursing Process (Implementation)

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

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

   DIF: Cognitive Level: Application/Applying or higher REF: N/A
   TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control—Accident/Injury Prevention)
   MSC: Integrated Process: Nursing Process (Implementation)

7. An older adult client presents with signs and symptoms related to digoxin toxicity. Which age-related change may have contributed to this problem?
   a. Increased total body water
   b. Decreased renal blood flow
   c. Increased gastrointestinal motility
   d. Decreased ratio of adipose tissue to lean body mass

   ANS: B
   Decreased renal blood flow and reduced glomerular filtration can result in slower medication excretion time, potentially leading to toxic drug accumulation. Aging results in decreased total body water and gastrointestinal motility and an increase in the ratio of adipose tissue to lean body mass, but is not related to digoxin toxicity.

   DIF: Cognitive Level: Comprehension/Understanding REF: p. 20
   TOP: Client Needs Category: Health Promotion and Maintenance (Aging Process)
   MSC: Integrated Process: Nursing Process (Assessment)

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

   ANS: C
   Changing the dose of medication without a correct understanding of the drug's use and appropriate schedule can cause serious problems. The other statements indicate good understanding of self-administering medications.

DIF: Cognitive Level: Application/Applying or higher REF: N/A
TOP: Client Needs Category: Health Promotion and Maintenance (Self-Care)
MSC: Integrated Process: Nursing Process (Evaluation)

9. An older adult client is being discharged from the hospital on several medications. Which intervention best reinforces medication teaching for this client?
   a. Have the client actively participate in drug administration during hospitalization.
   b. Include the client's children in discussions regarding medication administration.
   c. Give the client a pamphlet with the actions, side effects, and doses of all drugs.
   d. Make a chart showing which drugs should be taken at specified times during the day.

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

   DIF: Cognitive Level: Application/Applying or higher REF: N/A
   TOP: Client Needs Category: Health Promotion and Maintenance (Self-Care)
   MSC: Integrated Process: Teaching/Learning

10. An older adult client's spouse has died, and the family expresses concern that the client has lost weight recently and now refuses to attend the annual family reunion. The nurse should assess this client further for what clinical condition?
    a. Psychosis
    b. Depression
    c. Dementia
    d. Delirium

    ANS: B
    Situational depression can result after a loss and is defined as a mood disorder with cognitive, affective, and physical symptoms. Dementia is characterized by a gradual decline in intellectual functioning that is chronic and progressive compared with delirium, which is an acute state of confusion that is short term and reversible. Psychosis is a mental health problem that usually is not driven by loss.

    DIF: Cognitive Level: Application/Applying or higher REF: N/A
    TOP: Client Needs Category: Psychosocial Integrity (Grief and Loss)
    MSC: Integrated Process: Nursing Process (Assessment)

11. Which behavior exhibited by an older adult client alerts the nurse to the possibility that the client is experiencing delirium?
    a. Becoming confused within 24 hours after hospital admission
    b. Displaying a cheerful attitude despite a poor prognosis
    c. Becoming withdrawn and sleeping most of the day
    d. Beginning to use slurred speech and losing coordination

    ANS: A
    Delirium is characterized by acute confusion that is usually short term. Delirium can result from placement in unfamiliar surroundings, such as being hospitalized. Depression is characterized by an increase in sleep and lack of social contact. Slurred speech may indicate a stroke.

DIF: Cognitive Level: Comprehension/Understanding REF: p. 23
TOP: Client Needs Category: Physiological Integrity (Reduction of Risk Potential—Potential for Alterations in Body Systems) MSC: Integrated Process: Nursing Process (Assessment)

12. A client with Alzheimer's disease has been hospitalized for dehydration. In making an assessment, the nurse notes the presence of a cluster of bruises on the client's buttocks. What is the nurse's priority action?
    a. Call the local police to report a crime.
    b. Notify the client's physician and social worker.
    c. Confront the client's caregiver with the suspicions.
    d. Alert security to prevent visits by the client's caregiver.

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

    DIF: Cognitive Level: Application/Applying or higher REF: N/A
    TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control—Abuse/Neglect) MSC: Integrated Process: Nursing Process (Assessment)

13. An older adult client is suspected of being neglected by the caregiver. What assessment provides the nurse with the best information about this possibility?
    a. Inspect skin in the "bathing suit zone" for bruises.
    b. Assess the client for orientation to person, place, and time.
    c. Compare the client's current weight with prior recorded weights.
    d. Perform orthostatic pulse and blood pressure readings.

    ANS: C
    Neglect is often manifested by dehydration, undernutrition, pressure ulcers, or contractures. Injuries raise the suspicion for abuse, whereas disorientation and rapid heart rate/high blood pressure can be the result of disease processes. Noting the client's weight trend would be a helpful assessment related to this suspicion.

    DIF: Cognitive Level: Application/Applying or higher REF: N/A
    TOP: Client Needs Category: Psychosocial Integrity (Abuse/Neglect)
    MSC: Integrated Process: Nursing Process (Assessment)

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

    ANS: C
    Older adults on fixed incomes are unable to adjust their income to meet rising costs associated with meeting basic needs.

    DIF: Cognitive Level: Comprehension/Understanding REF: p. 18
    TOP: Client Needs Category: Physiological Integrity (Basic Care and Comfort—Nutrition and Oral Hydration) MSC: Integrated Process: Nursing Process (Planning)

15. An older adult client is in the hospital. To what government resource would the nurse refer the client to help meet the cost of health care?
    a. Preferred provider organizations
    b. Health maintenance organizations
    c. Medicare Part A
    d. Medicare Part B

    ANS: C
    Medicare is a federal insurance program designed to assist older adults to meet the cost of health care in the hospital. Medicare Part B covers a certain percentage of outpatient services and is paid for by the older adult. Preferred provider organizations and health maintenance organizations are private providers of health care.

    DIF: Cognitive Level: Application/Applying or higher REF: N/A
    TOP: Client Needs Category: Safe and Effective Care Environment (Management of Care—Advocacy) MSC: Integrated Process: Nursing Process (Planning)

16. A nurse is assessing a client at risk for dehydration. Which statement by the client indicates that more education by the nurse is required?
    a. "I try to limit coffee to one cup in the morning and one cup in the early evening."
    b. "During the day I drink at least six to seven glasses of water."
    c. "Alcohol causes me to frequently urinate so I cut it out of my diet."
    d. "I stop drinking fluids in the afternoon to avoid bathroom trips at night."

    ANS: D
    Older adults have less body water than younger adults. It is recommended that the older client drink at least six glasses of water each day to avoid dehydration. Caffeine and alcohol intake can stimulate more loss of fluid from the body, further increasing the risk for dehydration. The older client needs to continue to drink fluids throughout the day and should not limit fluids because of mobility problems, diuretic use, or incontinence.

    DIF: Cognitive Level: Application/Applying or higher REF: N/A
    TOP: Client Needs Category: Health Promotion and Maintenance (Self-Care)
    MSC: Integrated Process: Teaching/Learning

17. An older adult recently had a hysterectomy and has requested some medication for pain. The physician leaves an order for meperidine (Demerol). Which action by the nurse is most appropriate?
    a. Assess the client's pain 1 hour after giving the medication.
    b. Call the physician and request a different pain medication.
    c. Assess the client's respiratory rate often after administering the Demerol.
    d. Ensure that the client does not receive iron supplements at the same time.

    ANS: B
    Meperidine (Demerol) is included among the Beers criteria for potentially inappropriate medication use in older adults. Morphine, codeine, and hydromorphone are acceptable medications for the older adult that the nurse could suggest to the physician. Assessing the client's pain and monitoring respiratory rate are important interventions for any client receiving narcotic analgesics, but in this case, client safety is best ensured by not administering inappropriate drugs. Iron supplements can be administered without regard to Demerol.

DIF: Cognitive Level: Application/Applying or higher REF: N/A
TOP: Client Needs Category: Physiological Integrity (Pharmacological and Parenteral Therapies—Adverse Effects/Contraindications/Side Effects/Interactions)
MSC: Integrated Process: Nursing Process (Planning)

18. A nurse manager is planning a comprehensive care plan for older clients admitted to the medical-surgical unit. To decrease hospital stays and lessen the pain that older clients experience, which standard intervention should the manager include in the care bundle for this population?
    a. Assess all clients for depression.
    b. Obtain a dietary consult for nutrition assessment.
    c. Perform medication reconciliation on admission.
    d. Screen all clients for alcohol and drug use.

    ANS: A
    All actions would be important parts of a care bundle for older adult clients admitted to a hospital. However, depression is the most common mental health/behavioral health problem among older adults in the community. Early detection can prevent the effects of depression, including worsening of medical conditions, increased pain and disability, and delayed recovery from illness. Failure to diagnose and treat depression can result in risk of physical illness, alcoholism, and suicide.

    DIF: Cognitive Level: Application/Applying or higher REF: N/A
    TOP: Client Needs Category: Physiological Integrity (Reduction of Risk Potential—Potential for Complications from Surgical Procedures and Health Alterations)
    MSC: Integrated Process: Nursing Process (Planning)

MULTIPLE RESPONSE

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

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

    DIF: Cognitive Level: Comprehension/Understanding REF: p. 23
    TOP: Client Needs Category: Physiological Integrity (Reduction of Risk Potential—Potential for Alterations in Body Systems) MSC: Integrated Process: Nursing Process (Planning)

2. An older adult client has been admitted to a skilled nursing facility following surgery. What interventions should the nurse add to this client's care plan to assist with adjusting to this situation? (*(Select all that apply.)*

a. Make sure the client has hearing aids and glasses.
b. Offer the anxiolytic that the physician has prescribed.
c. Encourage the family to bring in favorite pictures.
d. Ask where the client wants the room furnishings placed.
e. Encourage the client to eat meals alone in his or her room.
f. Set a daily schedule for the client that includes group activities.

ANS: A, C, D
An anxiolytic may increase the difficulty that the client has in interpreting new surroundings. Encouraging the client to eat alone and setting a daily schedule for the client discourages decision making about activities of daily living. Making sure that the client can see and hear will help in environmental interpretation, familiar possessions will provide a sense of identity, and having some input into the organization of his or her immediate surroundings helps develop a sense of control.

DIF: Cognitive Level: Application/Applying or higher REF: N/A
TOP: Client Needs Category: Psychosocial Integrity (Coping Mechanisms)
MSC: Integrated Process: Nursing Process (Planning)

3. The nurse is assessing several clients. Which clients does the nurse identify as being at high risk for falls? *(Select all that apply.)* The client:
   a. With visual impairment such as presbyopia
   b. Who is reluctant to use a cane while walking
   c. Who performs Tai Chi exercise daily
   d. Who wears a hearing aid and glasses
   e. Who has difficulty arising from a sitting position
   f. Who is male and over 55 years of age

   ANS: A, B, E
   Vision, hearing, and mobility difficulties are associated with increased fall risk. Tai Chi improves balance and mobility. Wearing a hearing aid and glasses would lessen problems with auditory impairment. Being a male over 55 years of age is not considered a risk factor for falls.

   DIF: Cognitive Level: Application/Applying or higher REF: N/A
   TOP: Client Needs Category: Safe and Effective Care Environment (Safety and Infection Control—Accident/Injury Prevention) MSC: Integrated Process: Nursing Process (Assessment)

4. What interventions can the nurse apply to help an older adult client who is having trouble sleeping while in the hospital? *(Select all that apply.)*
   a. Changing the client's sheets each night before sleep
   b. Decreasing the level of light surrounding the client's bed
   c. Attempting to keep the client awake during the daytime
   d. Keeping staff conversations as quiet as possible
   e. Administering sleeping pills at night
   f. Administering pain medication before bedtime
   g. Asking the client if he or she would like to pray

   ANS: B, C, D, F

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

DIF: Cognitive Level: Application/Applying or higher REF: N/A
TOP: Client Needs Category: Physiological Integrity (Basic Care and Comfort—Rest and Sleep)
MSC: Integrated Process: Nursing Process (Implementation)

5. An 89-year-old is admitted to the medical-surgical floor. The nurse is formulating the client's plan of care. In assessing the client, which findings would be considered part of the clinical syndrome of frailty? *(Select all that apply.)*
   a. Increased appetite
   b. Weight loss
   c. Weakness
   d. Decreased sleep
   e. Slowed gait

   ANS: B, C, E
   Frailty as a clinical syndrome is characterized by unintentional weight loss, weakness, exhaustion, and slowed physical activity such as walking. Increased appetite and decreased sleep are not necessarily part of this syndrome.

   DIF: Cognitive Level: Knowledge/Remembering REF: p. 16
   TOP: Client Needs Category: Physiological Integrity (Reduction of Risk Potential—Potential for Alterations in Body Systems) MSC: Integrated Process: Nursing Process (Assessment)