

Geriatric Nursing Principles

A Home study

Course

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Course Objectives

Upon completion of this program, each participant will be able to:

1. Define the term, “Later Maturity” rather than using the term “Old Age” as the last developmental stage
2. Name and describe the stereotypes and attitudes used in describing and dealing with elderly clients
3. Explain how personal values, attitudes and feelings about the elderly, will affect the behavior of people toward the elderly
4. Name and describe at least two methods of effective communications that allow the nurse to obtain a good nursing history during the assessment process
5. Name at least two interventions that can be useful for individualizing the nursing care for the elderly client
6. Name and discuss at least two characteristics of the helping relationship
7. Name at least two behaviors that indicates a helping relationship for the elderly patient
8. Name and describe at least five physical changes that commonly occur in later life
9. Name and describe at least two ways in which the nurse can intervene supportively, using self, environmental, or physical aids, to help the senior maintain or regain cognitive competency
10. Name and describe at least one method of exploring the meaning of death and personal attitudes toward dying, death and the maintenance of life

Introduction

Understanding the aging process provides the nurse with an important perspective on the care of the elderly patient. The longest living humans today, live no longer than they did centuries ago. Maximum human life span is approximately 100 years of age. This has not changed. However, the average life expectancy has increased dramatically. The average life expectancy in 1900 was 47 years old. In 1990 the average life expectancy is now 75 years old. In 1900 only about 4% of the population was age 65 years or older. Today about 12-13% of the population is over 65. Within the next 50 years, the over 65 population is expected to double.

One of the prime reasons for this increased life expectancy is the dramatic increase of infant survival. The advent of good prenatal care and improved delivery techniques have given people in our country a tremendous advantage at the start of our lives. There are other contributing factors as well. Better sanitation, better nutrition, better standard of living, better medical care and prevention and treatment of diseases have all contributed to our longer life expectancy in this country and around the world. All these factors contribute to a better survival rate for children born in America. Once these children reach adults, they are more likely to get to old age.

These major reasons for the lengthening of life EXPECTANCY are:

- a. Better prenatal care
- b. Better delivery techniques
- c. Better medical care
- d. Better nutrition
- e. Better use of preventative measures
- f. A generally higher standard of living
- g. More leisure time

- h. Research in many areas that contributes toward making life more comfortable and healthier (Murray 1980)

In addition, society's attitudes and the attitudes of each of us toward those who have lived long enough to become a part of the aged statistics are also important. These attitudes cannot be so quickly listed and resolved. The medical and nursing professions have not been quick to plan for, or implement health care to meet the unique needs of people in later maturity, the not-so-old, and the very old.

One of the objectives of this program is to stimulate you, the nurse, to look at the person and family in later maturity with a more positive yet realistic attitude. This objective includes stimulating your senses of empathy and compassion. Empathy and compassion for elderly clients are fostered by your understanding of the aging process and all the social attitudes and stressors imposed upon the person (Murray 1980).

Remember how very important you, the nurse, are to the elderly person with whom you work. Through an appraisal of your involvement with the person living through the last developmental stage, you will grow in self-knowledge, self-acceptance and fulfillment. These qualities, which indicate a personal depth and integrity, may then become the basis for further compassionate caring and knowledgeable nursing (Murray 1980).

Later Maturity refers to the last developmental stage in life. This stage begins after retirement age, usually 65-70 years of age, in this country. Traditionally, this era has been called old age. However, this encompasses such a large time span. Therefore, some persons refer to these ages of 65 to 75 as the YOUNG-OLD Ages. The OLD-OLD Ages are considered the years of 75 and greater. The end stage of later maturity is stereotyped by some authors as being a period of dependency upon

others for assistance in meeting basic needs. This stereotype often persists and is what some people refer to as old age.

The definitions of the terms “old”, “aging” and “aged” are pertinent to later maturity, but not necessarily in the same in meaning. “Old” is defined (Murray 1980) as having existed for a long time or being advanced in years. “Aged is defined as that point in the life span of a person when changes of aging markedly interfere with functioning. “Aging” is commonly thought of as those changes associated with declining function after the person reaches maturity.

The words “OLD” and “AGE” have different meanings to each of us.

This meaning depends upon:

- a. Our self-image
- b. Personal patterns of adjustment
- c. Emotional conflicts
- d. Past experiences with elderly persons
- e. Socio-cultural background
- f. Ethnic background
- g. Religion
- h. Personal age

To the 4-year old, 20 may seem ancient. To the teenager, 30 may seem old. To the 30-year old, 50 begins to look younger. To the 75-year old, old means anyone over 80. To the average white American, old is associated with retirement from the job. To the Mexican-American, 50 years may be considered old. The word “old” has negative connotations to many people in the United States. However, in some cultures, the old are even revered as very special and knowledgeable.

No other developmental era (the elderly) is so rigidly stereotyped. In no way can all older people be alike. Just as all toddlers, all

adolescents, or all young adults cannot be considered to be alike. Seniors must be perceived to be individual, each having a wide range of personality characteristics, distinct patterns of coping with life and unique relationships to others (Murray 1980).

In order to perceive the senior as a unique person, you must consider your personal definitions, values, attitudes and feelings about old age and aging.

What does old age mean to you?

What do you value or consider important: Beauty, youth and strength?

Or do you consider wisdom thoughtfulness, experience and age as important?

What is your mental set or attitude toward elderly people, which in turn affects your behavior, or overt reactions?

What is your feeling or subjective response when you are with the elderly person?

Do you feel pleasure or impatience, respect or repugnance?

Do you fear growing old or do you look forward to later maturity?

When you initially care for elderly people, you may feel afraid, disgusted or impatient. These feelings are not at all unusual. It is important that you face these feelings and try to understand your values and attitudes.

Certainly, you will not like every old person that you care for. However, you will be a more effective care-giver if you are not sad, angry at or

disgusted with him or her only because he or she is old. You could also be more effective if you can appreciate their strengths as well as their limits. Respect the elderly person simply because he or she is a human being like yourself. Accept their limits and perceive him or her as a unique person. He or she will then respond to your acceptance. Understand and respect the elderly person. He or she will then share more of themselves with you. This sharing is gratifying and will enable you to give even more of yourself. A helping relationship will then develop. It can be a relationship in which both of you mature (Murray 1980).

CHAPTER I

THE NURSING PROCESS AND GERIATRIC ASSESSMENT

THE NURSING PROCESS

ASSESSMENT:

In the assessment process, data about the person, the family, the group, or the situation are obtained. This assessment is accomplished by means of astute observations and examination. Also used in assessment are: purposeful communication and the use of special skills and techniques. This data gathered by the nurse and other health team members can be used to gain a broader perspective about the elderly person. The objective and subjective data are critically analyzed, interrelated and interpreted through the use of inference, knowledge, personal or health care team experience, records and a variety of other sources as indicated. Nursing judgments are made based on this extensive assessment information (Beland 1975).

First level assessment is done on initial contact with the elderly person or family to determine the perceived health threat, the ability to adapt to the threat and immediate necessary actions. Second-level assessment continues throughout the time of contact with the person. It adds depth and breadth to understanding of physical, emotional, mental, spiritual, family, social, cultural characteristics and needs. This more comprehensive view of the person enables you to plan and give care better suited to the whole individual or situation (Bower 1972).

A nursing history form or assessment tool is an organized method of recording the information obtained in the first and second-level assessments. It is distinct from the medical history in that it focuses on the meaning of illness and health care to the person instead of primarily on pathology. The form serves as a guide to obtain information that does not repeat data collected by other health care team members, although it may include, aspects of the medical or social history that is pertinent to nursing care.

The nursing assessment including the nursing history provides a composite picture of the patient. Other health care team members may use this as an introduction to the patient.

Although the form used, and the kind of information collected must be adapted to your individual work setting and your clientele, Bower states that the nursing history should include the following information:

1. **Previous experience** with illness, hospitalization, health agencies, nurses and nursing (also the meaning of these experiences).
2. **Intellectual understanding** and interpretation of health problems, diagnostic regimen, treatment regimen, specific questions or concerns.
3. **Educational level** and intellectual capacity.
4. **Language usage** and communication pattern.
5. **Usual patterns of living**, health, religion and recreation pursuits
6. **Occupational and social** roles and responsibilities.
7. **Developmental status** and level of behavior
8. **Usual behavior** patterns in the presence of stress or crisis
9. **Close relationships** with others; ability to help in this situation.
10. **Expectations**, goals and needs related to health care.

The nursing history should also include daily preferences and idiosyncratic patterns of living. For example, many elderly persons drink prune juice or a glass of water on arising each morning. If this pattern is not continued after admission to the hospital or residence, the person may feel a sense of loss. He or she may become irritable or depressed. Adhering to their established pattern may promote their wellness, physically, and their feeling of being cared for. Such preferences, minor to us, can only be obtained through a carefully obtained nursing history.

You may think that obtaining a lengthy assessment and nursing history is too time-consuming and is impractical. However, it is a vital activity for the purpose of individualizing patient care. A nurse-patient relationship is begun during the assessment process. Assessment conveys interest and concern to the patient. It also establishes a sense of trust from the patient. A nursing diagnosis and realistic care objectives cannot be formulated without information obtained in a nursing history or without patient involvement.

In addition, the last step of the nursing process evaluation will be difficult to complete unless there is baseline patient data. Every nursing unit should have a formal guide for performing a nursing assessment and history. All of the nurses should be involved in the development of the tool. Development of the assessment and history tool includes trial usage and revisions so that the tool will be useful in daily practice. (See assessment guide at the end of this section.)

Good communications skills will help you to obtain assessment and nursing history data. Use open-ended statements. Indicate your observation of the senior's behavior. Indicate your level of understanding of their implied communication. Silence may also be therapeutic. Let the senior elaborate on answers. Be attentive to the non-verbal communication and its possible meaning(s).

These behaviors on the part of the nurse can help to add to the total amount of information gathered in the interview process. Do not ask a barrage of direct questions. Many direct and pointed questions will tend to stifle the senior's expression, resulting in superficial and brief answers. The interviewer who is too active obtains less pertinent data. An assessment tool is not meant to be used as a probe.

Ask questions related to what the senior is saying in order to fill in the gaps of needed information. In this way, you may obtain information that was not anticipated, but might turn out to be significant. Some information might better be collected by direct observation of the senior. Information such as their interpretation of reality might be observed. Their ability to abstract might be observed in real-life situations. You will probably not be able to fill in all the spaces on the form on the first interview with the client or the family. You will probably get more accurate information if you use the assessment tool as a guide over a period of several visits.

In several visits, you will be better able to determine patterns of behavior and the usual health-illness status of the senior. Drawing conclusions on the first interview data may not be very accurate. Several interviews will add reliability and completeness to the data collected. In addition, the more skillful you are as a communicator, the more reliable your data will be as the basis for continued care.

Cultural Perspectives on Aging (Gioiella 1985)

Black Americans

There are several different cultural groups represented with Black Americans. The population descended from Africans brought to the U.S. as slaves is different from the more recent immigrants from Africa and the Caribbean Islands. Not all studies differentiate among these groups. In general, the Black American reports more illnesses than White Americans and puts off getting care, especially care of the teeth and eyes. The Black American equates health or wellness with being able to labor productively.

A study of dietary patterns of urban elderly revealed that Blacks had significantly poorer nutrition. Males had a significantly poorer diet than females regardless of race. The same researchers found that even though elderly Blacks had poorer nutrition and lower income than elderly Whites, they found no differences in life-satisfaction. Both groups (and elderly Mexican-Americans) reported the same satisfaction with their lives.

Another study on physical function in White and Black elderly revealed that Blacks had greater decreases in mobility and self-care capacity than Whites. Black women had more limitations than Black men. Blacks also had twice as much time spent in bed due to illness than the White elderly subjects.

Hispanics

This cultural group includes both Mexican-Americans and Puerto Ricans. Many values and beliefs are similar in both cultures. Some Hispanics view illness as having social, spiritual and physical origins and wellness as a holistic balance and equilibrium between the individual and the universe. Illness may be due to fright, a punishment, or supernatural influences. Rituals, prayers and magic to deal with the evil eye are used in healing by the espiritualista or the curandero.

The Hispanic may also use herbs, massage and warm baths to restore balance between hot and cold, dry and moist. Illnesses, foods and treatments are described as hot, cold, or moist and must be combined appropriately by the caregiver.

The Grandparent or Godparent roll is important in the Hispanic culture and often is an important role for the elderly family member. The extended family is also more common in this group, although, erosion of this family structure is a growing phenomenon in younger generations of Hispanics.

Chinese-Americans

The Chinese and to some degree, other Asians, have a system of beliefs about health, illness and the practice of medicine that differs greatly from Western beliefs and practices. Emphasis in the East is on prevention, maintaining a balance between energy systems in the body, the Yang and the Yin.

The Chinese have their own diagnostic techniques, avoid intrusive procedures that they believe affect the wholeness of the system and avoid drawing blood if possible. Herbs, acupuncture, meditation, massage and diet are all used to treat illness. Healers play an important role in health care.

The elderly have an important role and great respect in Asian cultures. Children are expected to care for their elders. Some of this tradition is present in Asian immigrants in the United States. However, the elderly may expect more than their more westernized children or grandchildren are prepared to give.

Native Americans

Health beliefs and practices of Native Americans vary from tribe to tribe. Healers are important in many, especially if the tribe relates illness to evil spirits. In general, Native Americans believe that health is God-given and reflects living in harmony with the universe. Many traditional treatments including diet, massage, herbs and rituals are used.

In some Native American tribes the elderly are considered a source of wisdom for the younger generation. Direct questioning or asking the individual to repeat information is considered a mark of disrespect.

White Ethnic Americans

Very little is known about the health beliefs and practices of the elderly who continue to identify with Irish, Italian, Polish, German or other European cultures. Cross-cultural studies do reveal differences in expression of pain, differences in diet, differences in life-style and differences in perception of importance of certain symptoms. Another study looked at the use of formal social support systems by white ethnic aged. It found that use in this group was generally low. Family, friends and church groups were more likely to be used for assistance.

Implications of Culture

Many clients may retain folk health practices as links to their cultural heritage in an effort to maintain identity. Most nurses in the U.S. are socialized into the scientific model of health care. A conflict of beliefs and practices may, therefore, arise between client and nurse. Certainly nurses should not abandon their own respect for science; however, respect for the alternative healing methods and traditional health practices should be maintained.

To overcome cultural barriers to health care, use of ethnic providers, ethnic organizations, native languages and foods should be considered by the nurse in providing care.

STATEMENT OF NURSING DIAGNOSIS:

Once a sufficient amount of information has been collected, the information can be analyzed and interpreted. Next, the nurse can formulate an explicit statement about the presenting problem or unmet needs. These unmet needs can then be addressed by nursing care.

The term diagnosis means to state a decision or opinion after careful examination and analysis of facts in a situation or condition. The term diagnosis is not limited to medical conditions. The Nursing Diagnosis is a description of behavior at variance with the desired state of health, a commonly recurring condition. It also means unmet needs that interfere with health and adaptation, or the present or anticipated problem or difficulty experienced by the person or family which is amenable to nursing intervention.

The diagnostic statement or label provides a guideline for intervention and indicates prognosis, potential, or desired outcome (Murray 1980). Nursing diagnoses do not label medical entities. They refer to conditions that can be helped by nursing action. Nursing diagnoses that may be applicable to the psychological and physical status of the elderly are listed next in this section.

Nursing Diagnoses applicable to the psychological and physical status:

- a. Anxiety or agitation
- b. Confusion
- c. Emotional or social deprivation
- d. Disengagement
- e. Mourning
- f. Impaired adjustment to crisis, stress or the aging process
- g. Maladaptive family process
- h. Altered level of consciousness (lethargy, stupor, coma)
- i. Lack of understanding
- j. Non-compliance with treatment
- k. Pain
- l. Altered ability to perform activities of daily living (self care)
- m. Impaired mobility

- n. Impaired nutrition-hydration status
- o. Impaired integrity of the skin
- p. Impaired sensory processes (blindness, deafness, paresthesias)
- q. Negative self-concept
- r. Impaired verbal communication (aphasic, mute, asocial)
- s. Suspicion
- t. Withdrawal
- u. Insomnia

This above list is not complete. Various medical problems would also generate pertinent nursing diagnoses (physical and psychological).

FORMULATION OF PATIENT-CARE AND GOALS AND PLAN OF CARE

After assessment and statement of nursing diagnosis, various nursing actions, approaches or solutions are considered in view of the nature and probable source of the person's unmet needs. At this point, patient-care goals, statements about a predicted or desired patient outcome can be formulated cooperatively with the person or family. Short-term goals are individualized to the person, are derived from the diagnosis and can be accomplished in a short span of time. Long-term goals are future-oriented and state the ultimate desired result of nursing intervention (Murray 1980).

Priority of goals is affected by the following criteria:

1. Nursing diagnosis is identified in collaboration with the senior or family.
2. Severity of health problem or senior's life situation.
3. Potential for recovery or susceptibility to relapse.
4. Amount of time needed by the senior or the nurse.
5. Receptivity to nursing care by the senior.
6. Cost in terms of money or energy to the senior, nurse, agency, society.
7. Demands of external constraints such as agency policies, legal factors.

Short term goals for the elderly hospitalized patient might include relief from pain or insomnia. The long-term goal might include increased mobility or self care. Short-term goals for the elderly client admitted to the nursing home might include orientation to the facility and its policies. Long-term goals might include resolution of the crisis of death of a spouse and admission to the nursing home.

When goals are formulated and priorities set, the details of the meeting of these goals can be written in the nursing care plan. The Nursing Care Plan is a record summarizing the information obtained from the assessment. The Care Plan is needed in order to properly implement appropriate nursing care. It is also a guide to meeting specific goals for the elderly person or family at a given time.

The written plan includes:

- a. The patient's needs and problems.
- b. Patient-care goals and priority in reaching them.
- c. Nursing orders or the approaches or actions that have been selected from the available alternatives.
- d. Expected behavioral outcomes.
- e. Evaluative criteria to measure actions.

Care measures prescribed by the physician and general measures determined by the person's situation or agency policy are also included in the plan. The care plan is begun when the senior is admitted to the agency. It must be updated throughout his or her stay as more information is obtained or as their condition changes. The nurse who first contacts the person is usually responsible for beginning the care plan. Thereafter, all nursing personnel should be encouraged to write observations and care suggestions on the care plan.

Only then can the following purposes of the care plan be realized: (Bower 1972)

1. To communicate information about the person or family and appropriate nursing actions or approaches.
2. To provide individualized and comprehensive care.
3. To provide coordination and continuity of care.
4. To facilitate ongoing and accurate evaluation of care.

The nursing care plan will be used for a long period of time in the nursing home, residential center for the aged or extended care facility. Since hospital stays are extremely limited in duration, both the nursing care plan and the nursing history are justified for short term care intervals and should become a permanent part of the senior's record.

It would then be available for understanding the patient on future admissions and for further care planning. Additionally, the copy of the care plan (and history) should be sent with the senior upon transfer to another agency (Murray 1980).

INTERVENTION

Intervention refers to all of the actions that you engage in, as well as the approach you use, to promote the patient's well-being.

Intervention includes:

- a. Verbal and nonverbal communications.
- b. Aid recovery of the client.
- c. Your approach and reactions to the person as you promote and maintain biopsychosocial health.
- d. Visible actions.

- e. Comfort, protection, enhanced stability.

Intervention occurs when you prevent harm or further dysfunction or assist the senior to function as effectively as possible within the limits imposed by his condition. Many tasks done unwittingly are nursing interventions and should be defined as such to the patient. The scientific rationale for performing the nursing activity should also be explained to the person or family. Nursing interventions with the elderly or family include:

1. Giving sickness care including intensive care or daily care such as feeding, bathing, range of motion, turning.
2. Enabling the senior to perform his or her own hygiene and grooming.
3. Implementing medical procedures and treatments as ordered by the physician.
4. Encouraging the senior to use energy-saving devices.
5. Adapting procedures or techniques to the home situation.
6. Encouraging a regimen of activity or rehabilitation to reduce disengagement.
7. Maintaining communication with the senior, for example, by listening to him reminisce.
8. Reduce sensory and emotional immobility, i.e., visiting with an elderly couple or bring them a bouquet of flowers.
9. Meeting spiritual needs by calling the minister, read passage from the Bible, say a prayer at their request.
10. Maintaining communication with the family or significant others.
11. Teaching and counseling the person or family to help them become more adaptive or independent.
12. Reducing anxiety by being supportive and available to the person and family experiencing death.
13. Referring the elderly person or family to health, social and welfare agencies as indicated.

The list could go on and on. Through nursing interventions, you help the person or family meet the needs that cannot be met by the self.

To summarize, nursing interventions include:

1. Helping the person/family cope with actual or potential stressor.
2. Eliminating a source of stress.
3. Helping the senior develop new behavior, strengthen an existing one or modify or diminish a present behavior.
4. Supporting the senior in his or her present behavior.
5. Preventing further injury or complications.
6. Manipulating the environment to promote adaptation (Bower 1972).

The elderly person may have many needs to be met – physical, social, emotion and spiritual. Often the following basic needs are overlooked. However, they can be met with little extra effort on the part of the nurse. **Remember that the elderly person desires to:**

1. Be recognized as a person and not regarded as a room number, a disease, a problem, “grandma”, or less of a person because of age.
2. Be listened to
3. Be comforted, to have distress recognized, perceive that health care workers are making efforts to make him or her physically and emotionally comfortable;
 The aged person can tolerate pain if he or she is not being neglected.
4. Be remembered: The person fears being overlooked and forgotten.
5. Learn what is causing health problems or distress in terminology that he or she can understand.
6. Know what treatment and care is planned, length of treatment and what can be expected as an end result.
7. Receive quality care.
8. Have some self-determination about what activities he or she will take part in so long as he or she does not injure self or others.

Family members of the patient often have basic needs that are overlooked. The family members may also be aged. However, they deserve the same consideration as the patient. They should not be treated as infants or as incompetents. Family members also need to be comforted emotionally, and sometimes physically, when they feel guilty or worried.

The family needs to be informed as fully as possible about the situation and expected results of the treatment and care. Family members also need encouragement and support as they encounter the stress of illness in the loved one and work to restore and maintain well-being and prevent further complications in the patient.

Intervention includes the **INDEPENDENT FUNCTIONS** of:

- a. Doing all hygiene and comfort measures.
- b. Planning and creating an environment conducive to wholeness and safety from injury and risk.
- c. Teaching and counseling, either formally or informally.
- d. Offering of self to impart strength and courage to another as he or she copes with problems.
- e. Socializing in a purposeful manner.
- f. Making a referral to another agency when indicated.

Intervention includes the **DEPENDENT FUNCTIONS** of:

- a. Doing all the ministrations or procedures that implement the medical regimen outlined by the physician.
- b. Doing all the ministrations or procedures that implement the regimen by other health care team members.

Intervention also includes:

- a. Coordinating care given by other health team members.
- b. Collaborating with others to provide continuity of care.

- c. Directing others, including the family, to give care to the elderly person.

Bower classifies intervention into three nursing actions:

- A. Supportive
- B. Generative
- C. Protective

Supportive nursing actions provide comfort, treatment and restoration. These measures augment the person's present adaptive capacity, help him or her cope more effectively with stress and prevent further health problems. In addition, supportive interventions maximize the person's or family's strengths and provide guidance, encouragement or relief to enable the person to regain health.

Generative nursing actions are innovative and rehabilitative. They help the person or family develop different approaches to coping with stress or crisis and are especially used when assisting another with struggles involved in role changes or identity crisis.

Protective nursing actions are measures that promote health and prevent disease. They improve or correct situations. Examples are immunizations, health teaching or anticipatory guidance; or preventing complications and disease sequelae (Bower 1972).

EVALUATION

Evaluation is the purposeful examination and use of measurement data, devices and methods to determine effectiveness of nursing actions and your approach toward achieving short range and long range patient care goals.

Evaluation also includes determination of the problems that have been resolved, that are still unresolved and new ones that have arisen. Evaluation is the last step in the nursing process. However, evaluation cannot be separated from assessment, formulating a nursing diagnosis, determining objectives and planning care and intervention.

Evaluation includes predicting outcomes through long term and short term goals. These outcomes are expressed as behavioral objectives (patient responses) that you expect to see after nursing intervention. They indicate progress in achievement of stated goals. The current behaviors of the patient act as a baseline for expected change within a certain limit.

Statements of goals help you not only to determine specific interventions to use, but also the specific patient behaviors that would indicate that these goals have been achieved. When a behavioral objective (predicted outcome) is reached, a new objective corresponding to progress in status is written (Murray 1980).

Behavioral objectives are based on priorities of care. They establish the criteria for evaluation. They must be either observable to the client or to the nurse. If they are not observable, they must be measurable in some way. Therefore, the cause of unexpected outcomes can be determined and further negative effects can be avoided.

Nursing can be evaluated for:

EFFORT, EFFECT, EFFICIENCY (Curtis 1975)

Measuring EFFORT involves asking the following questions:

1. What has been done compared to the stated objective of care?
2. Was as much done as could have been done?

Measuring EFFECT involves seeking information about change or lack of change in the patient's situation:

1. Was the change important?
2. Was the change intended?
3. Was the change expected?
4. Was the change safe?
5. Was the change necessary?
6. Was the change desirable to the patient and the nurse?

Measuring EFFICIENCY involves seeking information on:

1. How actions were performed in terms of time, energy and materials?
2. If the results of nursing care were satisfactory, how many actions were necessary to accomplish the care?

Evaluations should be continuous so that insights gained can be used to reassess the person, modify plans and improve care throughout the nursing process. Evaluation benefits the senior and the nurse because it provides a final statement about patient progress and is a critical examination of nursing practice (Murray 1979).

Evaluation of care is directly related to accountability. Accountability is the state of being responsible for your actions and being able to explain, define or measure the results of your decision making. Accountability involves measuring your effectiveness against a set of criteria. These criteria might be the unit's general care standards, the agency's policies or the patient's care objectives. Accountability involves validating intangibles such as attitudes and subtle nuances as well as overt care measures. You are accountable to the client, the family, the group, the agency, the physician, other health care team members and the community. Your accountability assures optimum health care delivery.

In summary, your responsibility is to:

1. Assess thoroughly the senior's health care needs. This cannot be delegated. Tools can be utilized, but it is your responsibility to validate any information on a nursing history form collected by someone other than yourself.
2. Determine nursing diagnosis based on your assessment.

3. Plan with the team, supervise others and teach care measures needed by the person or family. You must assume responsibility for the patient care objectives and the level of care rendered. Therefore, your responsibility will include supervising, teaching and assigning personnel according to their qualifications and the senior's needs.
4. Give care when indicated, acting as a role model for other staff members.
5. Evaluate care and determine whether or not goals have been met. You must take corrective action as indicated.

Through this process you demonstrate accountability.

As you read the steps of the nursing process, you are no doubt aware that the process is continuous and circular. Some steps of the process overlap. For example, while you are doing one intervention, such as bathing the senior, you are simultaneously assessing him or her and mentally making a plan. That plan might be how you will continue with your intervention of giving skin care and ambulation. You may think that your mental or verbal plan is sufficient. However, you will likely find that a written plan is essential to provide for consistency of care. Other nursing team members cannot read your mind. Share what you know and plan, both the team and the patient will benefit.

THE GERIATRIC ASSESSMENT

BASIC CONSIDERATIONS

Approaching an elderly patient for a health history and conducting the interview need not be difficult if you anticipate his/her special needs. If possible, plan to talk with the elderly client early in the day when he/she is likely to be most alert. Many elderly experience the so-called "sundown syndrome". This means their capacity for clear thinking diminishes by late afternoon or early evening. Some of these patients may even become disoriented or confused late in the day.

Have a comfortable chair available for your elderly patient, (if not on bed-rest) especially if the interview will be lengthy. If the patient is on bed-rest, then have a comfortable chair for yourself. Be sure to encourage your patient to move around in bed or change position often because some orthopedic disabilities may make being in one position for a long time uncomfortable.

The elderly may have mild hearing and vision loss. Sit close and face him/her. Speak slowly in a low-pitched voice. Do not shout at the patient who has a hearing problem. Shouting raises the pitch of your voice and may make understanding more difficult, not easier. Hearing loss from aging affects perception of high-pitched tones first.

Try to evaluate your patient's ability to communicate, and his reliability as a historian, early in the interview. If you have doubts about these matters before the interview begins, ask if a family member or close friend can be present to verify facts.

Do not be surprised if your elderly patient requests that someone accompany him/her during the interview. The patient may have concerns about getting through the interview alone. Having another familiar person present during the interview gives the nurse an opportunity to observe the patient's interaction with this person and provides more data for the history. However, this might also prevent the patient from speaking freely about certain subjects. Therefore, plan to have some private time with the patient as well as time with the other person present.

GERAITRIC ASSESSMENT TOOL

A SOCIOCULTURAL ASSESSMENT

(For use on admission to the hospital, nursing home or residence for senior citizens.)

I. Identifying data

Name:	Sex:
Age:	Race/Ethnicity:
Date of admission/or first contact:	Referral source:
Previous occupation or present employer:	

II. Environment

- a. Describe neighborhood and geographical area in which you reside:
What about it was important to you?
- b. Describe your current or previous home and arrangement of space:
What health hazards are or were present?
- c. What transportation facilities do or did you use?
- d. What leisure activities or recreation do you pursue?
Where? With whom?
- e. What was or is the environment at work?
What health hazards were or are present?

III. Socioeconomic Level and Life-Style

- a. How would you describe your socioeconomic level and life-style?
How do you think these have affected your health?
- b. How has your health status affected your life-style?
- c. What changes do you expect in your life-style as a result of growing older?
Illness, hospitalization, admission to hospital?
- d. What special practices or foods do you consider essential?

IV. FAMILY PATTERNS

- a. Marital status.
- b. Children.
- c. Other important members of the family.
- d. Who resides in the home with you?
- e. What is the usual daily living pattern in your family?
- f. What family events are important?
- g. What rituals are important in your family?

h. How do daily living pattern and rituals affect your health?

Family Functions and Interactions:

What is your role in the family?

How are decisions made in the family?

Who helps provide for the family?

Who has the responsibility for the various family tasks?

What are your special concerns in your family?

V. RELIGIOUS PRACTICES

a. What church or religious denomination do you belong to as a member?

b. Are you active in that church?

c. Are there special beliefs that you adhere to?

How do these beliefs affect your health?

d. How do you see your relationship to God during this time period?

What affect does God have on your health or illness?

e. If you do not prescribe to a particular religion, what are your basic beliefs and values?

f. How do these beliefs and values affect your health or illness?

g. What can the nurse do to assist you in practicing your religion or beliefs during your stay at this center?

VI. MEMBERSHIPS

a. What groups/organizations in the community do you belong to?

b. What is your role in these groups?

c. How much satisfaction do you get from group activities?

VII. PERSONAL VALUES (consider expressed ideal vs. real)

a. What are your ideas about the following:

1. Man and the environment relationship?

2. Privacy vs. group interaction (being with others)?

3. Possessions (personal vs. shared)?

b. Time orientation:

1. Do you like to have things done promptly?

2. Do you rely on past experiences primarily?

3. Do you like to plan ahead into the future?

4. How do you feel if you know that you or someone else is going to be late to an event?

c. Work or Activity – Leisure Orientation:

1. How much time do you spend in work tasks daily?

2. Do you prefer to be busy? Sitting and thinking; Reading or relaxing?

3. What do you do to relax?

4. How much time do you spend in leisure daily?
- d. Attitude toward change:
 1. How do you feel when you hear the word change?
 2. How often do you make/have you made changes in your life?
 3. What changes would you like to make in yourself? In others? In the environment?
- e. Education:
 1. Level of school achievement?
 2. How important is education to you?
 3. What do you consider necessary for achievement?
- f. Health-Illness Value or Definitions:
 1. When do you consider yourself or members of your family healthy?
 2. When do you consider them ill?
 3. What do you do when you or members of your family become ill?
 4. What customs, special practices or rituals do you and your family engage in to keep healthy?
 5. Do you and your family have any specific beliefs or observe any specific traditions concerning health?

NOTE: This tool could be adapted by the nurse who is working in the home health care agency and in other settings.

PHYSICAL ASSESSMENT

(For use on admission to the hospital, nursing home or residence for senior citizens.)

The Health history Includes the Following Data:

I. Identifying Data:

Name:	Sex:
Address:	Race/Ethnicity:
Age:	
Marital Status:	If widowed, when?
Occupation:	If retired, date?
Reason for contacting health agency:	

II. **A concise statement of the Chief Complaint and its Duration**

III. **Concise chronological description: Present health status and present illness**

IV. **Past Medical History**

(Beginning as far back as the person can remember and continuing up to the time when he considered himself to be in good health.)

- a. Childhood:
- b. Medical:
- c. Surgical, including accidents:
- d. Psychiatric:

- e. Obstetrical:
Number/outcomes of pregnancies, abnormalities or complications.
- f. Hospitalizations:
Include names of hospitals, dates, attending physicians and problems.
- g. Previous routine or periodic examinations.
- h. Exposure to known cause of illness:
Travel in foreign countries, exposure to toxic substances.
- i. Allergies – to what and what reactions:

V. Personal and Social History

- a. Childhood:
Birth (when & where), family group, education, environment, problems:
- b. Adulthood – employment history, military service:
- c. Sexual & marital history – marital status, sexual activity, children:
- d. Present life-style:
Descriptions of home, occupation, family life, affiliations, habits:
Tobacco: Type – cigarettes, cigars, pipe, chewing, snuff.
Age at which began use.
Current level of usage.
Beverages: Coffee, tea, cola.
Alcohol: Average daily use or weekly consumption.
Drugs: Drug use – including legal and illegal drugs, prescription drugs,
over-the-counter drugs.
Present schedule and dosage – Sleeping pills, aspirin, weight-control drugs,
antihistamines, folk remedies, laxatives,
enemas, vitamins.
Personal Habits: Sleep, working hours, travel, vacation, hobby or leisure activities
- e. Nutrition and hydration (sample one day's diet and fluid intake).
Special diet needs.
- f. Family history:
- g. Health status of close relatives:
- h. Presence of specific diseases: Diabetes, tuberculosis, cancer, mental illness, illness similar to the patient's present illness:
- i. Family tree: Include grandparents, parents, siblings, children
- j. Religious practices: Denomination, church location, pastor, usual attendance.
- k. Do you anticipate any specific spiritual/religious needs? If so, what?

THE REVIEW OF SYSTEMS AND THE PHYSICAL EXAMINATION

INCLUDES THE FOLLOWING DATA:

I. MEASUREMENT OF VITAL SIGNS

Weight: Height: Pulse: (rate, rhythm)
Temp: Resp: (rate, rhythm) BP: (arm & position)

II. GENERAL APPEARANCE

Opening statement describing muscular development, posture, position of body, body movements, nutritional status, appearance of acute or chronic illness, whether he/she appears his/her age, personal hygiene.)

a. HISTORY OF ANY WEAKNESS:

Fatigue, malaise, fever, chills, weight gain or weight loss.

b. SKIN:

Color, temperature, turgor, moisture, pigment changes, bruises, pressure areas, decubitus, lesions, rashes and scars (location), dryness, texture, appearance of nails, size and shape of fingers (clubbing), use of hair dyes or other agents.

c. HEAD:

History of headache, head injury, dizziness, syncope.

d. EXAM:

1. Skull – deformities
2. Scalp – scaling
3. Hair – color, baldness, parasites
4. Face – expression, edema, muscle tics, paralysis

e. EYES:

History of pain, use of glasses, last change in refraction, diplopia, infection, glaucoma, cataract.

1. Vision – near, distant and peripheral
2. Pupils – reaction to light and accommodation, equality of size
3. Condition of lids, conjunctiva and sclera – movements, the expression, presence of discharge

f. EARS:

History of earaches, hearing loss, use of hearing aid, presence of tinnitus, vertigo, discharge, infection, pain.

1. External – auditory meatus, tympanic membrane, general appearance
2. Hearing – distance whispered word heard

g. NOSE:

History of sinus pain, epistaxis, obstruction, discharge, postnasal drip, colds, sneezing.

1. External – size, shape, smell, difficulty in breathing, discharge
2. Internal – patency, polyps, septal deviation, others.

h. MOUTH:

History of toothache, recent extractions, soreness or bleeding of lips, gums, mouth, tongue or throat, disturbance of taste, thirst, hoarseness, tonsillectomy.

1. Lips – pallor, cyanosis, lesions, dryness
2. Teeth – natural, state of repair, dentures.
3. Gums – bleeding, retracted, color, hypertrophic.
4. Tongue – color, size, deviation, hydration, lesions, tremors, paralysis.
5. Pharynx – motion of palate, uvula, tonsils, gag reflex, posterior pharynx-hoarseness, difficulty speaking or swallowing, ulcerations, inflammation.

i. NECK:

History of pain, limitation of motion, thyroid enlargement.

1. General – stiffness, R.O.M., tenderness, veins, pulses, bruits.
2. Thyroid – enlargement, nodules, tenderness.
3. Lymph glands – size, consistency, tenderness.

j. THORAX:

History of pain, breast lumps, discharge or operations.

1. Chest – size, shape and movements.
2. Breasts – nipple discharge, areola, contour, symmetry, masses (size, location, shape, consistency, fixation), skin ulceration, axillary nodes.

k. HEART:

History of pain or distress, palpitations, dyspnea (relate to effort), orthopnea, paroxysmal nocturnal dyspnea, edema, nocturia, cyanosis, heart murmur, rheumatic fever, hypertension, coronary artery disease, anemia, last EKG.

1. Inspection:
 - a. Apex beat, relation to midclavicular or midsternal line.
 - b. Other pulsations.
2. Palpation:
 - a. Size, vigor of apex beat.
 - b. Left sternal lift, epigastric palpation, thrills.
3. Percussion:
 - a. Distance of dullness from midsternal line in left second to sixth or seventh interspace.
4. Auscultation:
 - a. Quality and intensity of S1 and S2 in each valve area.
 - b. Splitting.
 - c. Extra sounds – S3 and S4.
 - d. Murmur – location, radiation, systolic or diastolic, intensity, frequency, character-crescendo, decrescendo, holosystolic.

l. LUNGS:

History of pain, cough, sputum (character, amount), hemoptysis, wheezing, asthma, shortness of breath, bronchitis, pneumonia, TB, or contact with, date of last x-ray or skin test and the results of these.

1. Inspection:

- a. Breathing pattern.
 - b. Symmetry.
 - c. Venous pattern.
2. Palpation:
 - a. Vocal fremitus.
 - b. Use of accessory muscles.
 3. Percussion:
 - a. Location by inter-space dullness, flatness, hyperresonance, or tympany.
 4. Auscultation:
 - a. Type of breath sounds – vesicular, bronchial, or bronchovesicular.
 - b. Adventitious sounds – rales, cavernous breathing, asthmatic breathing, friction rub.
 - c. Vocal resonance – bronchophony.
- m. ABDOMEN:
- History of appetite, food intolerance, dysphagia, heartburn, pain or distress after eating, colic, jaundice, belching, nausea, vomiting, hematemesis, flatulence, character and color of stools, any change in bowel habits, rectal conditions, ulcer, gallbladder disease, colitis, hepatitis, appendicitis, parasites, hernia.
1. Inspection:
 - a. Distention.
 - b. Masses.
 - c. Peristalsis (visible).
 2. Palpation:
 - a. Tenderness of light or deep palpation.
 - b. Masses (location, consistency, mobility, nodularity).
 - c. Rigidity.
 - d. Organ outlines (liver, spleen).
 3. Percussion:
 - a. Abdominal distension (air or ascites).
 - b. Bladder distension.
 4. Auscultation:
 - a. Bowel sounds.
 - b. Bruits.
- n. EXTREMITIES AND BACK:
- History of intermittent claudication, varicose veins, thrombophlebitis, joint pain, stiffness, swelling, arthritis, gout, bursitis, flat feet, infection, fracture, muscle pain, cramps; assistance devices utilized (prostheses, cane, crutches, walker, wheelchair).
1. Blood vessels – pulse veins.
 2. Joints – tenderness, deformities, crepitation, range of motion.
 3. Edema – location, pitting, discoloration.
 4. Reflexes.

5. Sensation – pain and temperature, vibration position.
 6. Muscular function – standing on toes, strength of movement.
 7. Gait and stance – walking, standing with eyes closed.
 8. Back – pain (location and radiation, especially to extremities), stiffness, limitation of movement.
- o. GENITOURINARY:
- History of urinary tract – renal colic, frequency, nocturia, polyuria, oliguria, hesitancy, urgency, dysuria, narrowing of stream, dribbling, incontinence, hematuria, albuminuria, pyuria, kidney disease, facial edema, renal stone, cystoscopy; genital (male) – testicular pain, scrotal change, nodules in scrotum; genital (female) – menstrual history, vaginal bleeding or discharge, menopause and associated symptoms, date of last PAP smear, venereal disease – gonorrhea or syphilis (note date, treatment, complications); sexual – drive, activity, pleasure, discomfort, impotence.
1. Examination of the male genito – Urinary System:
 - a. Penis
 - b. Scrotum – size, symmetry, consistency, tenderness, masses, atrophy.
 - c. Inguinal region – pulses, lymph glands, hernia, parasites.
 - d. Character of urine – presence of indwelling catheter, date changed.
 2. Examination of the female reproductive system:
 - a. External genitalia.
 1. Vulva – ulceration.
 2. Urethra – discharge
 3. Pelvic relaxation – cystocele, rectocele, prolapse uterus (degree).
 - b. Internal genitalia.
 1. Speculum exam of vagina (discharge, ulcerations, irregularities).
 2. Cervix (ulceration, irregularity), PAP smear.
 - a. Examination of the rectum:
 - a. External inspection - hemorrhoids, perianal skin, pilonidal cyst.
 - b. Internal palpation – sphincter tonicity, abscess, prostate enlargement, rectal masses, impaction.
- p. CENTRAL NERVOUS SYSTEM:
1. General history – syncope, loss of consciousness, convulsions, meningitis, encephalitis, stroke.
 2. Mentative – aphasia (describe), emotional status, mood, orientation, memory, change in sleep pattern, psychiatric illness.
 3. Motor – tremor, weakness, paralysis (describe involvement), clumsiness of movement.

4. Sensory – neurological pain, reduced sensation, paresthesia.

q. HEMATOPOIETIC:

Bleeding tendencies; of skin or mucous membranes; anemia and treatments, blood type, transfusions, any reactions; blood dyscrasias, exposure to toxic agents or radiation.

r. ENDOCRINE:

History of nutrition and growth; thyroid function – (changes in skin, relationship of appetite to weight, nervousness, tremors, thyroid medications), diabetes or its symptoms, hirsutism, secondary sex characteristics, hormone therapy.

Activities of Daily Living Survey

	Independent	Needs assistance, describe type of assistance needed	Dependent
Bathing	yes	Any Comments	yes
Dressing	yes	Any Comments	yes
Toileting *	yes	Any Comments	yes
Feeding	yes	Any Comments	yes
Transferring	yes	Any Comments	yes
Ambulating	yes	Any Comments	yes
Turning in Bed	yes	Any Comments	yes

*Describe whether person can ask to be taken to bathroom or is totally incontinent.

Note: This too can be adapted to the home health setting and other nursing care settings.

CHAPTER II

PSYCHOLOGICAL ASSESSMENT

IV. Perceptual Ability:

- a. Describe your sensory ability or any impairment related to:
 - Sight Taste
 - Hearing Smell
 - Touch Balance
 - Pain or unusual body perceptions
- b. Do bright lights or loud noises bother you?
- c. If you are more sensitive to light or noise now, is it related to your illness or to conditions existing in the hospital or residence?
- d. Do you have special visions?
If so, describe them and when and where they occur.
- e. Do you hear voices?
If so, what do they say and are you able to converse with them?
- f. What are your food preferences?
What foods are not tasteful or enjoyable to you?
- g. What kinds of feelings do you have in various body parts?
Are you especially aware of any body part or function?
- h. What situations require assistance to maintain balance/mobility?
What kind of assistance do you need?

V. Emotional Status:

- a. Self concept:
 - How would you describe yourself?
 - How do you feel you handle yourself and your life?
 - What would you describe as your attitude toward life?
 - What are the most important values to you?
 - What do you like best about yourself?
 - If it were possible, what is the primary aspect of yourself that you would like to change?
 - Do you prefer doing things alone or with others?
- b. Ego ideal:
 - What goals or aspirations do you presently have?
 - Do you feel you have managed to achieve your goals in life?
- c. Super ego:
 - Which of the following comes first for you?
 1. Pleasure
 2. Your goals
 3. Essential tasks
- d. How do you respond to situations that require you to do something you are reluctant to do?
 1. Do you ignore the task?
 2. Do you plunge in and complete it as soon as possible?
 3. Do you delay the task as long as possible?
- e. What rules or customs are difficult for you to follow?

- f. What do you consider the most important teachings that were given to you by your parents or family?
 That you have lived by?
 What causes you to feel guilty?
- g. Relations to others:
 Do you share your feelings with another with ease or with difficulty?
 With whom do you share your feelings?
 Who can you trust to help you in time of need?
 Who or what do you care about the most in your life?
 Who do you think cares most about you?
 How do you see your life fitting into the lives of others?
 How dependent or independent of family or friends are you?
- h. Sense of autonomy:
 What does the term "fate" mean to you?
 What do you feel has control over what is happening to you?
 How much control do you exert over others?
- i. How has aging or illness or hospitalization or admission to nursing home or residence affected your feelings of control or lack of control?
- j. Reaction and coping with situations:
 What situations or persons cause you to feel calm, secure and happy?
 What situations or persons cause you to feel upset, embarrassed, anxious or anger?
 What usually results from your behavior?
- k. Adaptive pattern:
 What is your usual pattern of relating to those close to you?
 To a group situation?
 How much does another's reaction or behavior influence how you will act?
 How important is another person's behavior or feelings to you?
 What is your reaction to frustration? To success?
 Which of the following are you likely to do?
 Go along with the person or situation to keep peace?
 Blame others if something goes wrong for you?
 Consider yourself the cause if something goes wrong?
 Feel more angry than is warranted by the situation?
 Let others know abruptly of your feelings?
 Say little about your feelings, hoping the other person will guess how you are feeling?
 Feel reluctant to act in an unfamiliar situation without permission or encouragement from someone?
 Feel confident in unfamiliar situations and take charge of things if it is indicated?
 Encourage others to do their best work possible?
 Consider that others are unlikely to do the job as well as yourself?
 What do you find best relieves your tension – eating, smoking, drinking, drubs, sleep, activity etc?

VI. Use of Leisure:

- a. What activities do you enjoy for recreation or relaxation?
- b. How often do you engage in these activities?
- c. How do these activities affect your health?

VII. Communication Pattern: (Observe and listen for)

- a. Ability to express thoughts and feelings (talks freely or hesitancy, writes, draws, uses nonverbal behavior primarily).
- b. Describes vocabulary (variety of words used, repetition of words, slang or correct grammar).
- c. Enunciation of words.
- d. Rate of expression of speech (how quickly answers, rapidity in flow of speech, hesitations, smooth vs. uneven rate, urgency of speech).
- e. Ability to express his ideas (coherent, logical, confused, circumstantial, tangential, poverty of ideation).

VIII. Cognitive Status: (Observe and listen for)

- a. Level of consciousness (alert, lethargic, confused, stuporous or comatose).
- b. Orientation to time, place, person.
- c. Education level.
- d. Ability to recall far past, immediate past and present events (what brought you into the hospital or residence? Tell me about the events that led you to your hospitalization or admission to nursing home or residence. Tell me MAJOR things about yourself and your past life).
- e. Attention span (attends to immediate stimuli; length of concentration or attention span; is not distracted by external stimuli; how capable of following train of thought, what stimuli distracts, how long interview proceeded before person showed signs of fatigue, preoccupied with self or some event).
- f. Speed of response to verbal stimuli (answers immediately, quickly or slowly, hesitates, ignores certain statements).
- g. Remains in reverie state or in primary process (daydreams, fantasizes, talks about material that seems nonsensical or is difficult to follow).
- h. Ability to grasp ideas to follow directions.
- i. Ability to do logical thinking or problem solving (or unable to do cause-effect associations, states loose, magical or nonsensical logic).
- j. Ability to abstract (answers questions literally, is able to elaborate or explain, can give meanings for behavior situations).
- k. Presence of delusions or degree of reality in belief system.
- l. Apparent insight into problem or situation:
 - What have you been told about your illness?
 - What do you think is the cause of your problem?
 - Why do you think you have been admitted to hospital or nursing home or residence?
- m. Aware of need for more knowledge about illness situation:
 - What questions or concerns do you have about your illness, hospital stay, admission

to nursing home or residence?

IX. Ego Functions:

a. Interviewer should note the following during the interview:

What was the primary emotion? Was it appropriate to the situation?

During the interview, what nonverbal behavior accompanied statements?

What questions elicited behavioral manifestations of discomfort or anxiety?

Was there accentuated use of any one pattern of behavior during the interview?

Did the person use "they" instead of "I" when responding to questions?

Was he/she aware of body parts and functions without excessive preoccupation with him or herself.

Was the person realistic or did he/she show disturbed reality twisting?

For example – Is the person adapting to reality?

Does he/she show poor judgment?

Does he/she understand the consequences of his/her behavior?

Does reality interfere with creative behavior?

Presence of delusions? Hallucinations?

Has the person learned the socially acceptable method of dealing with drives and feelings?

What defense mechanisms are apparently commonly used?

What defense mechanisms were used during the interview?

Does behavior appear over-controlled, under-controlled or without control? Describe.

Does the person appear able to have the various aspects of his personality integrated?

What aspects of his behavior appear fragmented or lacking in unity or autonomy?

Summary of impressions

(Note: Any discrepancies between patient's or client's perception and that of interviewer or caregiver.)

A. Intrapersonal Factors:

1. Physical (appearance; posture; faces; dress; hygiene; range of body functions; physical findings that evidence anxiety).
2. Psychological (cognitive and perceptual abilities; thought process; emotional status; ego functions; adaptive or defensive mechanisms used; feelings about self and body image; values; attitudes; needs; expectations; aspirations; behavior patterns; creative expressions; needs; strengths; limits).
3. Developmental (degree of apparent normalcy; apparent stage of behavior and coping or defensive mechanisms; past learning history; perception of environment and family values; goals and ideas and the influence of these; how current level of functioning and life-style relate to culture or ethnicity; age, and sex of person).
4. Social (super ego functions; behavior or socialization pattern; use of language and communications skills; activities of daily living; perception of relations to others; value system; customs; taboos or superstitions; understanding of own roles and roles of others).
5. Interpersonal factors (family structures; relationship with family, friends and others;

communication ability; socialization level; expectations of family, friends, care-givers and others in present situation; ability to anticipate consequences of behavior; resources).

6. Extra-personal factors (cultural factors; social class level; occupation; work related resources; environmental or work related stresses; residence and geographical location; financial resources; relationship to community; community resources; effective of time of day, temperature and weather on behavior; use of space and privacy).

B. Recommendations:

Short-term goals:

Long-term goals:

*This tool could be adapted by the nurse who is working in the home health agency.

ATTITUDES TOWARD AGING

Communicating with an elderly patient may challenge you to confront your personal attitudes and prejudices about aging. Examine these feelings before taking the patient's history, and decide in advance how you will handle them. Any prejudices you reveal will probably interfere with your efforts to communicate, since elderly patients are especially sensitive to others' reactions and can easily detect negative attitudes and impatience.

Then consider your patient's attitude toward his or her body and health. An elderly patient may have a distorted perception of his or her health problems; may dwell on them needlessly or dismiss them as normal signs of aging. A patient may ignore a serious problem because he or she doesn't want these fears confirmed. If your patient is seriously ill, the subjects of dying and death may arise during the health history interview. Listen carefully to any remarks your patient makes about dying. Be sure to ask about his religious affiliation and spiritual needs. Many elderly patients find comfort in their religious beliefs and practices. You should also inquire tactfully about the matter of a living will (Health Assessment Handbook 1992).

THE NEED FOR PATIENCE

Patience is the key to communicating with an elderly patient. He or she may respond slowly to your questions. Do not confuse patience with patronizing behavior. Your patient will easily perceive such behavior and may interpret it as a lack of genuine concern for him or her. Keep your questions concise, rephrase those he/she doesn't understand and use non-verbal techniques in a meaningful way.

To further foster your elderly patient's cooperation, take a little extra time to help him or her see the relevance of your questions. You may need to repeat this explanation several times as the interview progresses. However, do not repeat questions unnecessarily. Ask only for information that is relevant to the condition. For example, you would not obtain a detailed obstetric history from a 75 year old woman who does not have a gynecological problem.

Once you have obtained an elderly patient's cooperation, you may have some trouble getting him or her to keep the story brief. He or she has a great deal of history to relate and may reminisce during the interview. Try to find time for this. Let the patient talk. You may obtain valuable clues about the current physical, mental and spiritual health. If you must keep the history brief, let him or her know prior to beginning the interview. Let him or her know the exact time limits. Offer to come back at another time in order to chat with him or her informally (Health Assessment handbook 1987).

THE ELDERLY PATIENT'S PAST HISTORY

A geriatric patient's past medical history can be extensive. In order for you to complete the history, it is important that the patient have a detailed recall of all major illnesses, surgical procedures and minor illnesses. Fractures the patient may have experienced early in life, for example, may figure significantly now in osteoporosis. As you record the past history, try to find out the amount of stress he/she has had recently and the way he/she has handled previous health problems. Do not be concerned if he/she cannot relate this medical history chronologically, just be sure to record his/her age at the time each medical condition occurred.

Pay special attention to your elderly patient's medication history. He or she is probably taking some type of medication routinely. Find out the names of all current and past medications whether over-the-counter or prescription drugs. Find out the dosage and frequency of each drug and the purpose for taking the drug. Ask to see a sample of each drug, if possible, (Health Assessment Handbook 1987).

THE ELDERLY PATIENT'S PSYCHOLOGICAL HISTORY

Make it a point to talk with your elderly patient about his family and friends. Ask with whom he lives. Ask how he spends his time. Find out what significant relationships he enjoys. If your patient is hospitalized and seriously ill, or must transfer to another type of institution (such as a nursing home), he or she will need the emotional support of family and friends. If he/she is returning home after an illness, he/she may need their assistance.

If your patient does not have a family or any friends on whom he/she can depend for support, record this in the psychological history for possible later referral of the patient to a social worker. Record the names of the next of kin. Without your intervention here, loneliness may discourage the elderly patient from getting well.

If your patient is employed, inquire about his or her job in order to find out if the current health problems will interfere with their return to work. Talk with the patient concerning plans for retirement. If they have any such plans, also explore their attitudes toward the retirement phase of life.

If your patient expresses financial concerns, explore them further in a financial history. Remember to ask your elderly patient if he or she receives any pensions or Social Security payments.

When appropriate, inquire about the patient's sex life. Do not ignore it because of a patient's age. Approach this aspect of the psychosocial history with the same sensitivity and respect for privacy that

you would show with younger patients. If the patient is reluctant to discuss this part of their life, do not press for the information.

GERIATRIC ACTIVITIES OF DAILY LIVING

Your geriatric patient's activities of daily living may affect his/her health. In turn, his/her health problems may threaten his/her independence. Ask him/her to describe a typical day at home. Have them include activities, sleep patterns and eating habits (Table I). His/her eating habits may suggest other significant lines of questioning. Find out how much of an appetite he/she usually has. Find out how they prepare food and how much fluid is normally consumed. You can put this information into a chart showing which foods the patient eats at which times during the day.

Ask about matters related to the patient's mobility. Is he/she able to move around at home easily and safely? Can he/she supply the basic needs; food, clothing and shelter? Does he/she drive to the supermarket or does a friend drive them? Does he/she use public transportation? Ask if he/she expects to be able to continue with his/her normal routine after discharge from the hospital. If necessary, consult with a social worker to discuss what you have learned about the patient's activities of daily living (Health Assessment Handbook 1987)

Geriatric care is hindered by disabilities often associated with the elderly client. The elderly person is much less likely to report legitimate symptoms of disease in its early stages. This is a phenomenon that has been noted by many authorities. For whatever reasons, the elderly tend to wait until the disease has progressed until the symptoms are reported and they seek help. Even in countries that have completely free medical care, under-reporting is prevalent in the elderly.

Frequently found problems in the elderly are decompensated heart failure, correctable hearing problems, correctable vision problems, active tuberculosis, severe anemia, chronic respiratory insufficiency, uncontrolled diabetes, foot disease, dementia, depression and others. The following reasons are common reasons that these conditions are under-reported: (1) The stigma of reporting disease as a further sign of old age. (2) Due to depression the person is not interested in returning to optimal health. (3) They are often afraid that they will lose their independence if they report conditions. (4) Intellectual loss in old age could also be a reason for not reporting. Our health care system relies on people reporting symptoms and seeking treatment. When the elderly do not report illnesses, it only compounds their overall medical condition.

TABLE I GERIATRIC ACTIVITIES OF DAILY LIVING

When questioning elderly patients about daily activities, use general questions that will elicit his/her usual habits and whether he/she has problems performing them. Elderly patients may also have personal concerns, financial or transportation problems that keep him/her from his/her daily routine. Structure your questions as outlined here.

DIET OR ELIMINATION

What do you eat on a typical day?
Do you feel hungry between meals?
Do you prepare your own meals?
With whom do you eat?
What types of food do you enjoy most?
Do you have any problems eating?
Have you noted any changes in your sense of taste?
Do you snack? When are your snack times?
What do you usually eat for a snack?
What are your usual bowel habits?
Have you noticed any recent changes in your bowel habits?

EXERCISE/SLEEP

Do you take daily walks?
Do you do your own housework?
Do you have any difficulty moving about?
Has your doctor recently restricted your exercise?
Has your doctor recommended any special exercise programs?
What time do you go to bed at night?
What time do you awaken?
Do you follow any routines that help you sleep?
Do you sleep soundly or wake often?
Do you take a nap during the day? If so, how long?

RECREATION

Do you belong to social groups such as seniors' clubs or church groups?
What do you enjoy doing in your leisure time?
How many hours a day do you watch television?
Do you share leisure time with your family?

TOBACCO/ALCOHOL

Do you use tobacco? If so, do you smoke cigarettes, cigars, pipe?
How long have you smoked? How much do you smoke each day?
If you quit smoking, when did you quit?
Do you drink alcohol? How often and how much do you drink?
Do you drink alone or with friends? Has drinking increased lately?

PERSONAL CONCERNS

Do you wear dentures? Are they a hindrance when you eat or talk?
Do you wear glasses?
Do you have problems with your vision when you wear your glasses?

Do you hear those around you with no difficulty?

Does poor hearing hinder any of your activities?

What is your source of income?

Do you shop for your own groceries? If not, who does this for you?

CHAPTER III

PHYSICAL ASSESSMENT AND RECORDING THE FINDINGS

GERIATRIC REVIEW OF SYSTEMS

The review of systems for an elderly patient involves keeping in mind the following physiologic changes. These are considered normal in the aging process. These common pathologic disorders are described in Table II (Health Assessment Handbook 1992).

SKIN, HAIR AND NAILS

Skin color and texture commonly change as a person ages. Your patient may report that his/her skin seems thinner and looser, less elastic, than before. The patient also perspires less. The hair thins, grays and becomes coarser. Distribution of the hair on the scalp, face and body may also change. The patient may tell you that their scalp feels dry. The fingernails may thicken and change color slightly. Ask if the patient can take care of his or her own nails.

EYES AND VISION

Your patient may report increased tearing. He/she may also exhibit presbyopia (diminished near vision due to normal decrease in lens elasticity). Ask if he/she has experienced any changes in his vision, especially night vision. Does he/she need more light than usual when reading?

EARS AND HEARING

Your elderly patient's hearing may be affected by gradual irreversible hearing loss of no specific pathologic origin (presbycusis), common among elderly persons.

RESPIRATORY SYSTEM

Remember, shortness of breath during physical activity could be normal. Even if the shortness of breath has increased recently, this could be normal. A warning of problems could be if the shortness of breath has come on suddenly. If your patient has trouble breathing, explore the precipitating circumstances. Does he or she cough excessively? Does the cough produce much sputum, perhaps blood in the sputum? Aging can also affect the nose. Your patient may report sneezing, a runny nose, and a decreased sense of smell or bleeding from mucous membrane.

CARDIOVASCULAR SYSTEM

More than half of all elderly people suffer from some degree of congestive heart failure. Ask your patient whether he/she has gained weight recently and if his/her belts or rings feel tight. In addition, find out if he/she tires more easily now than previously. Ask if he/she has trouble breathing or if he/she becomes dizzy when rising from bed or from a chair (Stosky 1968).

GASTROINTESTINAL SYSTEM

An elderly patient may complain about problems related to his or her mouth and sense of taste. For example, he/she may experience a foul taste in his mouth because saliva production has decreased and mucous membranes have atrophied. If he/she has dentures, find out how comfortable they are and

how well they work. An elderly person's sense of taste decreases gradually. This may be why your patient reports that his/her appetite has decreased, or that he/she craves sweeter or spicier foods.

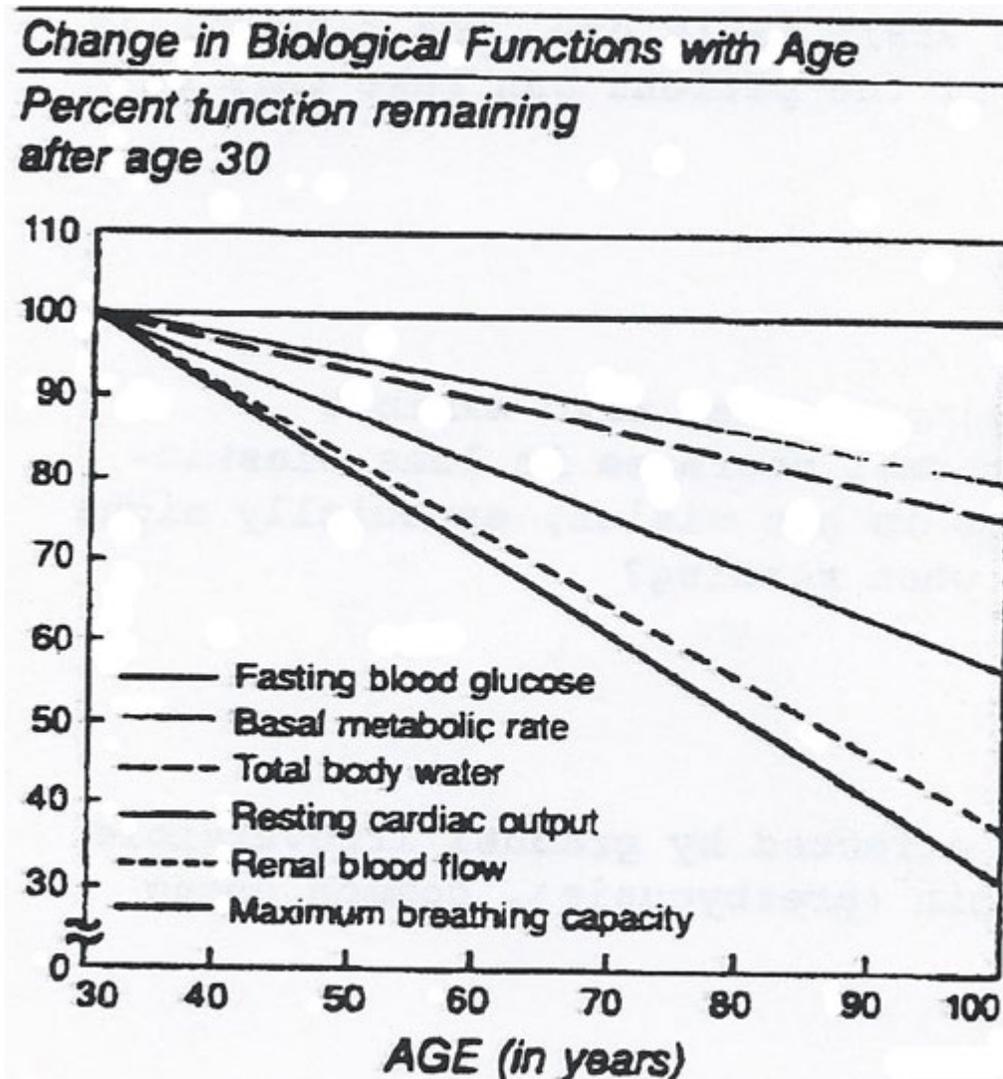
An elderly patient may also have nonspecific difficulty in swallowing. Carefully assess the possible causes of regurgitation or heartburn.

*Ask if he/she has the same degree of difficulty swallowing solids/liquids.

*Ask if food lodges in his/her throat upon swallowing.

*Does he or she experience pain after eating, or while lying flat?

Also question him about long-term or recent weight loss, rectal bleeding, altered bowel habits (Goldman 1991).



Energy metabolism, caloric intake and physical activity of aging. In Cariston LA (ed.): Nutrition in Old Age (X symposium of the Swedish Nutrition Fdn.) Uppsala: Almqvist and Wiksell.

FEMALE REPRODUCTIVE SYSTEM

Include questions about menopause for the elderly female. Ask when menopause began and ended (if ended). Ask what symptoms she experienced and how she felt about the process. Ask her whether she is now taking estrogen replacement therapy or in the past. If so, ask for how long and the dosage. Be sure to question an elderly female patient about symptoms of breast disease. Find out if she regularly performs a breast self-examination, if she is physically capable of doing so.

NERVOUS SYSTEM

Inquire about changes in coordination, strength or sensory perception. Does the patient have headaches or seizures or any temporary losses of consciousness? Has he or she had any difficulty controlling bowel or bladder (Tom 1976).

BLOOD FORMING AND IMMUNE SYSTEMS

Remember that anemia is common among older people and may cause fatigue or weakness. The immune system begins to decline at sexual maturity and continues to decline with age. An elderly person's immune system begins to lose its ability to differentiate between self and non-self. The incidence of autoimmune disease increases in the elderly. The immune system also begins losing its ability to recognize and destroy mutant cells. This inability presumably accounts for the increased incidence of cancer among older persons. Decreased antibody response in the elderly makes them more susceptible to infection. Tonsillar atrophy and lymphadenopathy commonly occur in older persons.

Total and differential leukocyte counts don't change significantly with age. However, some persons over age 65 may exhibit a slight decrease in the range of normal leukocyte count. When this happens, the number of B cells and total lymphocytes decreases. The T cells decrease in number and become less effective. As a person ages, fatty bone marrow replaces some active blood-forming marrow. This occurs first in the long bones and then in the flat bones. The altered bone marrow cannot increase erythrocyte production as readily as before in response to such stimuli as hormones, anoxia, hemorrhage and hemolysis. With age, vitamin B12 absorption may also diminish, resulting in reduced erythrocyte mass and decreased hemoglobin and hematocrit.

TABLE II

Certain disorders commonly affect the elderly. When reviewing your elderly patient's systems, note the following possibly pathological signs and symptoms:

SKIN: Delayed wound healing, change in texture

NAILS: Brittleness, clubbing, pitting

HEAD: Facial pain or numbness

EYES: Diplopia, tunnel vision, halo effect, glaucoma, cataracts

EARS: Excessive wax formation, use of wax softeners

NOSE: Epistaxis, allergic rhinitis

MOUTH/THROAT: Sore tongue, problems with teeth or gums, gums bleeding at night, hoarseness

NECK: Pain, swelling, restricted range of motion.

RESPIRATORY: Tuberculosis, difficulty or painful breathing, excessive cough producing excessive or blood-streaked sputum.

BREASTS: Discharge, change in contour, nipples, gynecomastia, lumps.

CARDIOVASCULAR: Chest pain on exertion, orthopnea, cyanosis, syncope, fatigue, murmur, leg cramps, varicosities, coldness or numbness of extremities, hypertension, heart attack.

RENAL: Flank pain, dysuria, polyuria, nocturia, incontinence, enuresis, hematuria, renal or bladder infections or kidney or bladder stones.

REPRODUCTIVE: Male – Hernia, testicular pain, prostatic problems.
Female – Postmenopausal problems (bleeding, hot flashes).

ENDOCRINE: Goiter, tremor

MUSCULOSKELETAL: Pain, joint swelling, crepitus, restricted motion, arthritis, gout, lumbago, amputations.

NERVOUS: Memory loss, loss of consciousness, nervousness, insomnia, changes in emotions, tremors, muscle weakness, paralysis, aphasia, speech changes, numbness.

PSYCHOLOGICAL ASSESSMENT

When you assess the psychological status of an elderly patient, remember that he or she is probably dealing with complex and important changes at a time in his/her life when his/her ability to solve problems may be diminishing. If he/she tends to cope well with stress and views aging as a normal part of life, he/she should be able to adjust smoothly to the changes that aging brings.

Common psychological problems among elderly patients include organic brain syndrome, depression, grieving, substance abuse, adverse drug reactions, dementia, paranoia and anxiety. Of course these problems are not limited to the elderly patients. Their incidence, however, is much higher in this age group than in all other age groups.

1. ORGANIC BRAIN SYNDROME

Organic Brain Syndrome is the most common form of mental illness in the elderly population. It occurs in both an acute form (reversible cerebral destruction) and a chronic form (irreversible cerebral cellular destruction). Characteristics of both types include impaired memory (especially recent memory), disorientation, confusion and poor comprehension.

In the elderly person, acute organic brain syndrome may result from malnutrition, cerebrovascular accident, drugs, alcohol or head trauma. Restlessness and a fluctuating level of awareness, ranging from mild confusion to stupor, may signal this condition.

The cause of chronic organic brain syndrome is unknown. The major signs of this disorder include impaired intellectual functioning, poor attention span, memory loss using confabulation and varying moods.

2. DEPRESSION

Depression is the most common psychogenic problem found in elderly patients. Since the symptoms of depression span a wide range, consider it as a possibility in any elderly patient.

Depression may appear as:

- A. changes in behavior (apathy, self-depreciation, anger, inertia).
- B. changes in thought processes (confusion, disorientation, poor judgment).
- C. somatic complaints (appetite loss, constipation, insomnia).

If you observe any of these signs, question your patient in detail about recent losses. Also find out how he or she is coping with those losses. Assess their feelings carefully. Remember that an elderly patient's attitude toward his/her own aging and death – and toward death and dying in general – will affect his/her chances for successful treatment of depression.

A common difficulty elderly patients' face is adapting to loss. The grieving process regularly intrudes on their lives. Your patient may have to deal with losing a job, income, friends, family, health or even his home.

These losses and associated feelings of isolation and loneliness can cause stress that has physiological and psychologic consequences. For example, the loss of a spouse or other loved one can trigger profound sorrow. The resolution of this may be difficult. Unsuccessful resolution of grief can cause a pathologic grief reaction. This reaction may take the form of physical or mental illness.

Many elderly people today are turning to substance abuse and suicide in response to severe stress. Suspect possible substance abuse or thoughts of suicide if your patient is taking an unusual amount of medications. Also observe for such signs of alcohol abuse as jaundice and tremor.

CLINICAL DEPRESSION IN THE ELDERLY (Gerontology 1991)

Depression has been shown to be the most frequent cause for hospitalization in the elderly. The nurse must be able to understand and then cope with this very common ailment in our elderly population. The depressed elderly man or woman represents a very challenging nursing problem. Depression in the elderly often manifests itself as a variety of symptoms, both physical and emotional. This life-threatening disorder should be treated aggressively; and the nurse can certainly play an important role in the overall treatment plan for the elderly client¹.

Depression is defined by the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as a persistently dysphoric and sad mood with loss of pleasure in usual pastimes. Much of the chronic disability in the elderly can be related to depression.

Many researchers claim that 25 to 30 percent of the population over 65 years of age suffer from symptoms of clinical depression. Some researchers have also concluded that the elderly tend to have more frequent recurrence of depressive episodes; and that symptoms tend to be more severe in the elderly. However, as the person ages, it is increasingly difficult to identify and diagnoses this condition.

Persons over the age of 65 will vary often suffer from poly pharmacy, increasing number of illnesses, more personal losses and more nutritional changes. Retirement, loss of status, family losses and other conditions seen in the elderly may lead to an increased risk of depression which, as we stated, is often difficult to diagnose.

Again, here is where the nurse may plan an important role. Be aware of the client who comes to the doctor with symptoms of insomnia, anorexia, constipation and feelings of uselessness. These may often be regarded as merely physical signs of aging. The nurse may further assess the client and determine whether or not the patient may have an underlying depression. Many times medications are prescribed for these "minor symptoms". Be aware that some of these medications prescribed for these illnesses can actually cause depression in the elderly person. Steroids, anti-hypertensive drugs, anticonvulsants, anti-inflammatory drugs, antihistamines, cytotoxic drugs and many other drugs may actually cause depression.

Assessment of depression in the elderly is the most important aspect of the nursing care. An important part of the assessment is the nursing history. Be sure to take a complete psychosocial history from the patient and/or the family.

This text has an excellent assessment tool for the psychosocial areas. Be sure to assess the psychosocial history that includes the person's "normal" characteristics and those characteristics that the person is now experiencing. The nurse needs to differentiate between a normal "blue spell" and a deep depression. Symptoms that persist for two weeks or more are signs of a severe depression. Be sure to complete a thorough physical assessment as well as the

psychosocial areas. Assess diet, skin, hygiene, elimination pattern, sleep pattern, exercise pattern, medication history and emotional discomfort. The assessment tool in this text includes all of these aspects.

Depressed persons are likely to ignore hygiene. This can lead to skin problems and skin breakdown. Constipation is a complaint often seen in the depressed client. Insomnia is probably the most common sleep problem seen in the depressed person. Look for these signs and symptoms when performing your nursing assessment. Also, begin to assess for the barriers to treatment of the depressed patient. Be aware of the patients' attitudes toward mental health services. Very often, the older person has very set ideas regarding the health care system and care-givers. They might be afraid of the doctor or the nurse for fear of being labeled as "crazy". Also observe their reaction to strangers (the nurse). Many elderly persons are very fearful of trusting strangers, even if the stranger is their nurse. You might wish to determine the type of health insurance the person has. Their financial position many times will dictate their reluctance to seek treatment. Be alert to these and other such situations that might be an obstacle to treatment. Later on in the hospitalization these factors may plan an important part of the treatment plan.

Finally, the treatment of depression in the elderly will usually involve some type of psychotherapy and/or counseling. Remember that depression in the elderly can be very serious. Symptoms of depression can be serious enough to lead to the death of the patient. Be sure that your facility can provide the type of services needed by the severely depressed patient. Many facilities lack the necessary trained staff to deal with severely depressed patients. Your assessment can be very important. Your assessment might lead you to inform the doctor that this client is very depressed and needs aggressive treatment².

Remember that depression in the elderly can be life-threatening. You, as the nurse, need to be aware of how depression develops in the elderly and the signs and symptoms. One of the nursing responsibilities is to educate the health care workers at your facility. Everyone on the health care team must be able to recognize depression and to alert the patient's physician. You also need to know how to take the appropriate action; and take it quickly, if we as nurses are going to provide the best possible care to the depressed elderly patients.

¹ We will use the term "client" and "patient" almost interchangeably. We understand that the terms "client" and "patient" tend to be used differently in different parts of the country. In the editor's opinion these terms, in this text, can be used interchangeable.

3. ADVERSE DRUG REACTIONS

When you assess an elderly patient, consider that his/her psychological problems may result from undetected adverse drug reactions. The incidence of these reactions increases in older people because they use more drugs. They also may not take medications in the prescribed manner. Physiologic changes related to the aging process also may alter a patient's reaction to drugs. Such routinely prescribed medications as tranquilizers and barbiturates can cause or

increase depression. Other medications, including anticholinergics and diuretics, may cause confusion in elderly patients. Always include a detailed drug history in your psychological assessment.

4. PARANOIA IN THE ELDERLY

Paranoia is defined as an unreasonable fear that they are in danger. Paranoia may be one symptom of psychosis, depression or dementia. It can also be a discreet illness, characterized by a slow, gradual development of a rigid delusional system in a patient who otherwise has clear thought processes.

If you detect signs of paranoia during the mental status examination, try to determine whether they are a result of sensory-loss problems (which may be corrected by glasses or a hearing aid), psychological problems or a realistic fear of attack or robbery. Make certain that you rule out the possibility that the “paranoia” is justified. In today’s society, many elderly are in fear of their lives. In some cases this may be true. Crime has become so prevalent and vicious that the nurse must make a decision. Is this person’s fear justified? Or are they paranoid?

2 The term “aggressive treatment” means that the patient needs “intensive” treatment. He/she might need powerful drugs or powerful treatments; but he/she also needs to be observed carefully.

5. THE EFFECTS OF ANXIETY

In an elderly patient, the need to adjust to physical, emotional and socioeconomic changes (such as hospitalization, loneliness or moving to a new neighborhood) can cause an acute anxiety reaction. These changes may raise the anxiety level to the point of temporary confusion and disorientation. Often an elderly person’s condition can be mislabeled as senility or as organic brain syndrome. Actually the condition should be considered a psychogenic disorder (Tom 1976).

6. DEMENTIA

Dementia is the loss of intellectual abilities, especially those higher order functions measured by memory, judgment, abstract thinking and visual-spatial relations, in the context of preserved alertness. Dementia is different from delirium, which is a clouding of consciousness with decreased awareness of both external and internal environment and a decrease in the ability to sustain attention manifested by disordered thinking and agitation (Wetle 1982).

DEMENTIA

- A. Develops slowly
- B. Progressive
- C. Present for many months or years
- D. Rarely altered consciousness
- E. Uncertain date of onset

DELIRIUM

- A. Develops abruptly
- B. Non-progressive
- C. Short duration
- D. Fluctuating consciousness
- E. Precise onset

Fifteen percent of persons over 65 have some degree of dementia. Less than 5 percent are severely impaired due to dementia. There are many terms that are commonly interchanged by the public. The nurse must be sure to use the correct terminology after assessing the condition of the patient. These terms often used interchangeably are: senile dementia, primary neuronal degeneration, chronic brain syndrome, Alzheimer's disease and primary degenerative dementia.

Once the condition has been accurately diagnosed by the physician, the treatment plan can be set to most effectively deal with the problem. Many times the underlying problem is Alzheimer's disease. Other times the diagnosis will be Parkinson's or other disease conditions. Whichever is the case, the nursing responsibility is to accurately assess and report history and symptoms of the illness in order to expedite the correct treatment plan.

Senile dementia induced by Alzheimer's disease is usually slow in onset. Women are more often affected by this type of dementia than are men. The patients tend to be of advanced years and the Alzheimer's dementia has a slow linear progression. These patients tend to have a flat affect (show little emotion) and no other organic disease conditions can be identified (they are ruled out by lab tests and by examination). Most other types of dementia (from brain disorders) tend to afflict younger old people and usually have an abrupt onset.

NUTRITIONAL ASSESSMENT

1. NORMAL AGING CHANGES

Aging is characterized by the loss of some body cells and reduced metabolism of others. These conditions cause loss of bodily function and changes in body composition. Adipose tissue store usually increases with age. Lean body mass and bone mineral contents usually decrease with age.

A person's protein, vitamin and mineral requirements usually remain the same as he or she ages. Whereas caloric needs of the elderly are decreased. Decreased activity may lower energy requirements about 200 calories per day for men and women aged 51 to 75; 400 calories per day for women over the age of 75; and 500 calories per day for men over the age of 75.

Other physiologic changes that can affect nutrition in an elderly patient include:

- A. Decreased renal function, causing greater susceptibility to dehydration and formation of renal calculi.
- B. Loss of calcium and nitrogen (in patients who are not ambulatory).
- C. Decreased enzyme activity and gastric secretions.
- D. Decreased salivary flow and diminished sense of taste, which may reduce the person's appetite and increase consumption of sweet and spicy foods.
- E. Decreased intestinal motility.

2. PATIENT HISTORY

Disabilities, chronic diseases and surgical procedures (for example, gastrectomy) commonly affect an elderly patient's nutritional status, therefore, to be sure to record them in your patient

history. Drug or substances taken by your patient for a medical condition may also affect nutritional requirements. For example, mineral oil, which many elderly persons use to correct constipation, may impair gastrointestinal absorption of vitamin A.

Some common conditions found in elderly persons can affect nutritional status by limiting the patient's mobility. Therefore, the ability to obtain and prepare food or feed him or herself could be compromised. Among such disorders are conditions such as degenerative joint disease, paralysis and impaired vision (from cataracts or glaucoma).

Gastrointestinal complaints, especially constipation and stool incontinence, commonly occur in older patients. A decrease in intestinal motility characteristically accompanies aging. Constipation may also be related to poor dietary intake, physical inactivity or emotional stress. Constipation may also occur as a side effect of certain drugs. Elderly patients often consume nutritionally inadequate diets consisting of soft, refined foods that are low in residue and dietary fiber. Laxative abuse, another common problem in elderly patients, results in the rapid transport of food through the gastrointestinal tract and subsequent decreased periods of digestion and absorption.

Socioeconomic and psychological factors that affect nutritional status include loneliness, decline of the elderly person's importance to the family, susceptibility to nutritional quackery and lack of money to purchase nutritionally beneficial foods.

3. ASSESSMENT TECHNIQUES

Currently, the adult standards for nutritional assessment are used for the elderly. These standards, however, are not as reliable for the elderly age group. Further research is needed to develop tools for assessing the nutritional requirements of elderly persons.

Measures you can use to assess such a patient's nutritional status include:

- A. Common sense.
- B. Consideration of factors that place any patient at nutritional risk.
- C. The dietary history.
- D. Your objective data (keeping their limitations in mind).
- E. Monitoring of the patient's intake (if hospitalized).

Remember, protein-calorie malnutrition is a major nutritional problem in patients over 75 years of age and contributes significantly to this age group's mortality (Goldman 1971) (Health Assessment Handbook 1992).

MUSCULOSKELETAL SYSTEM

1. SPECIAL HISTORY QUESTIONS

Biographical data are significant for the elderly, because osteoporosis commonly occurs after the age of 50.

If your patient's chief complaint is pain associated with a fall, determine if the pain preceded the fall. Pain present before a fall may indicate a pathological fracture. Also, ask if your patient has noticed any vision or coordination changes that may make him or her more susceptible to falling.

When recording the patient's past history, determine if he or she has had:

- a. Asthma (treatment with steroids can lead to osteoporosis).
- b. Arthritis (which produces joint instability).
- c. Pernicious anemia (inadequate absorption of vitamin B12 in pernicious anemia leads to loss of vibratory sensation and proprioception, resulting in falls).
- d. Cancer of the breast, prostate, thyroid, kidney or bladder may metastasize to bone.
- e. Hyperparathyroidism leads to bone decalcification and osteoporosis.
- f. Hormone imbalance can result in postmenopausal osteoporosis.

During the activities of daily living portion of the history, ask your patient if he/she decreased his/her activities recently. Inactivity increases the risk of osteoporosis. Also, ask your patient to describe his or her usual diet. Elderly persons often have an inadequate calcium intake, which can cause osteoporosis and muscle weakness.

2. PHYSICAL EXAMINATION FINDINGS

Your examination of the elderly individual with a suspected musculoskeletal disorder is the same as for a younger adult. However, older patients may need more time or assistance with such tests as range of motion and gait assessment. This is due to muscle weakness and decreased coordination.

Disorders of motor and sensory function, manifested by muscle weakness, spasticity, tremors, rigidity and various types of sensory disturbances are common in the elderly. Damaging falls may result from difficulty in maintaining equilibrium and from uncertain gait.

Be sure to differentiate gait changes caused by joint disability, pain or stiffness from those caused by neurologic impairment or another disorder. Bone softening from demineralization (senile osteoporosis) causes abnormal susceptibility to major fractures. Most patients, over the age of 60, have some degree of degenerative joint disease. This can cause joint pain and limits spinal movement (Health Assessment Handbook 1987) (Stosky 1968).

ENDOCRINE SYSTEM

1. ENDOCRINE SIGNS AND SYMPTOMS

Many endocrine disorders cause signs and symptoms in the elderly that are similar to changes that normally occur with aging. For this reason, these disorders are easily overlooked during the assessment. In an adult patient with hypothyroidism, for example, mental status changes and physical deterioration, including weight loss, dry skin, and hair loss, occur. Yet these same signs and symptoms characterize the normal aging process.

Other endocrine abnormalities may complicate your assessment because their signs and symptoms are different in the elderly than in other age groups. Hyperthyroidism, for example, will usually cause nervousness and anxiety, but a few geriatric patients may instead experience depression or apathy (a condition known as apathetic hyperthyroidism of the elderly). In addition, an elderly patient with Grave's Disease may initially have signs and symptoms of congestive heart failure or atrial fibrillation rather than classic manifestations associated with this disorder.

2. NORMAL VARIATIONS IN ENDOCRINE FUNCTION

A very common and important endocrine change in the elderly is a decreased ability to tolerate stress. The most obvious and serious indication of this diminished stress response occurs in glucose metabolism. Normally, fasting blood sugar levels are not significantly different in young and old adults. However, when stress stimulates the older person's pancreas, the blood sugar concentration increase is greater and lasts longer than in a younger adult. This decreased glucose tolerance occurs as a normal part of aging. Therefore, keep this fact in mind when you are evaluating an elderly patient for possible diabetes.

During menopause, a normal part of the aging process in women, ovarian senescence causes permanent cessation of menstrual activity. Changes in endocrine function during menopause varies from woman to woman. However, estrogen levels usually diminish and follicle-stimulating hormone production increases. This estrogen deficiency may result in either or both of two key metabolic effects; coronary thrombosis and osteoporosis. Remember, too, that some symptoms characteristic of menopause (such as depression, insomnia, headaches, fatigue, palpitations and irritability) may also be associated with endocrine disorders. In men, the climacteric stage causes a decrease in testosterone levels and in seminal fluid production.

CHAPTER IV

THE NURSE-PATIENT HELPING RELATIONSHIP

THE HELPING RELATIONSHIP WITH NURSE AND PATIENT

1. ROLES OF THE NURSE

As you use the nursing process daily with the patient or family in later maturity, you will be functioning in a variety of nursing roles. You will be responsible for physical care, technical procedures and for creating an environment that is safe, comfortable, stimulating and health promoting. You will often be called upon to teach informally and formally to enable the patient or family to manage self-care, learn about his or her illness, or response to a situation or better cope with his/her condition. Referral to other sources of help may be necessary, for no one health team member can meet all the patient's needs. You may serve as counselor and you can always serve as a source of emotional and social stimulation and support. Depending upon your behavior and the senior's needs, you may be seen as a parental figure.

All of us need loving contact with other people in order to stay human in the fullest sense. From the moment of birth, the infant cannot survive unless he or she is cared for by the nurturing person. Likewise, the elderly person cannot survive either, emotionally or physically, unless someone cares about him or her. Caring is essential to a relationship.

How the senior reacts to you, your attitudes, appearance and behavior will be influenced, at least initially, by past experiences with people. If experiences have been pleasant with others, he or she will respond more quickly to your caring. If he/she has primarily felt anxiety and tension in his/her contact with others, he/she is likely to be distant, to respond slowly or even to not respond at all and tell you to go away. He/she may also test your intentions with overtly obnoxious behavior. However, underlying this apparent rejection of you, there is usually a great need for interpersonal contact. Knowing this should stimulate you to continue to reach out, to care.

Important in the total care of the senior is the establishment and maintenance of a relationship. Your goals may be limited because you cannot always change the person's pathology and you cannot reverse the aging process. However, you can help him/her to accept and understand his/her situation; help him/her to find meaning in his/her life and to enjoy personal growth from the experience. This total care involves not only physical care, but also genuine concern for the patients' feeling of self-worth, regardless of social values or capacity for achievement.

The elderly patient presents the nurse with a variety of challenges and dilemmas. The medical problems of the elderly are usually vary complex and require a great deal of time and energy to help solve. The problems or obstacles encountered with treating the elderly are numerous. Society holds many negative opinions and beliefs concerning the elderly. The nurse must overcome these stereotypes and negative beliefs in order to effectively treat the patient.

The elderly patient has certain rights to medical and nursing care.

These rights are the same as any other patient:

- a. The right to assessment.
- b. The right of personal autonomy.
- c. The right to participate in health care decision-making.

These rights indicate that the elderly have the right to be treated just like any other adult patient. They are not to be treated like babies. There are many aspects of these rights that are under controversy today. This includes the right to die, quality of care, quality of life, Medicare and financial aspects, withholding treatment, patient dignity and others. The nurse will certainly face ethical and moral dilemmas in the near future concerning these rights. The nurse will have to be aware of these rights and be aware of court decisions affecting the care of the elderly in order to continue a therapeutic nurse-patient relationship.

Relationship can be defined as an interpersonal process in which one person facilitates the personal development or growth of another. The process takes place over a period of time. The process involves helping the other person to mature, to become more adaptive, more integrated and to open his or her own experience; or to find meaning in his/her present situation.

The nurse-patient relationship results from a series of interactions between a nurse and patient over a period of time. The nurse will focus on the needs and problems of the person or family while using the scientific knowledge and specific skills of the profession. This helping relationship develops through interest in, encounter with and commitment to the person.

2. CHARACTERISTICS OF THE HELPING PERSON

The capacity to be a helping person is strengthened by a genuine desire to be responsible and sensitive to another person. In addition, experience with a variety of people increases your awareness of others' reactions and feelings. The feedback you receive from others will teach you a great deal on both the emotional level and cognitive levels.

Characteristics of a helping person include: being.....

- a. Congruent - Being trustworthy, dependable, consistent
- b. Unambiguous - Avoiding contradictory messages
- c. Positive - Showing warmth, caring and respect
- d. Strong - Maintaining separate identity from patient.
- e. Secure - Permitting patient to remain separate, respecting his/her needs and your own
- f. Empathetic - Look at patient's world from his/her viewpoint
- g. Accepting - Enabling patient to change at his/her own pace
- h. Sensitive - Being perceptive to feelings, avoiding threatening behavior
- i. Non-judgmental - DON'T judge the patient moralistically
- j. Creative - Viewing the patient as a person in the process of becoming, not being bound by his/her past, and viewing self in the process

of becoming or maturing as well (Rogers 1976)

There are several more characteristics that correlate highly with being effective in a helping relationship. One characteristic is being open, instead of closed, in interaction with others. An additional characteristic is perceiving others as friendly and capable, instead of unfriendly and incapable. Another characteristic is that of perceiving a relationship as freeing, instead of controlling another.

Establishing and maintaining a relationship or counseling another, does not involve putting on a façade of behavior to match a list of characteristics. Rather, both you and, the patient will change and continue to mature. As the helper, you are present as a total person. You blend potentials, talents and skills. You do this while assisting the elderly patient to come to grips with his/her needs, conflicts and self (Rogers 1976).

Working with another in a helping relationship is challenging and rewarding. You will not always have all the characteristics just described. At times, you will be handling personal stresses that will lower your energy and sense of involvement. You may become irritated and impatient while working with the elderly client. Accept the fact that you are not perfect and that you are always in the process of becoming.

Analyzing your behavior in relation to the person or family can help you determine your effect on them and can help you to be more effective. Just as you help the senior to develop, you will also continue to expand your personality to better gain the above characteristics. As you open a panorama of possibilities to another, your own potential unfolds. Remember that the most important thing you can share with a patient is your own uniqueness as a person.

Nursing experience in itself can bring about a cool efficiency, an overt indifference and an impersonal attitude and environment for the patient. The distant behavior that may result when the nurse is not rewarded by the work system for demonstrating helping characteristics seems to be an occupational hazard of nursing. Yet, in an increasingly mechanical world, we have to remain human and treat our patients as human (Pollak 1976).

CHARACTERISTICS OF THE HELPING RELATIONSHIP

1. RAPPORT

A relationship begins with the ability to establish rapport, creating a sense of harmony between individuals. In order to establish rapport quickly, you must have the following social skills (Rogers 1976).

- a. A warm, friendly manner, appropriate smile and comfortable eye contact.
- b. Ability to treat the other as an equal, to eliminate social barriers, to convey acceptance and to promote a sense of trust.

- c. Ability to find a common interest or experience.
- d. Ability to show a keen, sympathetic interest in the other, to give him or her full attention, to listen carefully and to indicate there is plenty of time.
- e. Ability to accurately adopt his/her terminology and conventions and to meet him/her on his own ground.

2. TRUST

Trust is the firm belief in the honesty, integrity, reliability and justice of another person without fear of outcome, the inner certainty that the other person's behavior is predictable under a given set of circumstances (Rogers 1976).

The capacity to develop a trusting relationship is built upon your attitude toward people, your flexibility in responding and what you are personally. Techniques and knowledge are not enough. You will learn through experience what aspects of your personality are more effective with, and helpful to, others.

Trust is based upon consistency rather than compatibility. The senior cannot reveal him or herself nor share important information unless he/she can rely upon you. He must believe that you will react with the same behavioral characteristics each time he or she meets with you. He/she needs to know that you will keep content from the interview confidential, as mutually agreed upon. You may have to delay obtaining certain information until a sense of trust is established. This is because the elderly patient may feel very threatened by an interview or examination. In addition, you must feel that you can predict the person's behavior because you have an understanding of the person (Rogers 1976).

3. UNCONDITIONAL POSITIVE REGARD AND ACCEPTANCE

Two qualities often described as essential to a relationship are positive, warm feelings and acceptance. **Is it possible to give expert and professional care and not feel positively toward your patient?** Most patients would say "NO". The human spirit loses its sense of vitality and even the will to live when surrounded by hostile persons.

Realistically, it is not possible to like everyone. Similarly, it is not possible to establish and maintain a relationship with everyone. However, you will find some patients you will be genuinely interested in and can feel affection for. Likewise, other nurses will respond the same way to other patients. There are a few "cantankerous" or "repulsive" people whom no one seems to feel any rapport with or interest in. Perhaps your willingness to reach out will make a difference. Your ability to stimulate a more likable behavior in that person may also make a difference. Also your willingness to learn more about his or her uniqueness, will be the result of our unconditional positive regard, belief in the dignity, worth and importance of the person, regardless of his or her behavior (Murray 1980 (Pollak 1976).

4. EMPATHY

Unconditional positive regard and acceptance are easier to achieve if you have developed empathetic understanding of people. Empathy is feeling with the person and simultaneously understanding the dynamics of his or her behavior. As you and the senior feel and think together, your feelings for him or her impels you to act.

Empathy is the ability to sense the patient's private world as if it were your own. You can do this without ever losing the "as if" quality. You can sense the patient's anger, fear or confusion as if it were your own. You can do this without your own feelings getting bound up in the interaction.

You are empathetic to the degree that you are able to abstract from your own life experience, by way of recall or generalizations, common factors that are applicable to the patient's problems.

Certain qualities enhance empathetic skills. The ability to empathize varies with the patient, time and nurse. Certainly, a general interest in people, basic knowledge of human behavior and a warm, flexible personality encourages empathy.

Other characteristics that enable you to be more empathetic are:

- a. Similarity in values, experiences, social class, culture, economic level, religion, age, personality or sameness of sex.
- b. Ability to be alert, to listen with the "third ear", to become involved in another, to abandon self-consciousness.
- c. Ability to cope with egocentricity, anxiety, fears, feelings or stresses that block listening to and feeling with another.
- d. Variety of life experiences that help you to acquire a broad understanding of people, flexibility and spontaneity.
- e. Ability to maintain an adequate health and energy level.
- f. Ability to interpret correctly and to avoid distorting perceptions.

Empathy involves the following dimensions:

- a. Tone – expressing warmth and spontaneity nonverbally and verbally.
- b. Pace – timing remarks or behavior appropriate to the patient's feelings and needs.
- c. Perception – abstracting the core or essential meaning of patient concerns; discussing them with him/her in acceptable terms.
- d. Leading – formulating questions or statements that move the interview in the direction of the patient's concerns.

Empathy is not the same as sympathy or pity:

- The sympathetic person becomes stricken with emotion because he or she projects himself or herself into the other person's place. The empathetic person shares the experience but maintains objectivity. The sympathizer may be secretly happy that a certain situation has

not occurred to him/her, or he/she may feel guilty in his/her own good fortune. Empathy can be found in any situation, in grief, in joy.

Pity is contrary to helping. To cause another to feel like a victim debases the person right now. It also conveys that he will remain debased and helpless. Pity conveys that the other person receives help because you are obligated and pseudo altruistic. Spontaneous and genuine helping is "one-on-one" human being with another, simply because you are both human.

How do you communicate empathy? Use verbal and nonverbal communication so that the senior experiences a feeling of being understood. Your statements serve as an emotional mirror or as a reflection of his or her feelings without distorting or giving him or her advice. For example, you may say: "It seems as if you are very discouraged with P.T." or "It sounds as if you are quite concerned about whether you made a right decision". Avoid a response like, "I know how you feel". Such a response makes the senior unsure about your truly understanding of him/her. It is a rote response and is not based on a genuine understanding of his/her current feelings.

Talk on the senior's level of understanding and adjust your tone of voice to his or hers. For example, if you use a declarative, harsh tone of voice, it will seem as if you are telling the patient what he/she thinks and how he/she feels. That is not an example of reflecting his/her feelings. Using language that he/she does not understand will convey a lack of respect, regardless of the accuracy of your interpretation.

Evaluate the elderly person's true feelings. Sometimes he/she is not ready to admit certain feelings and needs time to deny them.

Reflect the senior's feelings frequently for correction, disapproval or approval. Remain open to his/her response. A patient who is free to correct you moves on to a higher level of self-understanding. If he/she cannot refute your reflection, he/she then can build up defenses. This leads to withdrawal, thereby defeating the primary purpose of the relationship. Some examples of how to begin your reflections are: "If I understand you correctly, you feel....." or you might say, "Is that right?".

Respond actively and frequently enough to the senior, without interrupting him/her. This indicates that you are focusing on his/her speech and feelings.

The ultimate purpose of the empathetic response is to convey to the person a depth of understanding about him/her and his/her predicament so that he/she can expand and clarify his/her understanding of self and others. The patient receives relief from loneliness and overcomes feelings of isolation and aloneness with his problems. Your willingness to understand how the senior feels about his or her world implies that his/her point of view is valuable. Also, the focus of evaluation is within the patient, so that he becomes less dependent on the opinions of others and grows to value him or herself. Empathetic

understanding is not a passive process. It will not happen without effort. You must concentrate intensely on the person. Intense concentration allows you little time to reflect on personal needs, values and ideals. It prevents judgmental thoughts or behavior.

Improvement in patients' conditions is correlated with empathetic responses, regardless of their diagnoses. Not only are high empathetic levels correlated with improvement, but it is found that low levels of empathy contribute to increased disturbance in patients. The lack of empathy displayed by nurses could, therefore, be hindering their patient's recovery.

5. **GOAL FORMULATION**

A helping relationship differs from a social relationship. In the helping relationship there is explicit formulation of goals. You may have certain goals that you hope to accomplish, but the senior must actively participate with you in setting mutual goals. As the relationship progresses, new problems or concerns will be identified and new goals will have to be set. The relationship is structured in that you share with the patient what he or she can expect. You then listen to what the patient expects of you. Together you determine the course of the relationship. Intentions and expectations are verbally and nonverbally conveyed to each other. Expectations will usually change as the relationship progresses.

General goals of the nurse-patient relationship include:

- a. Increasing the senior's self-esteem and promoting a positive self-concept and sense of security.
- b. Decreasing the senior's anxiety to a minimum.
- c. Providing a gratifying, positive experience.
- d. Assisting the senior in improving communication skills and in participating comfortably with others.
- e. Providing the opportunity for the person to grow emotionally.
- f. Helping the senior find meaning in his/her life situation.
- g. Maintaining and stimulating the person biologically, mentally, emotionally and socially.
- h. Gather data to gain in-depth assessment to provide individual care.

6. **HUMOR**

Intense interaction between two or more people cannot endure unless a sense of humor surfaces at times. Humor is the ability to see the ludicrous or the incongruities of a situation, to be amused by one's own imperfections or the whimsical aspects of life, to see the funny side of an otherwise serious situation. Humor does not necessarily mean joking and teasing. It does not involve the put-down of another and it does not always evoke laughter. Humor may be expressed as a tiny smile that lingers or the mental chuckle that occurs when you are sober-faced.

The purposes of humor include:

- a. Releasing tension, anxiety or hostility.
- b. Cautiously distracting from sadness, crying or guilt.

- c. Decreasing social distance.
- d. Conveying a sense of empathy to another.
- e. Expressing warmth and affection.
- f. Encouraging learning or task accomplishment.
- g. Denying painful feelings or a threatening situation.

The elderly patient often has experienced use of humor beneath those steely eyes and tight lips. He may test you with a few dry statements to see if you are really alert and if you can make the cognitive connections he insinuates. Too often these dry statements receive only a grunt in reply, or worse, they are ignored and the senior is labeled senile, confused or crazy.

If you do not respond to his humor, he/she loses emotional and social input and self-esteem. Although underneath he/she may consider you his/her inferior – less educated, less experienced, less wise. You lose when you cannot expand your mind with the humorous. You dry up emotionally and you have lost an opportunity to learn, to mature and to enjoy.

CHAPTER V

THE CHARACTERISTICS AND CRISES OF LATER MATURITY

COGNITIVE CHARACTERISTICS IN LATER MATURITY

1. STEROTYPES

Contrary to the stereotype, intellectual functioning does not automatically degenerate in later maturity. Assessment and nursing care must be directed toward the healthy characteristics as well as toward any limitations that might be present.

Chronological age is rarely a reliable index of the elderly person's mental development. The initial level of ability is crucial. Those persons with high IQ scores as children show progressive gains in general information, comprehension, vocabulary and arithmetic when retested in later life. A bright 20-year-old, all things being equal, will usually be a bright 70-year-old. This bright 70-year-old will function better in cognitive skills than the average 20-year-old.

Cognitive functions refer to mental and intellectual processes of drive, perception, interest, motivation, memory, reasoning, thought, learning, problem-solving and judgment. These functions include the ability to examine a situation; take in, process and recall information; orient self in time and place; organize complex data; and respond appropriately to stimuli in content, emotion and over time.

2. PROBLEM-SOLVING ABILITY

The brain possesses a tremendous reserve capacity. Perhaps this is why the senior may cope very well despite the decrease of functioning nerve cells in the central nervous system. This decrease is influenced by cellular, circulatory and metabolic changes occurring in the body with aging (Botwinick 1967).

The older person may be able to tolerate extensive degeneration in the central nervous system without serious alteration of behavior or cognitive function in a supportive social environment. The person often remains relatively unimpaired because he or she has developed ways to counteract slight memory loss or difficulty in learning. Certain social skills or pleasant responses help him/her through a situation. Therefore, others might not notice a slight cognitive deficit. If others' responses, in turn, remain positive, his/her self-confidence enables the senior to use skills he/she does possess. Thus, daily functioning is likely to be unimpaired. Even in unusual situations, he/she is likely to come up with the best solution for him or herself.

The initial level of ability is crucial for continued learning. Those with high IQ scores at a younger age are usually better to cope with current stresses, manage new situations or work more effectively in familiar situations. In familiar situations they can use a variety of skills that are enhanced by thoughtful experience and maturity.

The elderly person is likely to be superior to the younger person in overall factual knowledge; coordination of facts or ideas, life experience and wisdom; use of authority and power to get things done and maturity of judgment. All of these could enhance or maintain problem-solving ability and

work performance. Yet, how the senior uses his or her skills to do problem-solving may differ from that of a younger person. The older person performs more accurately when stimuli are logically grouped and sequential; and more accurately when given a larger amount of data, instead of isolated bits of information. He/she also does better when given a longer time to process the data. He/she is likely to work out mentally how to do something before he/she acts it out.

The senior is less likely to take advantage of information that is not directly relevant to the situation. He/she is unlikely to acquire new ideas or concepts unless they are better than currently held ideas or concepts. Tasks that require making analogies, forming new concepts, or new classifications and finding novel or creative answers are more difficult to perform. However, with enough time, the senior would come up with a workable solution to the problem.

3. CREATIVITY

Rigidity and concreteness in thought are typical of old age. The older person seems more rigid in his or her thinking because he/she is cautious and emphasizes accuracy instead of speed. Caution results from a tendency to avoid risky decisions. This is likely due to a fear of failure or he/she has learned from past experiences. Yet, when a decision can't be avoided, the elderly will choose high-risk or innovative solutions as are younger people. The elderly are more concrete in thinking and strive to be functional or practical instead of abstract.

Reduce use of abstraction skills has other results. Research indicates that appreciation of jokes increases but comprehension of subtle content decreases in old age. Past studies on creativity and productivity, measured by publications and discoveries, indicated that people are most creative between the ages of 30 to 50. Actually, there is no age limit for creativity, since creativity is not limited to publications and discoveries. The human is creative in various ways. Current research indicates that the senior is often creative, even if he/she has not had very much formal education. He/she uses past experience and insights in new ways in order to meet current situations. He/she usually integrates experience on a higher level – absorbing, sifting and reconstructing reality on his own terms. He treats as hypothesis what most people treat as fact. He recognizes that anything encountered is incomplete, that it is in need of further study and reflection.

Regardless of how creativity is defined – as superior quality or as total productivity – the peaks and declines are the result of more than intellectual changes. Will power, working strength, endurance and enthusiasm are all part of creativity. With the trends toward longer educational preparation in many fields of work, future studies may reveal that creativity increases with age, since many people will be older before they can become productive.

4. REACTION TIME

Reaction time usually becomes slower as the person ages. However, some older persons, especially physically active seniors, react as quickly as some younger people. The senior needs extra time to perform physical tasks. Performance scores tend to be lower and are used to explain intellectual decline. Yet, by practicing a task, the older person can learn to improve his or her reaction time.

Seniors perform certain cognitive tasks slowly do to:

- a. Decreased visual and auditory acuity.
- b. Slower motor response to sensory stimulation.
- c. Loss of recent memory.
- d. Changed motivation.

He or she may be less interested in competing in timed intellectual tests. Further, an apparently shorter duration of alpha rhythm in the brain wave affects the timing of response. Reaction time is also slower when the person suffers significant environmental or social losses. It also is slower when he/she is unable to engage in social contact and when he/she is unable to plan his/her daily routines. The person, who is ill, often endures environmental and social losses by virtue of being in the patient role. Thus, he/she may be slower responding to your questions or requests (Murray 1980).

Yet, some tests have shown that mental reaction time begins to decline after 26 years of age. In one study, adults who were 71 were compared with 43 year-olds. Both sets of subjects were given the same test for vigilance or clockwatching. Seniors were just as attentive and vigilant as young adults for 45 minutes. After that period, loss of interest and fatigue reduced their degree of vigilance. However, an attention span of 45 minutes is acceptable in young adults, as evidenced by the length of a class hour (50 minutes), in most colleges.

Reaction time is affected by pre-existing expectations for stimuli as well as expectations during the experiment. The senior is more likely to expect change rather than repetition in sequences. He had developed a bit of a "gambling" attitude toward life over the years. Thus, he/she responds faster to stimuli that are not repetitious. Most tests for reaction time involved repetitious stimuli, which may influence test scores.

The person over 50 performs less efficiently in tasks requiring speed or when given little advance time to respond to the task. The older person has a longer response initiation time, especially when hand movements are involved. He/she usually takes longer to convert verbal stimuli to a mental image. Response is slower if action must be carried out without seeing what is being done, when a large quantity of data are presented in illogical order, when a quantity of evidence must be placed together without using memory aids such as notes and when abstractions are presented. Yet many younger people also have difficulty under such conditions.

The average elderly man performs less accurately in fast-paced than in slow-paced situations. He is less likely to try in fast-paced situations unless he is sure of the accuracy of his response. Performance of the average elderly woman is comparable to that of younger highly verbal men and women in fast-paced situations. Throughout life, women excel in verbal ability and fluency tests. Older women respond more readily to cognitive, psychomotor tasks than to elderly men.

5. **MEMORY**

Memory is the ability to retain or recall past thoughts, images, ideas or experiences. A progressive loss of memory does not necessarily occur in later maturity, although memory loss affects more people as they get older. Loss of short-term memory, recall for recent events, is more likely to occur than loss of remote memory, recall for events that occurred in the past.

The person's permanent memory is an organized network of concepts interrelated in specific ways. If the relationship between these concepts cannot be used because of loss, decreased retrieval or lower access, the person loses conceptual richness or spontaneous use of memory links. Such loss is more likely to occur in older people than in younger people and in persons institutionalized than in persons living in the community, apparently because of the number of life crises and less intellectual stimulation for the former group.

Memory loss may occur for various reasons:

- a. Interference from other memories that are valued by the person and accumulated with age.
- b. Sense of worthlessness or depression, so that less energy is directed toward recall.
- c. Loss of interest in current events; past memories are more pleasant.
- d. Neurochemical and circulatory changes may affect cerebral function.
- e. Loss of cells in the central nervous system.
- f. Difficulty in information acquisition because of deficiency in neural synapses in the storage system.

Short-term memory is central to learning processes that would not otherwise decline with age. Synthesis, analysis, comparison and ability to organize content are less dependent on short-term memory, and these functions do not decline with age. The problem in learning occurs because the person loses the pieces of immediate information needed to process, code or synthesis. Short-term visual memory appears to be more susceptible to aging than is auditory memory.

The senior has difficulty in ordering the time sequence of more recent events, in rote memory and in immediate recall of new learning. He or she uses fewer mental images to enhance verbal phrases he/she hears and to act as memory mediators, which may account for the poorer performance on memory tests.

Long-term or remote memory, including vocabulary, personal history, past experience and basic knowledge, is highly resistant to the effects of normal aging.

6. **FACTORS THAT INFLUENCE COGNITIVE RESPONSE**

Many factors must be considered when you assess the intellectual level, problem-solving ability, creativity, reaction time or memory of the older person, including the following:

- a. Interest in living and in events about him or her.

- b. Sensory impairments that interfere with integration of sensory input into proper perception.
- c. Amount of time since in school or in an intellectually demanding position.
- d. Educational level, past involvement in learning activities or earlier cognitive incapacities.
- e. Amount of deliberate caution; using more time to answer or do a task, which can be interpreted as not knowing.
- f. Presence of adaptive mechanisms to conserve energy rather than showing assertion or time-consciousness.
- g. Degree of motivation to please those around him or her or to participate in a testing situation.
- h. Presence of ill-health.

Previous life-style, present behavior patterns and general coping mechanisms all affect cognitive function and must be considered in assessment. Observe behavior in a variety of situations and listen to the person's conversation and reminiscences. Talk with family members or friends. Consider the total, unique individual physically, emotionally and socially so that you can increase the accuracy of your cognitive assessment. Too often cognitive impairment of the person in later maturity is considered as irreversible brain damage or chronic brain syndrome. Recent research indicates that mental impairment may be caused by a number of interacting relationships of biological, psychological, social and environmental factors. Even when brain damage is present, impairment may range from slight to severe.

7. EMOTIONAL FACTORS

Some of what is called mental impairment results from our approach to older people. Society expects the older person to become deteriorated or "senile". If his or her self-image is affected by a role expectation of mental dysfunction, his/her behavior becomes "senile", an example of the self-fulfilling prophecy. Institutional life also limits motivation to behave appropriately because opportunities are not used to draw out functions assumed to be lost in old age. The institution is often devoid of time and environmental cues, and confinement causes disorientation and confusion. Reactions of others markedly affect the person's motivation to stay alert, to learn, to be creative. The person who feels worthless is less likely to try.

The person who suffers marked losses, especially the loss of a significant person, tends to perform less adequately on psychometric and personality tests. Often general behavior and problem-solving abilities are noticeably less effective as well.

The relationship among three cognitive ability factors (ability to process information, manual dexterity in response to stimuli and ability to analyze patterns), and three personality dimensions (anxiety, extroversion and openness to experience) were examined in over 900 males aged 25 to 82 years. Persons, who were highly anxious, scored lower on all three cognitive ability factors. Persons open to experience, scored higher on ability to process information and analyze patterns.

Introverted persons scored higher on ability to analyze patterns than did extroverts. Older people performed less well than younger ones on manual dexterity and ability to analyze patterns, but they did equally well on ability to process information.

The senior is more apprehensive about new learning situations, especially in a competitive atmosphere. He anticipates difficulty in learning new tasks and asks for more detail and specific directions. Certainly questions should not be interpreted as mental incompetency. The older person is usually more cautious than the younger adult because of his/her experience, which accounts in part, for the difference in experimental test performance. Whenever possible, tasks are selected that have less risk or at which the person has a higher probability of success, probably to avoid a negative self-evaluation.

8. SOCIAL FACTORS

Our culture values a rapid verbal and motor response. The older person has internalized that value. Because he/she cannot respond rapidly to a question, statement or task, he/she may devalue him or herself. Further, he/she may have internalized the cultural expectation that school is only for youngsters. Hence, he/she lacks confidence in pursuing formal or informal learning activities. He/she may consider him or herself and other older people too stupid or too slow to learn.

The older person should be seen as a productive person who has been learning all of his/her life. Any decline of mental power is more likely to result from the brain getting too little rather than too much work. Lack of environmental stimulation, forced isolation and disengagement hasten mental and physical decline. The person feels less like making the effort to respond intellectually. Those who continue to work have more normal brain function and have higher intelligence test scores in later maturity, than do those who are idle. Society needs the cognitive potential of our senior citizens and should provide opportunities for them to use their skills.

9. PHYSICAL FACTORS

Sensory impairments that accompany aging can cause the person to miss certain stimuli and as a result, appear intellectually impaired.

In one study of relationship between visual and mental function, subjects were divided into three groups on the basis of visual acuity:

- a. Adequate vision.....better than 20/70
- b. Low vision.....20/70 to 20/100
- c. Legally blind.....20/200 or worse

The group with adequate vision scored highest on the mental status questionnaire. Lowest scores were in the legally blind group. That most older people could cooperate with vision and mental testing, was also shown.

At this point, whether vision loss causes impaired mental functioning or organic brain disease causes impaired vision is unknown. They are probably interrelated. Also, medications, general physical health and emotional state, can affect both visual and mental function. A direct relationship also exists between hearing loss and reduced cognitive effectiveness. Hearing loss results in changed speech perception, reduced ability to define concepts, to describe abstract relationships and even to recall stored information. Thus, hearing loss affects cognitive test scores, reaction time and personality.

If the person cannot see adequately or hear what you are saying, his/her response may appear confused, disoriented or stupid when none of these characteristics is present. The problem is increased if you are speaking English and the elderly person's first language is not English. Inability to differentiate among environmental stimuli and decreased speed of processing information also limit the person's ability to assess the possible constraints and opportunities within the environment. This limits his/her coping strategies.

A serious illness or injury in early life often causes damage to certain brain cells. The person must relearn the functions regulated by these cells. Later cognitive impairment can result from incomplete relearning and the illness rather than from the aging process alone.

Numerous illnesses can reduce cognitive function and cause disorientation or confusion. Poor health and lower energy levels cause the person to resist becoming involved in planned learning activities and to score poorly on intellectual tests. Even mild disease negatively affects intellectual performance, especially memory, adherence to given tasks, answering appropriately and ordered sequence of thought. Thus, any ill person will show less mental acuity, which must be considered when planning and giving care.

Rapid declining cognitive function may be a predictor of death if the person has previously been alert and mentally capable. Studies indicate that intellectual functions decline in the aged person primarily one year before natural death (Murray 1980).

THE CRISIS OF DEATH

In the Middle Ages, the person was very aware of natural signs or premonitions that he/she was dying and was active in doing the rituals that prepared for death. Loved ones quietly kept the vigil with him/her. Death was familiar and near. It evoked no great sorrow, awe or fear. About the eighteenth century, death became romanticized and became intertwined with love. Concerns about the death of others became of greater concern than personal death. Gradually, death was viewed as a disruption. Sorrow was openly and intensely expressed.

In the twentieth century, death has become frightening, taboo and unfamiliar. Although death is frequently presented in the mass media and movies and many disasters are publicized, few people have direct contact with death. Mourning has been suppressed. The language of our culture avoids death

with phrase like; “He passed on.” “He grew weak.” “He is sinking.” “She is gone.”. Humor may be used to refer to dying, to express fears of death, to predict death or to convey doubts about staff competence. Medical care technology further depersonalizes and denies death. The person is no longer in charge of his/her dying, even if he/she are aware of his/her status (Murray 1989). The senior has lived through some of this evolution. He/she may have helped care for sick and dying parents at home and is perplexed, perhaps angry, when he/she is sent to a nursing home or hospital.

Although considerable literature and media coverage are devoted to death and dying, people in the U.S. still seem uncomfortable with the topic. In spite of increased efforts at professional education about death and dying, care of the dying elderly population still is neglected in many institutions.

Some cultures believe that life and death can be controlled by the person. Voodoo death or spontaneous deaths are well documented. The person was either a victim of the enemy or he/she “willed” him or herself to death when he/she has broken a taboo and then he/she dies shortly thereafter. The medicine man is important in many cultures to organize the community’s attitude toward the dying person. It has been seen that if support is withdrawn, the person gives up and soon dies. If the medicine man conveys that the person is curable, the community becomes supportive and the person survives.

The situation for our elderly may not be too much different. Being hospitalized and cut off from the rest of the community, may hasten death. This is something Native Americans, Orientals, Chicanos as well as the elderly have “known” as they were subjected to impersonal treatment. However, since hospitals are at times necessary, efforts have been made to create a warm, supportive environment.

Premonitions of death are apparently present in many seniors, although they may be reluctant to say so. Sometimes the senior will predict when he/she will die. The elderly may exert more control over their longevity and time of death than is commonly realized. Often it appears that the person will not give up life until he/she has said farewell to a certain loved one.

Longevity is increased when the older person posses the following characteristics:

Useful, satisfying role	willingness to adjust and change
Positive view of life	lifetime habits of moderation
Assertive attitude	interest in others and the future
Competent physical and mental functioning	creative and expansive thinking

Interestingly, one study found that the patient, who survived longer than predicted, was angry about his illness, fearful of death and determined to live instead of being resigned to death (Benoliel 1970). Attitudes about death differ in various cultures. Morality occurs at an earlier age in lower socioeconomic groups and among racial minorities in the United States. Therefore, death may be perceived differently by different groups. In a study comparing Black Americans, Mexican Americans and White Americans, fears of death were related more to age than to racial group. Middle-agers

expressed more fear than the elderly, and women were more expressive of their feelings than men. However, they did not think about death as frequently. Whites were less preoccupied with death than the other minorities. Elderly Mexican Americans expressed the least fear of death. Young Mexican Americans expressed the most.

In the United States, death is expected to come to the elderly, to people no longer in the work force. Thus, society overall is not concerned with death unless it occurs to the young or occurs violently. Even if death comes early, little disruption occurs because work is organized so that major institutions are relatively independent of the persons who carry out work roles within them.

Fear of death is apparently more common in the young than in the elderly. However, the elderly express fear of death when a crisis in the social environment is disrupting prior life-style and acceptance. For example, those who are moved to or live in a nursing home are more fearful than the elderly who live in the community and who are not experiencing relocation. The elderly suffering psychiatric illness may also express fear of death. The elderly in a stable situation feel more peace and equanimity about death.

1. MEANING F DEATH

To the elderly, death may have many meanings:

- ...a friend who brings an end to pain and suffering
- ...a teacher of transcendental truths uncomprehended during life
- ...an adventure into the unknown
- ...reunion with loved ones
- ...a reward for life well-lived

Death may mean the great destroyer; the cessation of life with eternal nothingness; punishment and separation; or a way to force others to give more affection than they were willing to give in the past. Suicide may be seen as a way to gain control over dying, join loved ones or end an apparently hopeless situation.

The mature person recognizes that dying and death are phases of living and life. The decreased energy level, religious beliefs and loss of most significant people also facilitate a philosophical attitude toward closure. Children and grandchildren also bestow on the older person the remainder of continuity of life and tangible evidence of his or her ongoing contribution to mankind. The person who has left issues unsettled, dreams unfulfilled, hopes shattered or let meaningful things pass him/her by, is sometimes reluctant to die. Knowing of one's morality allows the person to start preparing early for the last developmental stage—to live life instead of passing through it.

2. PREPARATION FOR DEATH

Most people admit to thinking about death at some time. Usually these thoughts are triggered by external events such as an accident or near-accident, a serious illness or death of someone close.

Yet, some older people do not make plans for death, as if planning will hasten death. The elderly are more concerned about the dying process and:

- a. The pain
- b. Being a burden
- c. Loss of bodily and mental functions
- d. Dependence upon others
- e. Rejection
- f. Isolation and separation from loved ones
- g. Inability to take care of personal business
- h. Loss of social roles

The more relationships that are important to the senior, the more ties he/she has to undo. This causes grief to be greater. Most do not wish to have life prolonged by machines. However, there are times that such treatment is warranted. Life-support machines give seniors and family extra time to prepare for their death. Some seniors feel the best way to avoid prolonged suffering, dying and preparation for death is to express their desires to family and physician through the Living Will.

Death can be planned in different ways. For example, a prominent Protestant theologian and his wife put their affairs in order, said their farewells. They wrote a note to their children and grandchildren. The note explained the reason for their behavior. They wrote that their health was quickly failing. They required almost constant care. Soon they would be too dependent to live without dignity. They did not want to take up space in a world where there were too many mouths to feed and too little food. They felt it was a misuse of science to keep them technically alive, so they committed suicide.

They thought carefully and believed they had the right to decide when to die, and the decision was not turning against life as the highest value. They clearly were not acting from depression, despair, pain or mental incompetence. They risked condemnation because their religion does not sanction this. However, they felt their action was logical and this will become more acceptable in the future.

Charles Lindbergh also planned his death, but in a different way. When he knew he was terminally ill, he selected his grave site. It was on a tropical island of Maui. He then made all the necessary legal arrangements. Eight days before his death, when the doctors told him he had little time left to live, he flew from New York City to Maui. Then, with his family, physician and two nurses spent the last two days looking at the place he loved and reminiscing. He received the necessary care, but no measures to prolong life. His death was like his life; simple, well-planned, considerate and humble.

Most seniors do not have the means to fulfill their dreams as Lindbergh did. Many are taken to institutions. They endure a variety of tests, drugs and procedures. They have minimal control

over their living or dying. Preoccupations with symptoms, pain and the rigors of treatment preclude quiet contemplation, meaningful life review or serene acceptance of death. Medical staff may resist death more vigorously than the patient and often do not credit the senior with enough maturity to understand or accept the finality of his/her condition.

Although a few seniors maintain denial, most desire a plan for their demise. You may be of assistance to them as they validate ideas or need specific tasks to be done. Or you may assist them by letting the doctor know that the senior can accept his/her condition. The doctor can state the diagnosis and prognosis honestly without conferring hopelessness. If the person insists that he/she does not want to be told anything, his/her request should be honored. Often, the person is aware of the truth, but avoids talking about it. Preparation for death is more important for some elderly than for others. Some need to make provisions for their heirs and finalize business and legal affairs.

For many elderly, a spiritual preparation for death is of great importance. Premonition of impending death may give opportunity for long-deferred self-examination and for gaining new meaning in life and death. A reconciliation of conflicts in one's religious faith can be accomplished. Personal hurts can be amended and tenuous relationships can be strengthened. Each day becomes precious and meaningful.

People die as they live. Those who found meaning in life are unafraid of its end. If success in life has been measured by material standards, death may be approached with bitterness and anguish. Religious faith is not necessarily a factor. Agnostics and atheist may accept death with as much tranquility as a religious believer.

Certain developmental changes occur in the last year prior to death that are unrelated to age and illness and appear to be predictors of death. These characteristics of approaching death which are often monitored by the ill elderly include:

- a. Poorer performance of various tasks
- b. Lower energy level
- c. Slower reaction time
- d. Decline in cognitive functioning
- e. Shortened memory
- f. Decreased planning ability
- g. Reduced emotional complexity
- h. Decreased planning ability
- i. Reduced emotional complexity
- j. Decreased ability to cope with stress
- k. A more negative self-image
- l. Less capacity for learning
- m. Less assertiveness and flexibility

n. Increased introspection

The senior expresses more anxiety, more hopelessness, but fewer expectations about the future. He feels that his/her body is no longer functioning as well as it did, even before overt signs and specific symptoms appear. The person may say, "I feel like I'm slipping and I don't think I'll be here next year at this time". The senior may show increased interest in his social and material environment; it is a disservice to isolate the senior at this time.

3. AWARENESS OF DYING

People today are better educated generally by the mass media about the manifestations of the main killers, cardiovascular disease and cancer, than they were in the past. Further, the legal aspects of informed consent are rigorous. Many procedures cannot be performed without giving the senior an honest explanation. Thus, most people are likely to know intellectually even if they do not emotionally accept their terminal illness. Yet, some doctors and families persist in wanting to keep the diagnosis and prognosis from the patient. They feel that the elderly person will be unable to accept the news.

Different stages that the terminally ill patient may experience include:

a. **CLOSED AWARENESS**

Closed awareness exists when the person has not been informed. Also he or she has not discovered the severity of his/her condition. He/she may not be aware because he/she is also not knowledgeable about the signs of terminal illness. Additionally, he/she may be in denial and not aware of the severity of the disease. Maintaining a closed awareness is easier in the hospital than at home. The nurse, of course, may be placed in the middle, in such a situation, for it is difficult to communicate openly when a secret must be kept. Family members are robbed of an opportunity to be honest, share their grief with the loved one or plan together for the future. The patient has no opportunity to work through his/her doubts or fears or make plans for his/her loved ones. No one ever learns of the resilience or maturity of the senior, who may be more able to cope than anyone realizes. Keeping the patient uninformed is a travesty of care, in most cases. However silent the patient might be about his/her condition, he/she may have a premonition about his/her status. The senior watches his/her caretakers and family closely for clues about him or herself. He/she may come to the conclusion that he/her is very sick and dying as he/she overhears snatches of conversation or sees teary eyes (Benoliel 1970).

Isolation is experienced when family and friends relate differently to the patient after they learn that he/she is dying from a known terminal illness. They no longer share with the patient. Conversation becomes superficial, stilted and lacks spontaneity as they try to keep the patient from learning his/her diagnosis. Suspicious awareness exists when the person believes he/she is dying but says nothing to confirm his/her idea. Usually his/her deteriorating physical status, others' silence or their brusque answers to his/her queries, a

move close to the nurses' station, extra attention from relatives rarely seen or shorter and fewer contacts with the health care team, confirm his/her suspicions. The senior knows that he/she is dying but realizes that others around him do not know that he knows.

Mutual pretense occurs when family, patient and staff enter into a game. All realize that the patient knows he/she is dying and continue to pretend otherwise. The patient can plan his/her remaining life, but he/she cannot share this with anyone close. No one can be honest; no one benefits from the patient's awareness. Even the patient cannot do anticipatory grieving or legal and business planning very well.

b. **OPEN AWARENESS**

Open awareness exists when the patient and family are fully aware of the terminal condition and can talk about it, although the nearness of death may not be established. Now the senior can reminisce and conduct life review. He/she can give treasured possessions to the right person. He/she can be in control of his/her situation to a greater degree as he/she finishes important work and makes plans for and says farewells to the family. He/she learns how family members perceive their coming loss; his/her death. He/she can share his/her feelings of loss as he/she anticipates death. The anguish is not reduced, but it can be faced together.

The staff will also be more involved with the senior as he/she talks to them about his/her death. The staff may find it more difficult to care for the person who knows. Staff cannot hide behind clichés. They have to involve something of the self and see him/her as a person, not a thing. The senior or family may request extra privileges, which the rule-bound nurse finds difficult to fulfill. He/she may wish to die at home, and the family and staff may work together to set up care at home and secure the help of a home health agency. The senior who knows, may quietly but firmly, convey that he/she wishes to be granted privacy and dignity, both of which may be difficult to obtain.

4. **SEQUENCE OF REACTIONS TO APPROACHING DEATH**

Dr. E. Kubler-Ross describes a series of reactions that the person and family go through as death approaches.

These stages are:

- a. Denial
- b. Anger
- c. Bargaining
- d. Depression
- e. Acceptance

a. **Denial**

Denial and isolation are the initial and natural reactions when the senior becomes ill or learns of a terminal diagnosis: “It can’t be true; I don’t believe it”. Denial is more likely in the person who is told too quickly or abruptly by the doctor. Denial may be manifested by minimizing or refusing to acknowledge his/her illness or diagnosis or that the diagnosis may change his/her lifestyle.

The senior may make overly optimistic comments about his/her condition, refuse to follow doctor’s orders, seek other doctors’ opinions, try home remedies or delay hospital admission. He/she may even begin unrealistic plans or projects that will be finished in the far distant future. However, denial does not usually last when pain, fatigue or weakness interfere with activity. As the senior becomes aware of his/her condition, either because of the extent of his/her symptoms or because he/she is repeatedly told by others, he/she may use emotional isolation as a defense. He/she talks about his/her illness and even the possibility of death intellectually, without emotion, as if the topic referred to someone else. Isolation enables the person to carry on practical activities of life that are necessary in order to prepare for hospitalization, prolonged illness or eventual death.

b. Anger

Anger is the second reaction and it occurs with acknowledgement of the reality of the prognosis. As denial and isolation decrease, anger, envy and resentments toward the living are felt. In America, direct expressions of anger are unacceptable. Therefore, angry feelings are likely to be displaced onto the doctor, nurse, family or even the food. Angry demands are a way to avoid neglect and to feel a sense of control over an uncontrollable event. The person feels that he/she does not deserve to be sick, let alone die. He/she can be bitter and hard to manage as he/she thinks, “Why me?”.

c. Bargaining

Bargaining, the third reaction may be difficult to observe unless you care for the elderly person regularly. The person tries to enter some kind of agreement which may postpone death. He/she tries to be on his/her best behavior in order to be granted the special wish of longer life, preferable without pain. Bargaining may be life-promoting. The person is hopeful and he/she expresses faith in God and the future. The body’s physical defenses may be enhanced by mental or emotional processes yet unknown, and a bargaining attitude may account for the not-so-uncommon cases in which the person has a prolonged, unexpected remission from a disease process. The senior who has a negative self-concept or is alone and isolated, lacks a sense of hope and is not likely to bargain. He/she feels that he/she has nothing to bargain for.

During this stage, the senior vacillates between doubt and hope. Sources of doubt include new and unexpected symptoms. Any additional or unexpected stressor related to treatment, financial concerns or the temporary absence of the doctor or primary nurse. When the source of stress is relieved, so is the doubt. Hope arises when the senior hears the medical personnel say “We can help you”. Hope also arises when the senior is encouraged to be actively involved in his/her treatment, by working with doctors and nurses against the disease, by being treated at a leading medical center, and by overtly hopeful attitudes of the staff.

d. Depression

Depression, the fourth reaction to his/her condition, occurs when the person gets weaker, needs more treatment or pain medication and worries about realistic mounting medical costs and even obtaining necessities. Role reversal and related problems add to the depression. The senior feels shame about his/her condition and guilt about being a burden on others. He/she may feel that they are being punished for past misdeeds. He/she may think about past losses and his/her present condition and he/she worries about the future. He/she feels hopeless. He/she fears being alone, losing independence, being disfigured, having pain or losing his/her sanity. The mild depression that is frequently present in the senior is worsened when he/she anticipates death. The senior may lay with his/her face to the wall; answer slowly, if at all; speak with an expressionless voice; talk in short and muddled sentences; or stare out of the window (Rogers 1976). Preparatory depression differs from reactive depression. He/she now grieves for the impending losses he/she will endure. Not only will his/her loved ones lose him/her, but he/she is losing all significant relationships and things. He/she will not be able to do some things that he/she wanted to do.

The person begins to separate him/herself from the world. He/she reviews the meaning of his/her life, tries to share his/her insights with others and gradually withdraws from involvement in life around him/her. If others continue to convey that they expect him/her to want to live, he/she may feel misunderstood and more depression, turmoil and grief. This depression is difficult for family and staff. However, he/she needs to be allowed to emotionally prepare for death.

The quality of life that is being left behind is defined differently by each person, depending upon:

- 1) Present life situation
- 2) Amount of pain
- 3) Family relationships
- 4) Feelings of despair and dependency
- 5) Work abilities
- 6) Amount of body mechanics

- 7) Religious beliefs
- 8) Amount of body mutilation
- 9) Past ability to cope with stresses
- 10) Feelings of loneliness and isolation
- 11) Loss of freedom imposed by medical care system
- 12) Ability to carry on usual routines
- 12) Sense of mastery over oneself and one's life

e. Acceptance

Acceptance, the final reaction, comes when the person has time to prepare for death, when he/she is given help in working through previous reactions and when he/she remains alert enough to emotionally resolve his/her death. Now he/she is resigned to his/her fate. He/she is withdrawn, neither angry, depressed, envious nor resentful of the living. The person is emotionally and socially bankrupt. Nothing of obvious importance can be added to his/her life and nothing can be regained. Apathy rather than serenity or acceptance may be seen.

The senior cannot or will not further accommodate to the indignities of his/her diseases. He/she has lived his/her life and does not wish to relieve it. He/she says his/her goodbyes. Only the senior who continues to add to the spiritual dimensions of his/her life will be able to use this time for growth emotionally and spiritually and feel that he/she is adding something to him/herself as he/she is dying. He/she may feel an inner peace and self-possession. He/she lives with the certainty of a limited future. He/she plans his/her inheritance and assigns his/her treasures to others.

Unless he/she is unconscious, the senior who is dying continues to feel, think and respond to the present and limited future, to his/her illness and to those around him/her. He/she does not just lie passively and await death. He/she may strive to control and manipulate others; to prevent their leaving him/her or withdrawing their love. He/she may pretend to avoid feelings of loss and despair.

The person may not proceed to acceptance. He/she may refuse to admit he/she is dying. He/she may show anger, bitterness and self-pity. He/she may retaliate against others, demand, cling or berate him/herself.

The person who is dying often fluctuates between avoidance, denial, anxious hope, rejection, uneasy resignation and calm acceptance. The person tries to maintain ties with those closest to him/her while he/she wrestles with impending extinction.

As a health professional, you must examine personal attitudes and values about life and death. You must be committed to helping the terminally ill person live as comfortably and with as much meaning as possible until he/she dies. Some authors feel that the elderly and the chronically or

terminally ill are taking space, food, oxygen and money that could be used for technological advances to help those who are well or at least curable.

It would be easy to assume that we are helping the chronically or terminally ill and the dying person by ending their misery; putting them to sleep; with their consent, of course. Each of us must work vigorously to prevent such an ethic from taking hold.

Do so by clearly knowing inside yourself that every person is valuable, including the dying person. Suffering can be comforted, although a vegetative state need not be artificially prolonged. The patient can refuse treatment. Know clearly that unless you work to humanize care of the chronically or terminally ill person, you can predict what you will receive when you are in the situation yourself.

For selfish reasons, if not for altruistic reason, it is essential to assert your values, knowledge and skills on the side of those most vulnerable and least able to speak for themselves. A look into yourself, and increase awareness about your values, is the first step in the right direction.³

Yet, modern methods of resuscitation that are used when lives can be saved are out of place when disease or accident has nearly ended the senior's life. This is especially true if resuscitation renews his/her suffering and he/she is prepared for and desirous of death. The dying ought to be allowed to depart in peace, and after death, the body should not be immediately disturbed. Disturbance of the dead body may have no effect on the deceased, but it robs bereaved bystanders of their peace and consolidation.

³Opinions expressed in this course are those of the author. It is recognized that there are varying opinions surrounding the topics of treating the terminally ill patient.

CHAPTER VI

DRUG THERAPIES FOR THE ELDERLY CLIENT

DRUG THERAPY IN THE ELDERLY

PHYSIOLOGIC CHANGES AFFECTING DRUG ACTION

As a person ages, gradual changes occur in the human physiology. Age-related changes may alter therapeutic and toxic effects of drugs.

1. **BODY COMPOSITION**

Proportions of fat, lean tissue and water in the body change with age. Total body mass and lean body mass tend to decrease. The proportion of body fat tends to increase. Varying from person to person, these changes in body composition affect the relationship between a drug's concentration and solubility in the body. For example, a water-soluble drug, such as gentamicin, is not distributed to fat. Since there is relatively less lean tissue in an elderly person, more drug remains in the blood, and toxic levels can result. Likewise, pentobarbital, which is distributed to fat, may produce lower levels.

2. **GASTROINTESTINAL FUNCTION**

In the elderly, decreases in gastric acid secretion and gastrointestinal motility, slow the emptying of stomach contents and movement of intestinal contents through the entire tract. Furthermore, although inconclusive, research shows the elderly may have more difficulty absorbing medications. This is a particularly significant problem with drugs having a narrow therapeutic range, such as digoxin, in which any change in absorption can be crucial.

3. **HEPATIC FUNCTION**

The liver's ability to metabolize certain drugs decreases with age. This is probably due to diminished blood flow to the liver. This results from the age-related decrease in cardiac output. When an elderly patient takes certain sleep medications, such as secobarbital, his/her liver's reduced ability to metabolize the drug, may produce a hangover effect due to central nervous system depression. Elimination of these medications is highly dependent on the liver.

Decreased hepatic function may cause:

- a. More intense drug effects due to higher blood levels
- b. Longer-lasting drug effects due to:
Prolonged blood concentrations
- c. Greater incidence of drug toxicity

4. **RENAL FUNCTION**

Most elderly persons' renal function is usually sufficient to eliminate excess body fluid and waste. However, his/her ability to eliminate some medications may be reduced by 50% or more.

Many medications commonly used by the elderly, such as digoxin, are excreted primarily through the kidneys. If the kidney's ability to excrete the drug is decreased, high blood concentrations may result. Digoxin toxicity, therefore, is relatively common.

Drug dosages can be modified to compensate for age-related decreases in renal function. Aided by laboratory tests, such as BUN and serum creatinine, clinical pharmacists and doctors can adjust medication dosages to provide the expected therapeutic benefits without the risk of toxicity. Patients should be observed for signs of toxicity. A patient taking digoxin, for example, may experience anorexia, nausea and vomiting.

5. **ADVERSE DRUG REACTIONS**

As compared with younger people, the elderly reportedly experience twice as many adverse drug reactions. This fact might be due to greater drug consumption, poor compliance and physiologic changes.

Signs and symptoms of adverse drug reactions; confusion, weakness and lethargy; are often mistakenly attributed to senility or disease. If the adverse reaction isn't identified, the patient may continue to receive the drug. Furthermore, he/she may receive unnecessary additional medications to treat complications caused by the original medication. Although any medication can cause adverse reactions, most of the serious reactions in the elderly are caused by a relatively few medications: diuretics, digoxin, corticosteroids, sleep medications and nonprescription drugs. Patients who take these drugs should be carefully observed for toxicities.

a. Diuretic toxicity

Because total body water decreases with age, normal doses of potassium wasting diuretics, such as hydrochlorothiazide and furosemide, may result in fluid loss and even dehydration in the elderly patient. These diuretics may deplete serum potassium, causing weakness in the patient; and they may raise blood uric acid and glucose levels, complicating pre-existing gout and diabetes mellitus.

b. Digoxin toxicity

As the body's renal function and rate of excretion decline, digoxin concentrations in the blood may build to toxic levels, causing nausea, vomiting, diarrhea and most serious, cardiac arrhythmias. Severe toxicity may be prevented by observing the patient for early signs such as appetite loss, confusion or depression.

c. Corticosteroid toxicity

Elderly patients on corticosteroids may experience short-term effects including fluid retention and psychological manifestations ranging from mild euphoria to acute psychotic reactions. Long-term toxic effects, such as osteoporosis, can be especially severe in elderly patients who have been taking prednisone or related compounds for months or even years.

To prevent serious toxicity, especially observe for subtle changes in appearance, mood, mobility, as well as for signs of impaired healing and fluid and electrolyte disturbances.

d. Sleep medication toxicity

In some cases, sedatives or sleeping aids, such as flurazepam, cause excessive sedation or residual drowsiness.

e. Nonprescription drug toxicity

When aspirin and aspirin-containing analgesics are used in moderation, toxicity is minimal, but prolonged use may cause gastrointestinal irritation and gradual blood loss resulting in severe anemia. Although anemia from chronic aspirin consumption can affect all age groups, the elderly are most vulnerable to it because of their already reduced iron stores.

Laxatives may cause diarrhea in elderly patients who are extremely sensitive to drugs such as bisacodyl. Chronic oral use of mineral oil as a lubricating laxative may result in lipid pneumonia due to aspiration of small residual oil droplets in the patient's mouth.

f. Patient noncompliance

Approximately one third of the elderly fail to comply with their prescribed doses or to follow the correct schedule. They may take medications prescribed for previous disorders, discontinue medications prematurely or use PRN medications indiscriminately.

The medication regimen should be reviewed with him/her. The patient must clearly understand the dose and the time and frequency of doses. Also, he/she should know how to take each medication, that is, with food or water or by itself.

The patient should be given whatever help is necessary to avoid drug therapy problems, and referred to a physician or pharmacist if further information is needed.

REFERENCES

_____, *Aging and Behavior*, New York: Springer Publishing Co, Inc., 1973.

Beland, Irene, and Passos, Joyce, *Clinical Nursing: Pathophysiological and Psychosocial Approaches*, New York: MacMillan Publishing Company, Inc., 1975.

Botwinick, Jack, *Cognitive Processes in Maturity and Old Age*, New York: Springer Publishing Company, Inc., 1967.

Bowern Fay, *The Process of Planning Nursing Care: A Theoretical Model*, St. Louis: The C.V. Mosby Company, 1992.

Carney, Beatrice, Understanding Clinical Depression in the Elderly, Gerontology, Spring 1991, pp 6-7.

Cowley, M., "No Cure, Just Care", Amer Journal of Nursing, 74:No.11 (1974), 210-12.

Curtis, J., Rothbert, M., Christian, B., "A Practical Evaluation of Nursing Care as Part of the Nursing Process", Nursing Digest, 3:No.3 (1975), 20-21.

Goldman, R., "The Decline in Organ Function with Aging", in Clinical Geriatrics, ed., Isadore Rossman, Philadelphia: J.B. Lippincott Company, 1971.

_____, Health Assessment Handbook, Nursing 93 Books, Springhouse Corporation, Springhouse, PA., 1993.

Kubler-Ross, E., On Death and Dying, London: Collier-MacMillan, Ltd., 1969.

McCain, R.F., "Nursing by Assessment – Not Intuition", American Journal of Nursing, 65:No. 4 (1965), 82-84.

Murray, R.B., Huelskoetter, M.W., O'Driscoll, D.R., The Nursing Process in Later Maturity, Prentice-Hall, Inc., Englewood Cliffs, New jersey, 1980.

Murray, R., Zetner, J., Nursing Concepts for Health Promotion, 2nd ed., Englewood Cliffs, NJ, Prentice-Hall, Inc., 1979.

_____, "The Physiology of Aging", Scient Amer, 206: (1962), 100-110.

Pollak, Otto, Human Behavior and the Helping Professions, New York: Spectrum Publications, Inc., 1976.

Professional Guide to Drugs, Intermed Communications, Inc., Springhouse, PA, 1993.

Rogers, Carl, Client Centered Therapy, Boston: Houghton Mifflin Company, 1976.

Rotrock, L., Miller, L., Active and Alert: Learning Experiences for Older Adults, Jefferson City, MO, Missouri Office of Aging, 1976.

Stosky, B., The Elderly Patient, New York: Grune and Stratton, Inc., 1968.

Tom, Cheryl, "Nursing Assessment of Biological Rhythms", Nursing Clinics of North America, 11:No. 4, (1976), 621-30.

Wyzant, W., "Dying, But Not Alone", Amer J of Nursing, 67:No. 3, (1967), 547-77.

GERIATRIC NURSING PRINCIPLES TEST

Each question has only one correct answer. Log back onto our website to input your test answers. Always keep a copy of your answers for future reference.

1. The major reason for the lengthening life span today is:
 - a. Better nutrition
 - b. Better medical care
 - c. Better use of prevention measures
 - d. All of these
2. The medical and nursing professions have _____ to plan for and implement health care to meet the unique needs of the elderly.
 - a. Move quickly
 - b. Ignored the need
 - c. Not been quick
 - d. Passed the amendments necessary
3. How important are you, the nurse to your elderly patients?
 - a. Very
 - b. Somewhat
 - c. A little
 - d. Not at all
4. Later maturity refers to the last developmental stage of life, usually beginning after retirement at about the ages of ____ to ____.
 - a. 60-64
 - b. 75-80
 - c. 65-70
 - d. 80-85
5. "Aged" is: that point in the life span of a person when changes of aging...
 - a. Associated with declining function
 - b. Make dependency on others necessary
 - c. Markedly interfere with functioning
 - d. Make no difference in life span
6. No other developmental era (the elderly) is so rigidly_____.
 - a. Biased in attitude
 - b. Victorian
 - c. Set in their ways
 - d. Stereotyped
7. In order to perceive the senior as a unique person, you must consider:
 - a. Your personal definitions about aging
 - b. Your values about aging

- c. Your attitudes about aging
 - d. Your feelings about old age
 - e. All of these
- 8.** First level assessment is done on _____ with the elderly person to determine the perceived health threat.
- a. Initial contact
 - b. Second visit
 - c. Admission
 - d. Discharge
- 9.** A nursing history form or assessment tool is _____ information obtained in 1st and 2nd level assessment.
- a. Never used for
 - b. An organized means of recording
 - c. A comprehensive view of
 - d. All of these
- 10.** The nursing history should include the following information:
- a. Developmental status and level of behavior
 - b. Previous experience with illness
 - c. Educational level and intellectual capacity
 - d. All of these
- 11.** Adhering to a senior's established pattern promotes their wellness and their feeling of:
- a. Being cared for
 - b. Security
 - c. Well being
 - d. Uniqueness
- 12.** Obtaining a lengthy assessment or history is a necessary activity for:
- a. Making a nursing diagnosis
 - b. Individualizing care
 - c. Improving communication skills
 - d. Making realistic discharge plans
- 13.** When taking a nursing history, asking a barrage of questions will tend to _____ the senior's expression.
- a. Enhance
 - b. Minimize
 - c. Expand
 - d. Stifle
- 14.** The more skillful you are a communicator, the better your assessment data will be as the basis for:
- a. Nursing care plans
 - b. Continued care
 - c. Nursing diagnosis
 - d. Behavioral objectives

15. Nursing diagnoses _____ label medical entities.
- Do
 - Do not
 - Never
 - Always
16. Nursing diagnoses refer to conditions that can be helped by nursing _____.
- Action
 - Care
 - Assessment
 - Intervention
17. Nursing diagnoses that may be applicable to the psychological and physical status of the elderly, include:
- Impaired mobility
 - Anxiety, confusion
 - Negative self-image
 - Impaired sensory process
 - All of these
18. Statements about a predicted or desired patient outcome formulated with the person or family are called:
- Long-term goal
 - Short-term goal
 - Patient-care goal
 - Nursing diagnoses
19. Priorities of patient-care goals are affected by which of the following:
- Potential for recovery or susceptibility to relapse
 - Can be accomplished in a short period of time
 - Outcome can be predicted with certainty
 - The demise of the patient
20. The written nursing care plan include the:
- Patient's needs, problems
 - Priorities of care
 - Patient care goals
 - Nursing orders
 - All of these
21. The purpose of the nursing care plan includes;
- To communicate information about the person or family
 - To provide individualized and comprehensive care
 - To provide coordination and continuity of care
 - To facilitate ongoing and accurate evaluation of care
 - All of these
22. Nursing intervention refers to all of the actions that the nurse engages in, as well as the approach used to promote the patient's_____.

- a. Holism
 - b. Well being
 - c. Death
 - d. Marriage
- 23.** Nursing interventions with the elderly person or family include:
- a. Encouraging the senior to use energy-saving devices
 - b. Maintaining communication with the senior
 - c. Giving wellness care
 - d. Not enabling the senior to give his or her own hygiene
 - e. a and b
 - f. c and d
- 24.** the elderly person may have many needs which need to be met, such as:
- a. Physical needs
 - b. Social needs
 - c. Emotional needs
 - d. a, b
 - e. a,b,c
- 25.** Bower classifies intervention into three actions: supportive, generative and_____.
- a. Helping
 - b. Collaborative
 - c. Protective
 - d. Encouraging
- 26.** Supportive nursing actions provide:
- a. Comfort
 - b. Restoration
 - c. Treatment
 - d. a and b
 - e. a,b,c
- 27.** Evaluation of nursing care is directly related to:
- a. Results
 - b. Effect
 - c. Accountability
 - d. Outcome
- 28.** When approaching an elderly patient for an interview, when usually is the optional time to talk to him/her?
- a. After lunch
 - b. Late in the day
 - c. After exercise
 - d. Early in the day
- 29.** _____is the key to communicating with the elderly.
- a. Patronizing behavior
 - b. Patience

- c. Attitude
 - d. Understanding
- 30.** A geriatric patient's past history is likely to be _____.
- a. Minimal
 - b. Extensive
 - c. Larger than life
 - d. Voluminous
- 31.** During review of the female reproductive system, include questions about:
- a. Thyroid replacement therapy
 - b. Menopause
 - c. Testosterone therapy
- 32.** The most common psychogenic problems found in elderly patients is:
- a. Anxiety
 - b. Depression
 - c. Paranoia
 - d. Confusion
- 33.** In the elderly, osteoporosis most commonly occurs after age _____.
- a. 60
 - b. 75
 - c. 80
 - d. 50
- 34.** Characteristics of being a helping person include:
- a. Secure
 - b. Positive
 - c. Strong
 - d. All of these
- 35.** The elderly person cannot survive, emotionally or physically, unless someone:
- a. Cares
 - b. Reaches out
 - c. Loves
 - d. Neglects