C475 Care of Older Adult study Guide

Organizational Behavior and Leadership (Western Governors University)

Chapter 1, 2 & 3

Gerontology is the broad term used to define the study of aging and/or the aged.

Geriatrics is often used as a generic term relating to older adults, but specifically refers to the medical care of older adults. Geriatricians are physicians trained in geriatric medicine.

- "old" is often defined as over 65 years of age
- young old (ages 65–74
- middle old (ages 75–84), and the old old
- frail elders (ages 85 and up)

Genomics is the identification of gene sequences in the DNA

Genetics is the study of heredity and the transmission of certain genes through generations

Sociological Theories- Changing roles, relationships, status, and generational cohort impact the older adult's ability to adapt.

- **Activity** - Remaining occupied and involved is necessary to a satisfying late life. Society expects retirees to remain active in their communities.
- **Disengagement** -Gradual withdrawal from society and relationships serves to maintain social equilibrium and promote internal reflection.
- **Subculture** -The elderly prefer to segregate from society in an aging subculture sharing loss of status and societal negativity regarding the aged. Health and mobility are key determinants of social status.
- **Continuity** -Personality influences roles and life satisfaction and remains consistent throughout life. Past coping patterns recur as older adults adjust to physical, financial, and social decline and contemplate death. Identifying with one's age group, finding a residence compatible with one's limitations, and learning new roles postretirement are major tasks.
- **Age stratification** -Society is stratified by age groups that are the basis for acquiring resources, roles, status, and deference from others. Age cohorts are influenced by their historical context and share similar experiences, beliefs, attitudes, and expectations of life-course transitions.
- **Person-Environment-Fit** -Function is affected by ego strength, mobility, health, cognition, sensory perception, and the environment. Competency changes one's ability to adapt to environmental demands.
- **Gerotranscendence** -The elderly transform from a materialistic/rational perspective toward oneness with the universe. Successful transformation includes an outward focus, accepting impending death, substantive relationships, intergenerational connectedness, and unity with the universe.

Psychological Theories -Explain aging in terms of mental processes, emotions, attitudes, motivation, and personality development that is characterized by life stage transitions.

- **Human needs** -Five basic needs motivate human behavior in a lifelong process toward need fulfillment.
- **Individualism** -Personality consists of an ego and personal and collective unconsciousness that views life from a personal or external perspective. Older adults search for life meaning and adapt to functional and social losses.
- **Stages of personality** -Personality develops in eight sequential stages with corresponding life development tasks. The eighth phase, integrity versus despair, is characterized by evaluating life accomplishments; struggles include letting go, accepting care, detachment, and physical and mental decline.
- **Life-course/life span** -Life stages are predictable and structured by roles, relationships, values, development, and goals. Persons adapt to changing roles and relationships. Age-group norms and characteristics are an important part of the life course.
- **Selective optimization** - Individuals cope with aging losses through activity/role selection, optimization, and compensation. Critical life points are morbidity, mortality, and quality of life. Selective optimization with compensation facilitates successful aging.

Stochastic Theories - Based on random events that cause cellular damage that accumulates as the organism ages.

- **Free radical theory** - Membranes, nucleic acids, and proteins are damaged by free radicals, which causes cellular injury and aging.
    - Exogenous Sources of Free Radicals (Tobacco smoke, Pesticides, Organic solvents, radiation, ozone and selected medications)
- **Orgel/error theory**- Errors in DNA and RNA synthesis occur with aging. Cells accumulate errors in their DNA and RNA protein synthesis that cause the cells to die
- **Wear and tear theory**- Cells wear out and cannot function with aging.
- **Connective tissue/cross-link theory**- With aging, proteins impede metabolic processes and cause trouble with getting nutrients to cells and removing cellular waste products.

Nonstochastic Theories - Based on genetically programmed events that cause cellular damage that accelerates aging of the organism.

- **Programmed theory**-Cells divide until they are no longer able to, and this triggers apoptosis or cell death.
- **Gene/biological clock theory**- Cells have a genetically programmed aging code.
- **Neuroendocrine theory** - Problems with the hypothalamus-pituitary-endocrine gland feedback system cause disease; increased insulin growth factor accelerates aging.
- **Immunological theory**- Aging is due to faulty immunological function, which is linked to general well-being.

Nursing Theories of Aging

- **Functional consequences theory-** Environmental and biopsychosocial consequences impact functioning. Nursing's role is risk reduction to minimize age-associated disability in order to enhance safety and quality of living.
- **Theory of thriving**- Failure to thrive results from a discord between the individual and his or her environment or relationships. Nurses identify and modify factors that contribute to disharmony among these elements.

Chapter 4- Review of Aging of Physiological Systems

Summarization of Cardiovascular Structural and Functional Changes That Occur with Age

Structural -Decreased myocardial cells, decreased aortic distensibility, decreased vascular tone

- Increased heart weight, increased myocardial cell size, increased left ventricle wall thickness, increased artery stiffness, increased elastin levels, increased collagen levels, increased left atrium size

Functional -Decreased diastolic pressure (during initial filling), decreased diastolic filling, decreased reaction to beta-adrenergic stimulus

- Increased systolic pressure, increased arterial pressure, increased wave velocity, increased left ventricular end-diastolic pressure, elongation of muscle contraction phase, elongation of muscle relaxation phase, elongation of ventricle relaxation

No change -Ejection fraction, stroke volume, overall systolic function

Aging of the Respiratory System

Three main physiological changes occur: These three factors contribute to the functional decline of the respiratory system.

- decline in chest wall ability
- decline in elastic recoil of the lung
- decline in respiratory muscle strength.

Aging in Key Components of the Gastrointestinal Tract

The two GI areas most affected by age are the upper tract (the pharynx and esophagus) and the colon, also referred to as the large intestine

- **The Mouth**
  - **Dental decay and tooth loss** affect many older individuals today, making it more difficult to chew and prepare food to be swallowed
  - **Dry mouth** can be attributed to prescription and over-the-counter medications, nutritional deficiencies, disease, and treatment therapies such as chemotherapy
  - **atrophy of those muscles and bones of the jaw and mouth** that control mastication. Consequently, it is more difficult for older adults to chew their food
- **The Esophagus**
  - **stiffening of the esophageal wall and less sensitivity** to discomfort and pain in the esophagus. These changes affect the older patient's ability to swallow.
  - The gag reflex also appears to be absent in around 40% of healthy older adults
- **The Stomach**
  - declines in peristaltic contractions and stomach emptying **do not appear to be clinically significant**
- **The Small Intestine**
  - **no change** or only minor changes in contraction intensity with age
  - prolonged gastric emptying is a decrease in gastric acid secretion
- **The Large Intestine**
  - Aging women experience a greater risk of anal sphincter changes due to laxity of the pelvic floor, decreased pressure in the rectum, and even menopause
  - experience longer colonic transit time (the amount of time needed for fluid and excrement to travel the length of the colon).
  - Increased colonic transit time also correlates with increased fibrosis in the colon

Resistance Training and Aging Muscle

- **Resistance exercise**, exercise aimed at increasing the force generated by muscle, has been shown to have the most beneficial effects
- **Resistance training** has also been shown to improve muscle quality

Age-Related Disease and Injury of the Bone

- **Osteoporosis-** reductions in bone quantity and strength. Generally very porous, containing numerous holes or empty pockets. They are thin and fragile and, consequently, extremely prone to fracture
- **Bone Fracture-** Fractures in elderly persons often occur as the result of only minimal or moderate trauma, whereas in younger persons considerable force is required to fracture a bone.
  - most common site of fracture is the bone shaft, whereas in older persons fractures generally occur next to a joint

Aging of the Joints

- **Immovable Joints**
  - With increasing age the collagen between the bones of immovable joints becomes coated with bone matrix. As a result, the space between bones gets even narrower and the bones may eventually fuse together completely. Consequently, the joints become stronger; therefore, with age immovable joints actually improve.
- **Cartilaginous Joints**

- The aging process is associated with a stiffening of the cartilage comprising cartilaginous joints. Ligaments also become stiffer and less elastic. The result of these changes is a reduction in the amount of movement allowed by the cartilaginous joints.

- **Synovial Joints**
  - The functional ability of synovial joints begins to decline around 20 years of age. As a person ages, both the joint capsule and the ligaments become shorter, stiffer, and less able to stretch. In addition, the cartilage lining the bones becomes calcified, thinner, and less resilient. Consequently, it becomes more difficult to move, and range of motion and efficiency of the joint are reduced

The Sensory System

Age-related changes to touch, smell, taste, vision, and hearing lead older individuals to interact with the environment differently than they did at a younger age.

- **Touch**
  - The ability to touch and distinguish texture and sensation tends to decline with age due to a decrease in the number and alteration in the structural integrity of touch receptors, or Meissner's corpuscles, and pressure receptors, or Pacinian corpuscles
- **Age-Related Olfactory Changes**
  - Olfaction, or the sense of smell, appears to be reduced with age, as demonstrated by threshold studies of stimulus strength. A decrease in smell is also referred to as hyposmia
- **Age-Related Gustation Changes**
  - Aging causes a decrease in taste, also known as hypogeusia, usually more noticeable around the age of 60 and with more severe declines occurring after the age of 70
- **Anatomy and Age-Related Changes in Eye Structure**
  - Many older adults experience dry eyes and/or a feeling of irritation, as if an object is in the eye. This condition is known as dry eye syndrome
- **Age-Related Changes in Visual Function**
  - One of the most common visual concerns in aging that occurs over time but becomes most notable around 40 years of age and older, is presbyopia, or the inability to focus on nearby objects, such as newsprint. This inability is also known as farsightedness

The Aging Skin-

- **Chronological aging** refers to those changes considered to be caused only to the passage of time
  - Chronologically aged skin is characterized by thinness and a reduction in elasticity. The wrinkles caused by chronological aging are usually very fine and thus the skin appears relatively smooth.
  - Chronological aging primarily affects skin's function rather than its appearance.
- **Extrinsic aging** is the result of chronic exposure of the skin to external factors such as smoking, poor nutrition, and especially UV light, which induces photoaging
  - In contrast, photoaged skin is characterized by deep wrinkles, sagging, and a leathery appearance.

Clinical Tip- The integumentary system (including skin, hair, nails) often shows the most visible signs of aging.

Clinical Tip- Due to the changes in the skin's ability to conserve heat, older persons may have a lower baseline body temperature. This should always be noted on admission, as a later temperature reading of 99.9 degrees Fahrenheit may actually be a fever and a warning sign of infection in a person with a lower baseline temperature.

Immunosenescence refers to the aging of the immune system. To date, the aging process is thought to involve primarily innate immunity and the T cells of acquired immunity. B cells are less highly affected by immunosenescence; however, the majority of investigations have been performed only in animal models

- **Innate Immunity**

- Clinical evidence suggests a dysfunction in the innate immune system. With aging, elevated levels of proinflammatory cytokines released from fibroblasts and macrophages are believed to be linked to age-associated diseases such as diabetes, osteoporosis, and atherosclerosis that appear to have an inflammatory pathway involved

- **Thymus Involution**
  - The most prominent morphological change characterizing immunosenescence is the involution, or atrophy, of the thymus
  - The thymus begins to atrophy around puberty and continues as an individual ages.

- **Naïve-to-Memory T-Cell Ratio**
  - At any given time, both naïve and memory T cells are present in the body. Naïve T cells are those that have not yet been exposed to an antigen; these are the cells that respond to any new antigen that might attack the body.
- **Replicative Senescence**
  - The greater the number of B or T cells available to fight off infection and disease, the more likely it is that the immune response will be effective. Thus, the replication or proliferation of immune cells subsequent to stimulation by an antigen is crucial to efficient immune function.
  - **Replicative senescence** is the result not of the passage of time per se, but of repeated cell division
- **Cell Signaling**
  - Effective cell-mediated immunity requires that when a T cell binds to its antigen, the presence of that antigen must be communicated or signaled to the interior of the cell.
- **Autoimmunity**
  - Despite the age-related decrease in immune response to foreign antigens, there is an increase in autoimmunity. There is an overall increase in the percentage of T cell– and B cell–generated antibodies that are directed against many of the body's own cells.

Clinical Implications of Immunosenescence

- **Vaccinations**
  - Due to changes characterizing immunosenescence, older individuals are more susceptible to infection and disease than are younger individuals. One method of strengthening the immune defenses is to administer vaccines such as those against influenza and pneumonia. By introducing the body to a foreign antigen, vaccines stimulate the production of antibody-producing B cells as well as memory T cells against the antigen. However, older individuals' antibody response to vaccines is slower and weaker than that seen in younger individuals
- **Infection and Disease**
  - Immunosenescence is associated with increased incidence of infectious diseases such as bronchitis and influenza. It is also implicated in the increased incidence of tumors and cancer that occurs with age. In addition, immunosenescence has been associated with a number of age-related autoimmune diseases and inflammatory reactions, including diabetes, arthritis, osteoporosis, cardiovascular disease, and dementia. Inarguably, the aging of the immune system has widespread implications for disease incidence and overall health within the elderly population.

Chapter 5- Teaching and Communication with Older Adults and their families

Normal and abnormal aging barriers might be:

- Internal (e.g., cognition and physical deficits)
- External (e.g., speaking too softly, noisy room, elderspeak)
- Language (e.g., misunderstanding of terms, the use of a word in a different generational context, idiom, and slang)

The Effect of Cognitive Issues on Communication

- reduce the individual's frustration when communicating by minimizing the demands on memory and providing enjoyable communicative opportunities
- use of pictures, objects, or music from the older adult's past, which allows individuals to practice communication without having to rely on memory.
- reduce their frustration during communication by minimizing the demands on memory and focusing on enjoyable communication opportunities that do not rely on memory.

Speech and motor impairments caused by neurological changes in the body

- **apraxia** is a speech impairment with an inability of the individual to send the correct messages to the mouth muscles for making motor planning
- **Dysarthria** refers to muscle weakness difficulties of the mouth affecting speech movements.
- **Aphasia-** Damage to the cortex. Cant read, write and say. EX: stroke, tumors, dementia, ALS
    - **Broca's Aphasia**- comprehension remains intact, but spoken communications is not fluid. Speech is low, effortless, choppy and often lacks proper grammatical markers.
    - **Global Aphasia**- greater damage to left hemisphere thank found in broca's aphasia. Effects on communication more devastated causing the person to have very limited spoken language and individuals may use only single words that are not always understood.
    - **Wernicke's aphasia**- which is caused by damage to the Wernicke's area of the brain. People with this aphasia have fluent speech with unintelligible content. Individuals will use real or nonsense words, but the string of words has no clear meaning

Strategies for Communication with Persons with Dementia That Support Personhood

- **Recognition** -Acknowledge the person, know the person's name, affirm uniqueness. "Come along Mrs. Jones, your dinner is being served."
- **Negotiation** -Consult the person regarding preferences, desires, needs. "That was a nice bit of fresh air. I'm ready for my dinner now; would you like to join me?"
- **Validation** -Acknowledge the person's emotions and feelings and respond. "Mrs. Johnson, it sounds like you would like to wait for your bath."
- **Facilitation and collaboration** -Work together, involve the person. Enable the person to do what he or she otherwise would not be able to do by providing the missing parts of the action. "What is it you are looking for Mrs. Smith? Can I help? Tell me what it is and we can look for it together."

Normal and Abnormal Changes in Vision

- cornea becomes less sensitive and the pupils decrease to about one third of the size during young adulthood
- lenses become less flexible, slightly yellowed, and cloudy
- Visual acuity also decreases with age
- **Presbyopia (aging eye**) occurs and causes difficulty seeing at close range, such as in reading.
    - common for older adults to experience an increase in sensitivity to **light and glare**

Care Partner Strategies for Vision Barriers

- Contrasting warm and cool colors should be used when creating visuals such as calendars, instructions, and signs with a contrasting dark print for reading messages.
- need larger print papers, books, or tablet screen print and icons.
- may need auditory visual support, as seen in movies and books for the visually impaired, or talking computers.
- Correct lighting for the task is important.

- Reading lamps are useful and special magnifying devices can be used to see something that has fine detail or smaller print.

Normal Aging Changes in Hearing

- inability to hear higher frequencies.
- **Presbycusis**- Permanent where higher frequency hair cells deteriorate and lose their function. They cannot be repaired nor do new hair cells grow back.
    - remains the most common sensory deficit in the older population

Care Partner Interventions for Hearing Impairments

- hearing aids to amplify the speech frequencies when considering interventions
- personal amplification devices that can aid in hearing and are less expensive
- reduce background noise

Physical Limitations- Physical abilities can decrease dramatically in a short period of time. The age when such physical limitations are noticed may be different for everyone.

Nonverbal communication is more powerful than verbal messages.

Partnering communication- ***Person-centered communication*** is an integral part of person-centered care and reflects a focus on the patients and their unique perceptions and experiences with health and illness.

Partnering Communication Model - **5Ps** method provides a unique example of person-centered care that builds trust and respect in any setting, but has been built for in-patient care settings originally.

- You did **partnering** already
- Ask about the restroom needs—**potty**
- Obtain a **pain** assessment
- Make **positioning** adjustments.
- Check the **pump(s)** to reduce potential noise distractions.

patient-centered communication as a key characteristic of quality health care.

Strategies for Effective Communication with Persons with Vision, Hearing, Cognitive, and/or Speech–Language Impairments

- **Vision**
    - Use person-first language
    - Include the patient
    - Provide written information in large, easy to read print
    - Position yourself in the person's direct line of vision
    - Make sure glasses or contacts are worn
    - Use relational connections and partner with the patient

- **Hearing**
    - Use person-first language
    - Use slower speaking rate and pause between phrases
    - Include the patient and ask if you are speaking loud enough
    - Provide additional time for the person to respond
    - Summarize
    - Speak into the ear with less hearing loss
    - Write out information

- Eliminate or minimize background noise
- Limit the number of speakers in the room
- Position yourself in the person's direct line of vision
- Make sure the hearing aid(s) or assistive listening device is on and working
- Say the person's name
- Use touch to gain attention
- Use relational connections and partner with the patient

- **Cognition**
  - Use person-first language
  - Use slower speaking rate and pause between phrases
  - Include the patient
  - Provide additional time for the person to respond
  - Simplify vocabulary and avoid jargon
  - Summarize
  - Write out information
  - Eliminate or minimize background noise
  - Limit the number of speakers in the room
  - Say the person's name
  - Encourage use of clues for word-finding difficulty
  - Use touch to communicate or to gain attention
  - Request clarification
  - Use relational connections and be calm and nonreactive, partner with the patient
- **Speech and language**
  - Use person-first language
  - Use slower speaking rate and pause between phrases
  - Include the patient
  - Provide additional time for the person to respond
  - Simplify vocabulary and avoid jargon
  - Summarize
  - Write out information
  - Eliminate or minimize background noise
  - Limit the number of speakers in the room
  - Position yourself in the person's direct line of vision
  - Make sure the assistive devices are on and working
  - Say the person's name
  - Encourage use of clues for word-finding
  - Request clarification
  - Use relational connections and partner with the patient

Teaching Older Adults Using Technology

Strategies for older adults to promote higher levels of success with technology, as follows:

- Develop a structured and simple interface process
- Maintain feedback processes offering ways to make adjustments
- Be ready to assist the user in how he or she thinks through an issue and give guidance for decision making
- Integrate learning principles allowing for diverse ways of gaining information

Chapter 6- Comprehensive Assessment of the Older Adult

Activities of Daily Living- (The Katz Index of ADL)- distinguished between independence and dependence in activities and created an ordered relationship among ADLs. It addressed the need for assistance in bathing, eating, dressing, transfer, toileting, and continence.

Instrumental Activities of Daily Living

- IADLs include a range of activities that are considered to be more complex compared with ADLs and address the older adult's ability to interact with his or her environment and community.
- Using the telephone, Taking medications, shopping, handing finances, preparing meals, laundry, light or heavy housekeeping, yard work, home maintence, using transportation

Clinical Tip- The Timed Up and Go Test (TUG) is a reliable measure of overall physical function and mobility for older adults.

- The Up and Go Test provides a quick assessment of an older persons mobility and overall function. The nurse should measure a distance of 10 feet from the persons chair and ask the patient to rise, walk to the line, turn, walk back, and sit down. An average time to do this is 10 seconds; greater than 10 seconds may indicate functional problems with ambulation

Cognitive Assessment

Mini Mental State Examination (MMSE)- developed to differentiate organic from functional disorders and to measure change in cognitive impairment, but it was not intended to be used as a diagnostic tool.

- It measures orientation, registration, attention and calculation, short-term recall, language, and visuospatial function.

Mini-Cog- can be administered in 5 minutes or less and requires minimal training

- This tool can be used to detect dementia quickly and easily in various settings, either during routine visits or hospitalization. Clinicians may use the tool to assess a person's registration, recall, and executive function.
- consists of a three-item recall and a clock-drawing test (CDT).
- This reliable tool can assist nurses with early assessment of cognitive problems.
- used to assess language comprehension, visual—motor skills and executive function while the three-item component assess recall.

Confusion Assessment Method (CAM)

- The Confusion Assessment Method diagnostic algorithm enables nurses to assess for delirium by identifying the four features of the disorder that distinguish it from other forms of cognitive impairment.

Psychological Assessment

- **Depression**
  - Clinical depression is the most common mental health problem among older adults, and it often goes undetected because clinicians attribute depressive symptoms to age-associated changes, chronic physical illness, medication side effects, or pain.
  - To meet the DSM-V criteria, older adult must experience 5 or more of following symptoms: sadness, lack of enjoyment of previously enjoyed activities, significant weight loss, sleep disturbances, restlessness, fatigue, feelings of worthlessness, impaired ability to think clearly or concentrate, suicidal ideation.

Clinical Tip- The suicide rate is highest among older white males, as depression is often undetected and underreported.

An Overall Assessment Tool for Older Adults: Fulmer SPICES

- The SPICES assessment tool is an efficient and effective instrument for obtaining the information necessary to prevent health alterations in the older adult patient. SPICES is an acronym for the common syndromes of the elderly requiring nursing intervention, including sleep disorders, problems with eating or feeding, incontinence, confusion, evidence of falls, and skin breakdown.

The Modified Caregiver Strain Index (MCSI)

- The Modified Caregiver Strain Index (MCSI) is a tool that can be used to quickly screen for caregiver strain with long-term family caregivers. It is a 13-question tool that measures strain related to care provision.

Assessing Family Preferences for Participation in Care in Hospitalized Older Adults (FPRI)

- The Family Preference Index (FPRI) is a brief, easy to administer instrument to measure family preferences or family caregivers' personal choice about providing care to their hospitalized relatives. Assessment of family preference should be supplemented with an evaluation of other factors that impact caregiving ability, including the family's legal authority (including power of attorney status), the family's understanding of the patient's needs, and the members' stress level.

Assessing Pain in Older Adults

- The most widely used pain intensity scales used with older adults are **the Numeric Rating Scale (NRS), the Verbal Descriptor Scale (VDS), and the Faces Pain Scale-Revised (FPS-R).** The most popular tool, the NRS, asks a patient to rate their pain by assigning a numerical value with zero indicating no pain and 10 representing the worst pain imaginable. The VDS asks the patient to describe their pain from "no pain" to "pain as bad as it could be." The FPS-R asks patients to describe their pain according to a facial expression that corresponds with their pain.

Health-Related Quality of Life)HRQOL)

- Well-being integrates mental health (mind) and physical health (body), resulting in more holistic approaches to disease prevention and health promotion. Well-being is a valid population outcome measure beyond morbidity, mortality, and economic status that tells us how people perceive their life is going from their own perspective.

Chapter 7- Promoting Healthy Aging, Independence, and Quality of Life

Exercise and **nutrition** are probably the two most widely publicized components of health promotion

Medicare Prevention- 2010 Affordable Care Act

- An initial physical examination that includes prevention counseling.
- Annual wellness visits.
- Smoking cessation—no longer limited to those who have an illness caused by or complicated by tobacco use.
- Comprehensive health programs that include complementary and alternative practices, developed by Dean Ornish and Herbert Benson for cardiac rehabilitation.
- Screening and intensive behavioral therapy for obesity.
- Depression screening in a primary care setting that can provide follow-up and referral;
- Alcohol misuse counseling sessions, up to 4 per year, in a primary care setting with a qualified provider.
- Elimination of all deductibles and copayments for prevention services to enhance access.

Exercise- Walking is one of the most beneficial exercises for older adults in preventing cardiovascular disease and decreasing mortality risk.

Clinical Tip- Tai chi is considered one of the best activities to promote balance in older adults.

Nutrition

- **nutrition bull's-eye** was developed by Covert Bailey (1996), and its goal is for people to consume the nutritious foods that are listed in the center of the bull's-eye.
    - These foods are low in saturated fat, sugar, and sodium, and high in fiber. They include skim milk, nonfat yogurt, most fruits and vegetables, whole grains, beans and legumes, and water-packed tuna.
    - As you move to the foods listed in the rings farther away from the bull's-eye, you eat more saturated fat, sugar, sodium, and low-fiber foods. In the outer ring of the bull's-eye, therefore, are most cheeses, ice cream, butter, whole milk, beef, cake, cookies, potato chips, and mayonnaise.

Quality of Life and Wellness

The most common conceptualization of wellness divides this term into seven components. These dimensions are:

- **Physical**: Exercise, eat a well-balanced diet, get enough sleep, protect yourself
- **Emotional**: Express a wide range of feelings, acknowledge stress, channel positive energy
- **Intellectual:** Embrace lifelong learning, discover new skills and interests
- **Vocational:** Do something you love, balance responsibilities with satisfying ways to occupy yourself
- **Social:** Laugh often, spend time with family and friends, join a club, respect cultural differences
- **Environmental:** Recycle daily, use energy-efficient products, walk or bike, grow a garden
- **Spiritual**: Seek meaning and purpose, take time to reflect, connect with the universe.

Chapter 8- Identifying and Preventing Common Risks Factors in the Elderly

U.S. Preventive Services Task Force (USPSTF): The USPSTF was convened by the U.S. Public Health Service to systematically review the evidence of effectiveness of clinical preventive services. The task force is an independent panel of private-sector experts in primary care and prevention whose mission is to evaluate the benefits of individual services and create age-, gender-, and risk-based recommendations about services that should routinely be incorporated into primary medical care.

Healthy People 2020: Healthy People 2020 is an initiative of a federal interagency workgroup with input from many governmental and private agencies. It is a set of healthcare objectives designed to improve the health of individuals and communities, eliminate health disparities, and improve access to care.

Health promotion activities are activities in which an individual is able to proactively engage in to advance or improve his or her health.

Primary prevention activities are those designed to completely prevent a disease from occurring, such as immunization against pneumonia or influenza.

- Pneumonia- All adults 65 years of age or older should receive a dose of PCV13 followed by a dose of PPSV23 at least 1 year later.
- Herpes zoster vaccine once after age 60, even if the older adult has had a prior episode of herpes zoster.
- Tetanus vaccination—Td or Tdap—every 10 years Tdap recommended for older adults who have contact with infants younger than 12 months of age.

Secondary prevention efforts are directed toward early detection and management of disease, such as the use of colonoscopy to detect small, cancerous polyps. **Health Screening**

Tertiary prevention efforts are used to manage clinical diseases to prevent them from progressing or to avoid complications of disease, as is done when beta-blockers are used to help remodel the heart in congestive heart failure.

The Focus of Health Promotion Efforts

A major focus of health promotion efforts for the older adult is to minimize the loss of independence associated with illness and functional decline. Healthy People 2020 and the USPSTF suggest the following focus areas for nurses to promote health and prevent disability in the elderly client:

- Physical activity
- Nutrition
- Tobacco use
- Health screening
- Injury prevention
- Preventive medications and immunizations
- Caregiver support

General dietary guidelines for older adults include (U.S. Department of Agriculture, 2010):

- Limit alcohol to one drink per day for women, two daily for men.
- Limit fat and cholesterol.
- Maintain a balanced caloric intake.
- Ensure adequate daily calcium, especially for women.
- Older adults should consume foods fortified with vitamins, such as fortified cereals or supplements.
- Older adults who have minimal exposure to sunlight or who have dark skin need supplemental vitamin D. Daily vitamin D intake should be 800 to 1000 IU and can be derived from fortified foods or supplements (Dawson-Hughes et al., 2010).
- Include adequate whole grains, fruits, and vegetables.
- Drink adequate water.

Tobacco Use

The 5 As:

- Ask about smoking status at each healthcare visit.
- Advise client to quit smoking.
- Assess client's willingness to quit smoking at this time.
- Assist client to quit using counseling and pharmacotherapy.
- Arrange for follow-up within 1 week of scheduled quit date.

Tobacco Cessation Counseling- Level A recommendation: The USPSTF found good evidence that screening, brief behavioral counseling, and pharmacotherapy are effective in helping clients quit smoking and remain smoke-free after 1 year. There are good data to support that smoking cessation lowers the risk for heart disease, stroke, and lung disease.

Safety

- **Falls** are the leading cause of unintentional injury death in older adults in this country.

Fall Prevention Counseling

- **Level C recommendation:** The USPSTF does not recommend comprehensive risk assessment and management of these risks to prevent falls in all community-dwelling adults aged 65 years or older because the likelihood of benefit is small. This assessment and fall-risk plan should be provided for those with a history of falls, comorbid illnesses that place the patient at risk for falls, poor performance on the Get Up and Go test, and use of ambulatory devices.

- **Level B recommendation:** The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.

Chapter 11- Polypharmacy

Polypharmacy and Medication Errors

Polypharmacy- is the concurrent use of several different medications consumed by a person.

- Four shared characteristics are associated with an increased risk of living with geriatric syndromes: older age, baseline cognitive impairment, baseline functional impairment, and impaired mobility.
- **Frailty** alters **pharmacokinetics** (how drugs are absorbed, metabolized, and eliminated), **pharmacodynamics** (how drugs work in the body), and a person's ability to manage medications

Brown Bag Assessment- which means that patients bring in all of the medications they are currently taking, including OTCs, supplements, and herbals, to their clinic visits or hospitalizations for assessment.

The Beers Criteria's- purpose is to identify drugs to avoid in older adults independent of diagnosis and considering diagnosis, to reduce ADRs, and improve medication selection and use in older adults.

- designed for any clinical setting and to be used as an educational, quality, and research tool

The Screening Tool of Older Persons' Prescriptions (STOPP)- Screening Tool of Older People's potentially inappropriate Prescriptions

the Screening Tool to Alert to Right Treatment (START)- Screening Tool to Alert doctors to the Right Treatment

Alcohol Abuse

Several screening tools are commonly used to screen for alcohol abuse. The CAGE questionnaire is a self-report screening instrument that is easy and quick to administer (Ewing, 1984). It asks four yes/no questions and requires approximately 1 minute to complete. **CAGE** is a mnemonic for the following four key screening questions:

- **Cut down:** Refers to attempts by the client to cut down on drinking
- **Annoyance:** Related to suggestions by friends or family to cut down on drinking
- **Guilt:** Relates to client guilt about drinking
- **Eye opener:** Relates to the need for a drink in the morning to get going

Clinical Tip- The CAGE questionnaire is a quick, reliable screening tool for alcohol abuse.

Elder abuse may include physical, sexual, psychological, and financial exploitation; neglect; and violation of rights.

Physical abuse includes shaking, restraining, hitting, or threatening with objects.

Sexual abuse includes unwanted contact with the genitals, anus, or mouth. Clients who are psychologically abused experience threats, insults, or harassment or are recipients of harsh commands.

Assessment of abuse can be very difficult because the victim may be cognitively impaired and unable to describe the abuse. It is not unusual for elderly clients to have multiple bruises due to poor balance and loss of subcutaneous fat. Clues to abuse may include the following:

- The presence of several injuries in different stages of repair
- Delays in seeking treatment
- Injuries that cannot be explained or that are inconsistent with the client's history
- Contradictory explanations by the caregiver and the patient
- Bruises, burns, welts, lacerations, or restraint marks
- Dehydration, malnutrition, decubitus ulcers, or poor hygiene

- Depression, withdrawal, or agitation
- Signs of medication misuse
- A pattern of missed or canceled appointments
- Frequent changes in healthcare providers
- Discharge, bleeding, or pain in the rectum or vagina or a sexually transmitted infection (STI)
- Missing prosthetic device(s), such as dentures, glasses, or hearing aids

Chapter 17- Dysphagia and Malnutrition

Dysphagia or problems with swallowing, is "an underrecognized, poorly diagnosed, and poorly managed health problem" that negatively affects the quality and potentially quantity of life

Interventions and Strategies for Care

- Actual treatment of the dysphagia depends on the specific diagnosis and the level of dysfunction. Restoration of swallowing has been attempted using a variety of strategies ranging from electrical stimulation to thermal stimulation, muscle exercises, and even black pepper oil—all with varying success at restoring muscular function and normal swallowing.
- Nursing interventions to manage dysphagia in order to minimize the risk of aspiration and promote nutrition and hydration involve compensatory eating techniques, diet modification, and oral care and may require adaptive equipment.

Laboratory Studies Associated with Poor Nutrition

- Serum albumin < 3.5 g/dL
- Serum prealbumin < 11 mg/dL
- Cholesterol < 150 mg/dL
- Leptin < 4.0 mcg/L in men, < 6.48 mcg/L in women

The U.S. Department Health and Human Services (DHHS) and the U.S. Department of Agriculture (USDA) compile recommendations and publish updated dietary guidelines every 5 years. The guidelines published January 11, 2016 (Dietary Guidelines, 2016), fit into the following broad categories:

- Maintain a healthy diet throughout your life
- Eat a variety of nutrient-dense foods, and manage portion sizes
- Limit caloric intake from added sugars and saturated fats, and reduce intake of sodium
- Shift current food and drink choices to healthier alternatives
- Support others in healthy eating

Chapter 18- Pressure Ulcers

Clinical Tip- Pressure ulcers result in pain, serious infections, death, and in increased healthcare utilization and costs.

The most **common sites for pressure ulcers** to occur are the coccyx, sacrum, ischial tuberosity, trochanter, and the calcaneus.

Braden Scale for Pressure Ulcer Risk Assessment is the most widely used instrument that determines risk of pressure ulcer development.

- The scale assesses **sensory perception, skin moisture, activity, mobility, nutrition, and friction/shear**. Each area is scored on a scale of 1 to 3 or 4, with a possible total score of 23 points—the lower the Braden score, the higher the risk of pressure ulcer development
- A Braden score of 16 or less indicates a high risk of pressure ulcer development in the general population, whereas a score of 18 or less is indicative of high risk in older adults or persons with darkly pigmented skin.

Subset scores of 2 or less in any one category also places one in a high-risk category even if the patient has an overall score greater than 16

Exudate Amount: Estimate the amount of exudate (drainage) present after removal of the dressing and before applying any topical agent to the ulcer. Estimate the exudate (drainage) as none, light, moderate, or heavy.

Tissue Type: This refers to the types of tissue present in the wound (ulcer) bed. Score as a 4 if there is any necrotic tissue present. Score as a 3 if there is any amount of slough present and necrotic tissue is absent. Score as a 2 if the wound is clean and contains granulation tissue. A superficial wound that is reepithelializing is scored as a 1. When the wound is closed, score as a 0.

4—Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges and may be either firmer or softer than surrounding skin.

3—Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous.

2—Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance.

1—Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface.

0—Closed/resurfaced: The wound is completely covered with epithelium (new skin).

Chapter 14- anxiety and Depression in the Older Adult

Risk Factors for Developing Anxiety

- Family history of anxiety disorders
- Female gender
- Perimenopause (due to hormonal changes)
- Increased frailty
- History of falls
- Acute or chronic illness
- Chronic pain
- Loss of family members, friends, independence, or home (including being moved to another residence such as a nursing home)
- Lack of social supports
- Recent traumatic event
- Poor self-rated health
- Concurrent diagnosis of depression, dementia, bipolar disorder, or schizoaffective disorder
- Certain medications

Nursing Care for the Patient Experiencing Anxiety

- Decrease environmental stimuli, Stay with the patient
- Make no demands and do not ask the patient to make major decisions
- Support current coping mechanisms (crying, talking, etc.)
- Do not confront or argue with the patient
- Speak slowly in a soft, calm voice (enunciate clearly)
- Avoid reciprocal anxiety (emotions can be contagious, and sensing anxiety in the nurse can worsen the patient's anxiety)
- Reassure the patient you will help develop a solution to managing the problem
- Reorient the patient to reality (unless this causes more anxiety)
- Respect the patient's personal space

Depression

Common causes of depression include the following:

- Decline in health or new onset of illness
- Exposure to multiple medications and their associated side effects, as well as drug–drug interactions, can cause elders to feel physically and mentally "down"
- Having outlived spouses, loved ones, and friends
- Having to move from private homes to assisted living or long-term care because of decreasing ability to live independently

Symptoms that are indicative of depression include the following (APA, 2013):

- No interest or pleasure in enjoyable activities
- No interest in sexual activities
- Feeling sad or numb
- Crying easily or for no reason
- Feeling slowed down
- Feeling worthless or guilty
- Change in appetite; unintended change in weight
- Trouble recalling things, concentrating, or making decisions
- Problems sleeping, or wanting to sleep all of the time
- Feeling tired all of the time
- Thoughts about death or suicide

Nursing Interventions

As part of developing an optimal plan of care, nurses are responsible for completing assessments for evidence of depression in all older adults in their care, making sure that other somatic conditions have been ruled out, and developing strategies to optimize function, independence, and promote psychological health.

- Providing a nonjudgmental atmosphere
- Instituting safety precautions for suicide risk for any patient who presents with severe symptoms or expresses suicidal ideation
- Monitoring and promoting nutrition, elimination, sleep/rest patterns, and physical comfort (especially pain control)
- Maintaining and/or enhancing physical function
- Structuring regular exercise/activity
- Considering referral to physical, occupational, and/or recreational therapies when necessary
- Encouraging the older patient to develop a daily routine/activity schedule

Risk Factors for Suicide

- Over age 65 years of age
- Male
- Painful or disabling illness
- Living alone
- Perceived or real perception of inability to afford living expenses, medications, or other healthcare costs; debt or poverty
- Bereavement or loss
- Humiliation or disgrace
- Depression, especially when accompanied by psychosis or anxiety
- Persistent sadness even when other symptoms of depression are lessening

- A history of drug or alcohol abuse
- A history of prior suicide attempts
- A history of suicide in family members
- Traumatic childhood experiences, including physical or sexual abuse
- Preoccupation with and talk about suicide
- Well-defined plans for suicide

Chapter 22- Culture and Spirituality

- **European Americans** value the healthcare system and tend to rely on science to explain health and illness.
    - generally do not have as close ties to their extended families as other cultural groups within the United States
    - tend to be individualistic when it comes to health care, often presenting a stoic attitude about illness, so as not to "be a burden" on others
    - accepting of the paternalistic nature of the healthcare system, are generally more trusting of authority, and therefore tend to follow the advice of healthcare providers to engage in more physical and mental activity than other cultural groups
- **African Americans** tend not to want to put their older relatives in nursing homes, rather choosing to care for them at home.
    - role of religion and spirituality plays an important part in the African American health and wellness belief system
    - equate good luck, good fortune, and good health with "being right with God."
    - tend to rely on their close family ties or close neighbors when in need of support rather than turning inward, as with other cultural groups.
    - coping strategies for chronic health conditions: dealing with it, engaging in life, exercising, seeking information, relying on God, changing dietary patterns, medicating, self-monitoring, and self-advocacy
- **Hispanic Americans** often use folk remedies before traditional Western medicine.
    - **emphasize family interdependence over independence.**
    - self-care is not as important as receiving care in recovery from illness.
    - first seek the use of homeopathic remedies in conjunction with religious artifacts before engaging a healthcare professional
- There are many subgroups of **Asian Americans,** each with a unique set of cultural norms.
    - Chinese cultural beliefs are influenced by forms of Buddhism, Confucianism, and Taoism, but it should be noted that many persons in China do not claim any religion or say that they are atheists.
    - Principle of Ren is considered the golden rule of Chinese decision making, and is embodied in Confucius's axiom, "Do not do to others what you do not want done to yourself"
- **Native Americans** often have a closed, close-knit community. Nurses working with Native American groups will need to earn their trust. The help of a key informant (or key person within the tribe) is often required.
    - follow a naturalistic approach to health and illness, believing that health is a balance of the mind, body, and spirit, and illness occurs when there is an imbalance or disharmony with nature

culturally competent- is to learn about different cultural and religious preferences, customs, and restrictions and then use this knowledge in planning and providing care. The following are essential in order to provide culturally competent, evidence-based care for older adults, otherwise known as **ethnogeriatrics**

- Awareness of one's personal biases through critical self-reflection
- Understanding of:
    - Culturally diverse health-related values, beliefs, and behaviors
    - Disease incidence, prevalence, or mortality rates
    - Population-specific treatment outcomes

    - Individuals, families, communities, and populations for whom they care
- Skills in working with culturally diverse populations

Other tools for cultural assessment have been developed by various authors. Berlin and Fowkes (1982) using the mnemonic, **LEARN**:

- Listen
- Explain
- Acknowledge
- Recommend
- Negotiate

Levin, Like, and Gottlieb (2000) used the word **ETHNIC** to cue cultural assessment of:

- Explanation
- Treatment
- Healers
- Negotiate
- Intervention
- Collaboration

Risk Factors for Osteoporosis

- **Age, low BMI, and failure to use estrogen replacement are the strongest risk factors for osteoporosis development**
- Personal history of fracture after age 50
- Current low bone mass
- History of fracture in a first-degree relative
- Being female
- Being thin and/or having a small frame
- Advanced age
- A family history of osteoporosis
- Estrogen deficiency as a result of menopause, especially early or surgically induced
- Abnormal absence of menstrual periods (amenorrhea)
- Anorexia nervosa
- Low lifetime calcium intake
- Vitamin D deficiency
- Use of certain medications, such as corticosteroids and anticonvulsants
- Presence of certain chronic medical conditions
- Low testosterone levels in men
- An inactive lifestyle
- Current cigarette smoking
- Excessive use of alcohol
- Being White or Asian, although African Americans and Hispanic Americans are at significant risk as well

Interventions- eating a well-balanced diet with plenty of calcium and vitamin D, no smoking or excessive alcohol intake, plenty of weight-bearing exercise, and discussing any needed treatments with the physician to minimize the risk of the disease.

Chapter 25- Pain Management and Alternative Health Modalities

Potential Consequences of Persistent Pain in the Elderly

- Poorer quality of life

- Worse self-reported health
- Functional impairment
- Falls
- Depression
- Decreased appetite
- Impaired sleep
- Social isolation
- Limitation or inability to perform activities of daily living

Nociceptive pain- Caused by tissue injury. Responds to traditional pain interventions, such as analgesics, and nonpharmacological methods

- **Somatic pain-** Originates in the muscles, joints, connective tissues, and bones and usually manifests as dull, throbbing, or aching. Include arthritis (bone and joint), and myofascial (muscle) pain.
- **Visceral pain-** Originates in the internal organs and may manifest as a squeezing or deep ache. Includes pain from gallstones, appendicitis, and pancreatitis

Urinary Incontinence

Elderly persons who experience UI often suffer from physical and psychological distress.

negative physical outcomes: dermatitis and possible skin ulceration, disruption of sleep patterns, UTIs and falls, which can lead to fractures

psychological issues: feelings of loss of control, dependency, shame and guilt, social isolation, avoidance of activities, anxiety, impaired self-esteem, and depression

A bladder diary is one of the essentials tools of assessment of urinary incontinence.

Model	Model Description
Beveridge model	Designed by National Health Service creator Lord William Beveridge, the Beveridge model provides healthcare for all citizens and is financed by the government through tax payments. This "socialized medicine" model is currently found in Great Britain, Spain, and New Zealand.
Bismarck model	The Bismarck model uses an insurance system and is usually financed jointly by employers and employees through payroll deduction. Unlike the U.S. insurance industry, Bismarck-type health insurance plans do not make a profit and must include all citizens. Doctors and hospitals tend to be private in Bismarck countries. This model is found in Germany, France, Belgium, the Netherlands, Switzerland, and Japan.
National Health Insurance model	The National Health Insurance model has elements of both the Beveridge and Bismarck models. It uses private-sector providers, but payment comes from a government-run insurance program that all citizens fund through a premium or tax. These universal insurance programs tend to be less expensive and have lower administrative costs than American for-profit insurance plans. National Health Insurance plans also control costs by limiting the medical services they pay for and/or requiring patients to wait to be treated. The classic National Health Insurance system can be found in Canada.
Out-of-pocket model	The out-of-pocket model is what is found in the majority of the world. It is used in countries that are challenged to provide any kind of national healthcare system. In these countries, those that have money and can pay for healthcare get it, while others may suffer a lack of care. In rural regions of Africa, India, China, and South America,

hundreds of millions of people go their whole lives without ever seeing a doctor.

Chapter 28- Care Transitions, System Models, and Health Policy in Aging

Acute inpatient rehabilitation ("acute rehab" is most appropriate for those who may benefit from an interprofessional approach to care and are able to tolerate at least 3 hours of therapy per day.

Transitional or progressive care is a broad term that encompasses a variety of skilled nursing services, including subacute, skilled, and some rehabilitative care services.

- Transitional care bridges the gap for patients with complex or multiple problems who are not stable enough to return to a home setting, but not sick enough to require long-term nursing care.
    - general debility, wound care, gait training, and intravenous therapy

Long-term acute care hospitals (LTACHs)-provide long-term intensive acute care, such as for patients on a ventilator, often within an acute care hospital setting on a designated floor or wing.

Home health care is designed for those who are homebound due to severity of illness or immobility.

- variety of nursing needs, such as wound care, intravenous therapy, management of newly diagnosed diabetes, tube feedings, and skilled assessment for exacerbation of a chronic illness.

The Long Term Care industry includes nursing homes, for both custodial and skilled care, assisted living homes, and independent living homes.

Care coordination is often done by gerontological nurses who work with older adults as coaches to help encourage self-care.

- encourages active patient participation, promotes healthy lifestyle choices, and facilitates better self-management. The focus is on improving continuity of care across settings, promoting the use of effective preventive and community services, increasing accessibility to healthcare providers, and improving communication among the providers and the patient and family

Transitional Care Models and Programs

Transitional care focuses on transitions or movements between facilities for the elderly and chronically ill. The **goal of transitional care** is to provide patients with a seamless transition that does not result in duplication of services or fragmented care

- **emphasize self-care**

The majority of transitional care interventions focus on the transition from acute care hospital to home **(BOOST, Care Transitions Program, Transitional Care Model)**

Other models focus on **in-home assessments (GRACE)** and additional models focus on **LTC (INTERACT**).

Interventions to Reduce Acute Care Transfers (INTERACT) is a quality improvement program aimed at reducing hospital admissions of nursing home residents;

- it was initially developed in a project supported by the CMS. Evidence supports that implementing INTERACT interventions has decreased hospitalizations from nursing homes

Geriatric Resource for Assessment and Care of Elders (GRACE) uses a geriatric IDT, including an APN and social worker in collaboration with a PCP and geriatrician.

- The team develops a plan of care and (with the PCP) modifies the plan if needed. The support team then meets with the patient to review and implement the plan of care.
- The team conducts an in-home assessment of the older adult and works with a geriatric IDT, using care protocols to evaluate and follow common geriatric conditions.

All models focus on the priority of reducing preventable hospital readmission and potentially avoidable hospitalizations, thus saving money while maintaining quality of life.

The Better Outcomes for Older Adults through Safe Transitions (BOOST) intervention that includes predischarge and postdischarge interventions to

- reduce 30-day hospital readmission rates for older adults
- (2) improve patient satisfaction
- (3) identify high-risk patients to prevent adverse events
- (4) improve communication between providers and patients, and (5) better prepare the patient and family for discharge (**Society of Hospital Medicine, 2016)**
- **Strength of the education and communication tools**
- **Provides tools to support nurses in improving care transitions**

Care Transitions Intervention (CTI) Developed by Eric Coleman is a patient-centered **4-week intervention program** designed to improve quality of care and contain costs for patients with complex care needs as they transition across care settings. It is based on four pillars:

- assistance with self-management of medications,
- (2) a patient-centered medical record that is kept by the patient,
- (3) timely follow-up with primary physician or specialist
- (4) a list of signs and symptoms that could indicate worsening of the condition
- One of the main features of this model is the use of a Transitions Coach (an advanced practice nurse [APN], RN, social worker, occupational therapist, or other professional or paraprofessional) who follows the patient before and after discharge from the hospital and for follow-up
- The coach's role encourages self-management and reinforces important aspects of care, including improved patient–physician communication, offering strategies on how to respond to changes in health or important concerns, and engaging patients in medication reconciliation. Coaches make one home visit after discharge and follow up with phone calls. Outcomes from the use of this model indicate a decrease in hospital readmissions and an increase in patient's self-identified goals regarding symptom management

The Transitional Care Model (TCM)) **(NAYOR)**is a nurse-led model that follows the patient from hospital to home. The nurse acts as the main care manager, who consults with the patient in hospital, at home within 24 hours of discharge, accompanies the patient to postdischarge follow-up visits, and provides weekly home visits and ongoing telephone support for an average of 2 months. The emphasis of TCM is care coordination and continuity of care.

Key components of this program include

- continuity of care at hospital discharge
- focus on individual and caregiver understanding (including early symptom recognition),
- management of chronic health issues and prevention of decline
- medication management. Specific research-based nursing protocols were developed to assist the nurse.

This model includes a patient-centered intervention to improve quality of life, improve patient satisfaction, and reduce readmissions.

Guided Care- Chad Boult, MD improve the health care of older adults with multiple comorbidities by providing comprehensive health care by a nurse–physician team.

Is based in a **primary care office and uses RNs trained** in Guided Care principles to coordinate cost-effective care. The Guided Care nurse curriculum includes training in areas such as transitional care, motivational interviewing, evidence-based guidelines for managing chronic conditions, health insurance coverage, and working with physicians, family caregivers, and community resources Services. Each Patient Receives from the Guided Care Nurse

- An in-depth assessment at patient's home
- Individualized care guide
- Proactive monitoring with phone contacts
- Coaching on self-management
- Referral to a chronic disease self-management course
- Education of caregivers
- Coordination of transitions between providers and sites of care
- Facilitation of access to community resources

Risk in Care Transitions- This risk is higher in older adults who may have several chronic diseases, cognitive dysfunction, sensory impairment, and functional decline that coexist with acute and chronic illnesses.

Clinical Tip- Transitions in settings of care are vulnerable exchange points for older adults. Nurses must pay particular attention during times of care transitions in order to promote quality outcomes for elderly patients.

Key factors that lead to poor outcomes in the transition of care across the continuum

- inadequate education to patients and their families about care management
- poor communication between patients and care providers
- inadequate assessment at point of care
- medication discrepancies
- lack of follow-up care
- health literacy issues
- lack of support systems
- cultural barriers.

Basic Information to Be Included in a Transfer

- Detailed assessment
- Treatments
- Wounds
- Current medications
- Allergies
- Level of independence
- Recent diagnostic testing
- Primary care practitioner notification upon discharge and admission to the receiving facility

Quality in Health Care

Healthcare systems that collaborate, coordinate care, communicate, and anticipate patients' needs are essential to ensuring quality nursing care that is "**safe, effective, patient-centered, timely, efficient, and equitable"**

Institute of Medicine (IOM) Aims for Improvement

- **Safe:** Avoiding injuries to patients from the care that is intended to help them.
- **Effective:** Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- **Patient centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

The IOM provides evidence for informed healthcare decision making to those in both government and the private sector. The IOM is a division of the National Academies of Sciences, Engineering, and Medicine.

Healthy People 2020 strives to:

- Identify nationwide health improvement priorities
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress
- Provide measurable objectives and goals that are applicable at the national, state, and local levels
- Engage multiple sectors to take action to strengthen policies and improve practices that are driven by the best available evidence and knowledge
- Identify critical research, evaluation, and data collection needs

A new goal in Healthy People 2020 involves improving the health and well-being of older adults. Emerging issues for improving the health of older adults include efforts to:

- Coordinate care
- Help older adults manage their own care
- Establish quality measures
- Identify minimum levels of training for people who care for older adults
- Research and analyze appropriate training to equip providers with the tools they need to meet the needs of older adults

Falls are the most reported incident in acute care hospitals.

Program Elements	Program Elements Description
Comprehensive Discharge Planning	Prior to discharge, hospital staff organizes follow-up services and address patients' financial and psychosocial barriers to receiving needed care, drawing on community resources as needed. Hospital staff call patients one to three days after discharge to address patients' questions, assess symptoms and medications, and reinforce patient/caregiver education. Discharge planning can be conducted by physicians, care managers, nurses, or pharmacists.
Complete and Timely Communication of Information	Clinicians in the hospital send discharge summaries to outpatient providers one to two days after discharge, using standardized formats. Essential information includes diagnoses, test and procedure results, pending tests, medication lists, rationale for medication changes, advance directives, caregiver status, contact information for the discharging physician, and recommended follow-up care.
Medication Reconciliaton	Clinicians reconcile medications at each transition (for example, to inpatient, outpatient, or post-acute care). Clinicians check the accuracy of medication lists and dosages and look for contraindications. Clinicians also assess financial barriers to filling prescriptions and provide medication lists to outpatient providers. Medications can be reconciled by physicians, pharmacists, nurses, or care managers.
Patient/Caregiver Education using the "Teach Back" Method	In this method, patients are asked to restate instructions or concepts in their own words. Education can be supplemented by illustrations and written materials at appropriate reading levels. Education focuses on major

	diagnoses, medication changes, time of follow-up appointments, self-care, warning signs, and what to do if problems arise. Physicians, nurses, care managers, or discharge planners provide education before and after discharge.
Open Communication between Providers	Communication occurs between care settings and among multidisciplinary teams within each setting. Responsibilities are clearly defined for the discharging provider and the subsequent provider. The discharging provider confirms that the subsequent provider received the discharge summary and pertinent test results and responds to questions promptly. Information transfer involves physicians, nurses, care managers, office personnel, and information technology staff.
Prompt Follow-up Visit with an Outpatient Provider after Discharge	Hospital staff schedule follow-up visits prior to discharge. Such visits are generally recommended within seven days of discharge. Providers offer follow-up care, ongoing symptom and medication management, and 24/7 phone access. Physicians, nurses, pharmacists, and/or care managers follow up with patients during office visits, home visits, or by phone.

Chapter 21: Technology and Care of the Older Adults

The use of assistive devices may enable **independent performance, increase safety, reduce risk of injury, improve balance and mobility, improve communication, and limit complications of an illness or disability.**

- **“low tech” (e.g., pencil grips, splints, paper stabilizers)**
- **“high tech” (e.g., computers, voice synthesizers, Braille readers)**

Guidelines for Introducing Technology and Teaching the Elderly about Its Use

- The use of technology must be perceived as needed and meaningful, and must be linked to the lifestyle of the person.
- Cautions and disbelief in one’s capability may be an obstacle in accepting new technology and must be considered when creating the learning environment.
- A generous amount of time, as well as repeated short training sessions, should be allowed
- More stress should be placed on the practical application of the device than on its technical features.
- Only selective, central facts should be presented.
- Mnemonics and cues will favorably affect self-efficacy in handling new products.
- Training sessions should be held in the home or natural meeting places of the elderly.
- The instructor should be well known by the elderly or introduced well in advance of the training.
- The attitudes of the instructors toward the aged must be positive and realistic

Common Applications of Assistive Technology

The following are common applications for AT:

- position and mobility
- environmental access and control
- self-care
- sensory impairment
- cognitive impairment
- social interaction and recreation
- computer-related technology

Augmentative and alternative communication (AAC) refers to all forms of communication that enhance or supplement speech and writing, either temporarily or permanently.

- AAC can both enhance (augmentative) and replace (alternative) conventional forms of expression for people who cannot communicate through speech, writing, or gestures.
- AAC devices offer dynamic displays (i.e., electronic displays that change with user input) and synthesized (computer-generated) and digitalized (recorded) speech, and are accessible through many input modalities, including touch screen, keyboard, and infrared headpointers
- **The goal of AAC** is to encourage and support the development of communicative competence so people can participate as fully as possible in home and community environments, and improve the efficiency and use of communication aids.

Hearing impairments can interfere with an older adult's speaking, reading, and ability to follow directions. Assistive devices to help with hearing and auditory processing problems include hearing aids, personal FM units, Phonic Ear devices, or closed caption TV.

Vision is also a major learning mode. General methods for assisting with vision problems include increasing contrast, utilizing stronger stimuli, and making use of tactile and auditory assistive devices. Devices that assist with vision include screen readers, screen enlargers, magnifiers, large-type books, taped books, Braillers, light boxes, high-contrast materials, and scanners.

Nursing Informatics

Nursing informatics is a 21st-century science with great potential for improving the quality, safety, and efficiency of health care.

- **Kathryn Hannah-** nursing informatics encompasses the use of information technologies in relation to any functions that are within the sphere of nursing and that are carried out by nurses in the performance of their practice
- **Graves and Corcoran (1989**) -nursing informatics is a combination of computer science, information science, and nursing science, designed to assist in the management and processing of nursing data, information, and knowledge to support the practice of nursing and the delivery of nursing care
- **ANA** more recently defined nursing informatics as "a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, and knowledge in nursing practice . . . to support patients, nurses, and other providers in their decision-making . . . using information structures, information processes and information technology"

Assistive Device Category	**Assistive Device Description**
Adaptive Switches	Modified switches that seniors can use to adjust air conditioners, computers, telephone answering machines, power wheelchairs, and other types of equipment. These switches might be activated by the tongue or the voice.
Communication Equipment	Anything that enables a person to send and receive messages, like a telephone amplifier.
Computer Access	Special software that helps a senior access the internet, for example, or basic hardware, like a modified keyboard or mouse, that makes the computer more user friendly.
Education	Audio books or Braille writing tools for the blind come under this category, along with resources that allow people to get additional vocational training.
Home Modifications	Construction or remodeling work, like building a ramp for wheelchair access, that allows a senior to overcome physical barriers and live more comfortably with a disability or recover from an accident or injury.
Tools for	Anything that empowers the elderly to enjoy the normal activities of daily living

Independent Living	without assistance from others, like a handicapped-accessible bathroom with grab bars in the bathtub.
Job-related Items	Any device or process that a person needs to do his or her job better or easier. Examples might include a special type of chair or pillow for someone who works at a desk, or a back brace for someone who does physical labor.
Mobility Aids	Any piece of equipment that helps a senior get around more easily, like a power wheelchair, wheelchair lift, or stair elevator.
Orthotic or Prosthetic Equipment	A device that compensates for a missing or disabled body part. This could range from orthopedic shoe inserts for someone who has fallen arches to an artificial arm for someone whose limb has been amputated.
Recreational Assistance	New methods and tools enable people who have disabilities to enjoy a wide range of fun activities. Examples include swimming lessons provided by recreational therapists or specially equipped skis for seniors who have lost a limb as a result of accident or illness.
Seating Aids	Any modifications to regular chairs, wheelchairs, or motor scooters that help a person stay upright or get up and down unaided or that help to reduce pressure on the skin. This could be something as simple as an extra pillow or as complex as a motorized seat.
Sensory Enhancements	Anything that makes it easier for those who are partially or fully blind or deaf to better appreciate the world around them. For instance, a closed caption decoder for a TV set would be an assistive device for a senior who is hard of hearing.
Therapy	Equipment or processes that help someone recover as much as possible from an illness or injury. Therapy might involve a combination of services and technology, like having a physical therapist use a special massage unit to restore a wider range of motion to stiff muscles.
Transportation Assistance	Devices for elderly individuals that make it easier for them to get into and out of their cars or trucks and drive more safely, like adjustable mirrors, seats, and steering wheels. Services that help the elderly maintain and register their vehicles, like a drive-up window at the Department of Motor Vehicles, would also fall into this category.

Triple Aim

The Institute for Healthcare Improvement developed the Triple Aim framework that describes an approach to optimizing health system performance. The Triple Aim framework is dedicated to improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care. The Institute for Healthcare Improvement recommends a change process that includes:

- Identification of target populations.
- Definition of system aims and measures.
- Development of a portfolio of project work that is sufficiently strong to move system-level results.
- Rapid testing and scale up that is adapted to local needs and conditions.

Chapter 27- End of Life

The SUPPORT study (the Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment) conducted between 1989 and 1994 reported that nurses often were the first to recognize the impending death of a patient.

The focus of care at end of life should center on living with terminal illness—with medical care, support, and interventions geared toward quality of life and comfort, rather than on prolonging suffering or the dying process—if that is what the patient wants.

Families and patients look to the nurse for support, education, and guidance at this difficult time, yet little education is provided to prepare nurses for this unique type of care

EPEC Project Module 2 presents a 6-step approach to communicating bad news as well as ELNEC

- Get started: Plan what to say, confirm medical facts, create a conducive environment, determine who else the patient would like present, and allocate adequate time.
- Find out what the patient knows: Assess his or her ability to comprehend bad news.
- Find out how much the patient wants to know: Recognize and support patient preference to decline information and to designate someone else to communicate on his or her behalf; accommodate cultural, religious, and socioeconomic influences.
- Share information: Say it, then stop. Pause frequently, check for understanding, and use silence and body language; avoid vagueness, jargon, and euphemisms.
- Respond to feelings: Expect affective, cognitive, and fight–flight responses; be prepared for strong emotions and a broad range of reactions. Give time to react; listen, and encourage description of feelings. Use nonverbal communication of touch and eye contact.
- Plan/follow-up: Provide additional tests, symptom treatment, and referrals as needed. Discuss potential sources of support; assess the safety of the patient and home supports before he or she leaves. Repeat the news at future visits.

Advance Directives

The Patient Self-Determination Act (PSDA), a federal law, requires healthcare providers to routinely provide information about advance directives

Five Wishes

- The person chosen to make decisions when the individual can no longer make them for himself or herself—a durable power of attorney for health care
- The kind of treatment the person wants or does not want—a living will
- How comfortable the person wants to be
- How the person wants to be treated by others
- What the person wants his or her loved ones to know

allow natural death (AND)- considered a more descriptive and more positive order than a DNR. Its focus is on **allowing death as nature** takes its course at the end of an illness.

Do not resuscitate (DNR) implies taking something away, or not doing something for the patient (i.e., resuscitation), and can be viewed as **a harsh and insensitive statement** of medical care that promotes a feeling of abandonment by patients and families alike.

POLST paradigm differs from an advance directive in that it is designed to instruct emergency personnel on what actions to take while the patient is still at home—before emergency treatment is given.

- segments concerning cardiopulmonary resuscitation (CPR), medical interventions, antibiotics, and artificially administered nutrition

- was developed for seriously ill persons receiving treatments that were inconsistent with their stated wishes and designed to honor the person's end-of-life treatment preferences even when transferred from one care setting to another
- Although not recognized in every state, promotion of the paradigm is becoming more prevalent as its value is more widely demonstrated. It is a doctor's order, once signed by the physician.

Hospice care is generally for those with 6 months or less until end of life, while palliative care may be covered for those with life-limiting illnesses that may be two years or thereabouts from end of life.

- dying as part of the normal process of living and focuses on maintaining the quality of remaining life
- provide comfort and dignity at end of life. Eligibility for hospice services is based on a life expectancy of 6 months or less, if an illness runs its normal course.
- address the physical, emotional, social, and spiritual needs of the patient and family

Palliative care refers to the comprehensive management of the physical, psychological, social, spiritual, and existential needs of patients. It is especially suited to the care of people with incurable, progressive illnesses

- best possible quality of life for patients and their families.
- Control of pain, other symptoms, and psychological, social, and spiritual problems is paramount
- been found to not only promote improved quality of life, but to prolong life itself.
- It assists increasing numbers of people who experience chronic, debilitating, and life-limiting illnesses and can be practiced in a variety of settings, including hospitals, outpatient settings, community home health programs, and hospices

According to the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation and Standards, hospice services include, but are not limited to:

- Nursing services and coordination of care
- Physical therapy, occupational therapy, or speech–language pathology service
- Medical social services
- Home health aide and homemaker services
- Physician services/medical director
- Counseling services (including dietary, pastoral, bereavement, and other) relative to the terminally ill individual and adjustment to his or her death
- Short-term in-patient care
- Medical appliances and supplies
- Medications and biologicals

The **interdisciplinary group or team (IDG/IDT)** provides or supervises the care and services offered by the hospice, including ongoing assessment of each of the patient, caregiver, family's needs. Its members consist of:

- Doctor of medicine or osteopathy
- Registered nurse—coordinates the plan of care for each patient
- Social worker
- Pastoral or other counselor
- Other team members who also are required include:
- Volunteers with training appropriate to their tasks—must contribute at least 5% of all staff hours
- Clergy/spiritual support and counseling
- Additional counseling (dietary, bereavement)

symptom management- nurse's primary responsibilities to coordinate the patient's care and to assist

Complementary therapies are not required but are often provided to enhance the patient and family care with services such as massage, healing touch, music therapy, pet therapy, and others.

Grief is the natural and normal response to loss of any kind and is experienced psychologically, behaviorally, socially, and physically

Mourning is the cultural and/or public display of grief through one's behaviors.

Wolfelt- six needs of mourning:

- Acknowledge/accept the reality of the death
- Embrace the pain of the loss
- Remember the person who died
- Develop a new self-identity
- Search for meaning
- Receive support from others

Components of Peaceful Dying

- Instilling good memories
- Uniting with family and medical staff
- Avoiding suffering, with relief of pain and other symptoms
- Maintaining alertness, control, privacy, dignity, and support
- Becoming spiritually ready
- Saying goodbye
- Dying quiet

good death is possible and can be facilitated by the nurse who advocates for and works to ensure that the patients, families, and caregivers are free from avoidable distress and suffering, that the process is in accord with the wishes of the patient and family, and that it is consistent with clinical, cultural, and ethical standards

In pronouncing the death, it is customary to identify the patient and note the following:

- General appearance of the body
- Lack of reaction to verbal or tactile stimulation
- Lack of pupillary light reflex (pupils fixed and dilated)
- Absent breathing and lung sounds
- Absent carotid and apical pulses (in some situations, listening for an apical pulse for a full minute is advisable)

Physical Care of the Body

- Careful and gentle handling of the body communicates care and concern on the part of the nurse.
- The nurse should allow the family to spend time with the body if desired.
- Rituals and customs should have been identified before the death, to now be incorporated into this care, reflecting the patient and family wishes.
- Nursing care also includes the removal of drains, tubes, intravenous lines, and any other devices.
- Family members should be allowed to touch the body if they so desire and are comfortable with this action.

Ten Self-Care Tips for the Nurse Caring for Patients at End of Life

- Become educated—knowledge is power! Develop expertise in symptom management. It lessens anxiety in working with patients and their families.
- Maintain professional boundaries and relationships with patients and families.
- Utilize the other palliative care or hospice team members. Each has a perspective and expertise to add to the case. The nurse does not have to do it all.
- Develop an interdisciplinary care team in your palliative or end-of-life care setting or facility.
- Utilize all facility staff/team members in their respective roles.
- Find and maintain balance in your personal life.
- Locate and use appropriate support persons for debriefing during and after a difficult case.
- Allow yourself and all team members to grieve the death of your patient.
- Include the other members of the team (including CNAs, housekeeping, and other staff who knew the patient) in rituals or memorial activities following the death of your patient.

- Practice good self-care in your personal and professional life. Eat, sleep, play, laugh, cry (. . . enough!!), . . . and wear comfortable shoes.

Informed consent- person clearly understands the choice offered

Decisional- if patient demonstrates satisfactory response in all 4 areas

- Ability understand relevant information
- Ability to appreciate current situation
- Ability to reason or manipulate information rationally
- Ability to communicate a choice

Competence- mental clarity and appropriateness for decisions making must be present to exercise. Autonomy and their right to decide, right to choose, right to informed, right to refused treatment

Autonomy- each person has a right to make independent choices and decisions

Self determination- patients right that is the right to decide

Veracity- truthfulness- telling the truth

Fidelity- being faithful and loyal

Beneficence- duty to do good

Nonmalfience- Do NO harm

Random Things to Know

- Know passive and active enthanasia
- Senile Kyphosis
- Atrophy of sweat glands, what happens
- Respite care
- Know what is Quality of Life
- Orthropenic postion
- Types of assistive devices